KPMG

FSC FINANCIAL SERVICES COUNCIL

The impact of Psychosocial factors on Mental Health and their implications in Life Insurance

Research Paper

October 2019

Foreword

Frank Quinlan
Mental Health Australia

Many of us have experience of a mental health illness, whether it be our own personal experience or that of caring for a family member, friend or colleague. We know that one in five Australians are affected by mental illness annually, yet many don't seek help because of stigma. At a time when people are vulnerable, we want them to be able to access the support they need without the stigma that has caused so much discrimination in the past. Stigma which only makes recovery harder. And stigma that is often perpetuated by ignorance.

As such, Mental Health Australia sees this important work as crucial to developing the evidence base. This research paper makes a valuable contribution to the work of the life insurance industry to better understand psychosocial factors and their subsequent impact on wellbeing and mental health of people. It also provides the research evidence on some of the predictors and protective factors associated with mental illness.

There remains much that needs to be done to make real and lasting change to address the many challenges that confront people who are affected by mental illness, and the stigma associated with mental illness. This paper is a step in the right direction to better inform an industry facing increasing scrutiny about its practices, while at the same time seeing an increase in the numbers of people who are making mental health related claims.

I trust its findings will generate new ideas and discussion with a view to a future industry that is more inclusive of people affected by mental illness.

Introduction

Sally Loane
Financial Services Council

I am delighted to be publishing this research that explores the vital work that could be done to treat people suffering from mental ill-health. Almost one in two people will suffer from a mood, anxiety or substance use disorder some time in their lives[1] - so the importance of mental health is paramount.

The FSC and its life insurance members started meeting with representatives from the mental health industry twice a year in March 2017, establishing the Mental Health and Life Insurance Roundtable to identify mental health issues critical to our life insurance members. The Roundtable members continue to collaboratively discuss issues of mutual concern, with a view to resolving them together. This BPS research was borne out of that engagement. As a sign of our members' commitment to mental health issues, two further research papers have been planned.

Additionally, larger life insurance companies have engaged dedicated staff members who consider mental health issues full time. Last calendar year FSC member life insurance companies paid $750 million in claims relating to mental health.

The life insurance industry's role in the economy cannot be understated. The Productivity Commission recently found that income protection insurance can provide a substantial benefit to Government budgets over the long term[2]. Income protection provides a solid safety net to the Disability Support Scheme and workers compensation payments.

The research in this paper confirms what we suspected: it is more than nature contributing to the onset of mental illness; and it is more than pharmaceuticals that drive recovery.

An individual's support networks, personal environment and personal resilience all contribute to their journey towards recovery. We now need to focus on how life insurers can more effectively use this research to support people suffering from mental ill-health[3].

As the research reveals, the health benefits of returning to and maintaining "good work" (not just any work) are significant. The FSC's members strongly support people returning to work when a medical professional informs them that they are fit to do so.

Our life insurance members are also eager to pay for rehabilitation to support people in the early stages of illness. One example of how insurers may assist is by paying for additional counselling sessions after a patient has had his/her ten reimbursable (under Medicare) visits. Unfortunately, the current law does not allow life insurers to make such payments. We are working hard with the mental health community to remove this barrier.

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[1] OECD, 2012, cited in Productivity Commission, 2019
[2] FSC's Life Insurance Industry Data Collection, 2018 – 2021, managed by KPMG
[3] Productivity Commission (2018) Fiscal impacts of insurance in superannuation, Technical Supplement 9 to the Inquiry Report Superannuation: Assessing Efficiency and Competitiveness.

Hoa Bui
KPMG Australia

Mental illness is the second highest cause of disability claims for Life Insurers in Australia, behind accident. It accounts for 24 % of TPD claims paid and 20% of disability income claims across Group and Retail; a significant shift from 20 years ago when the most common cause of disability behind accident was cancer then cardiovascular disease.

Individuals that develop mental health problems are more likely to be absent from work for a longer period than those who have been physically injured, and are also at risk of re-presenting with similar symptoms at a later time, resulting in further absence from work.

The most widely acknowledged social and individual psychological impact of mental health problems are the flow on effects of no employment – the psychosocial impact of financial, familial and personal factors.

We now know that the best treatment for a disease is not always through medication; sometimes the best treatment is prevention. For example, we learnt over time that diet and exercise play a critical role in combatting cardiovascular disease, although initially they appeared to medical specialists unrelated to heart disease.

Similarly, there is a growing body of evidence that psychosocial factors play a key role in forecasting and managing mental ill health.

At KPMG, we believe it is time to adopt a holistic approach to managing mental health claims in life insurance. We need a shift of mindset. We need to consider more than just improved claims management, but also about how we can intervene to prevent stress and mental health issues occurring in the workplace. This requires a whole of business mindset to make our product, underwriting and claim process as customer centred as possible and ensure our policyholders feel understood.

Acknowledgements

The production of this white paper was supported and funded by the Financial Services Council (FSC) of Australia and made possible through significant partnership and collaboration with representatives from the life insurance Industry, Mental Health advocacy groups, academia and a select group of national and international experts in the area of psychosocial risk, mental health and insurance. We wish to acknowledge the significant contribution of these individuals and organisations.

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Contents

Abstract

The growing recognition of the social and economic impact of mental health conditions has provided the impetus for pertinent policy considerations across many organisations, industry and government. From an Australian perspective, the cost of mental illness to collective wellbeing has reached $211 billion pa, approximately 12% of our annual economic output (FL-Index, 2017). The life insurance industry is a sector experiencing an increase in mental health income replacement claims. The most widely acknowledged social and individual impact of mental health problems for adults are the flow-on effects (financial, familial and social) of unemployment. This paper describes the results of a systematic review of the relevant literature relating to the development of mental health conditions based on the biopsychosocial model of healthcare. Evidence is supplemented by interviews with six (6) experts in the field of mental health, insurance and the workplace. The experts consist of academics, disability and workers compensation policy advisors, a disability services executive, clinical and organisational psychologists and an expert on return to work and life insurance. All of these experts have worked with insurance companies either in Australia or overseas.

We found significant evidence to suggest that in addition to the biomedical factors, psychosocial factors can assist to predict the onset and prolonging of mental health issues. The assessment of psychosocial factors can be used in underwriting and managing mental health claims in order to support the needs of customers early with the right level of service intervention.

In deriving strategies for the life insurance industry in relation to mental health, we focus on three key areas: product design, claims and underwriting. A brief summary is provided:

Claims

- Consider the individual interpersonal factors when managing claims;
- Continuously case manage and monitor mentally ill people on claim;
- Collect data on psychosocial factors;
- Improve return to work strategies through improved relationships with medical practitioners and better differentiation between clinical diagnosis and sub clinical presentations;
- Development of industry standards relating to the management of psychosocial issues in claims management; this may require upgrading claims professional skills; and
- Encourage or assist employers to enhance workplace connection and social support to people on claim.

Product Design

- Design product and claims processes to minimise mental distress to policyholders; and
- Utilise a multidisciplinary approach to mental ill health to deliver better patient/customer outcomes, for example; more collaboration with healthcare professionals, provide community support based services and, provide support programs to employers in relation to mental health issues.

Underwriting

- Incorporate psychosocial factors into underwriting decision guidelines;
- Better understand psychosocial factors contribution to mental health issues, drivers of past recoveries and likelihood of recurrence;
- Provide incentives to employers to promote wellness in the workplace through pricing or other means; and
- Collect psychosocial data at underwriting.

This paper considers in its recommendations prevention of mental health issues with the adoption of strategies that have a psychosocial focus. Results of this research are intended to guide Life Insurers on the integration of psychosocial factors into their business practices, recognising they impact the continuum of a customer's mental health lifecycle.

Glossary

Terminology	Definition
Absenteeism	A pattern of unplanned non-attendance to work where work attendance is scheduled.
Actuarial	The computation of insurance premium rates, dividends, risks, etc., according to probabilities based on statistical records.
Biopsychosocial	The interaction between biological, psychological and social factors in understanding health and illness.
Case Management	A client-centred practice that focuses on identifying the needs of the client and designing and implementing strategies to meet those needs. This is underpinned by comprehensive assessment, client-centred action plans and individualised service delivery, with the case manager as the client's single point of contact, ensuring that they are involved in all aspects of the planning and service arrangement.
Claim	An application for compensation under the terms of a life insurance policy.
Customer	An individual who holds a life insurance policy.
Disability	An impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. It substantially affects a person's life activities and may be present from birth or occur during a person's lifetime.
Employee Assistance Protram (EAP)	A work-based intervention program designed to enhance the emotional, mental and general psychological wellbeing of employees and includes services for immediate family members.
Good Work	Work which: • Is engaging, fair, respectful and balances job demands, autonomy and job security; • Accepts the importance of culture and traditional beliefs; • Is characterised by safe and healthy work practices; • Balances the interest of individuals, employers and society; • Has effective change management, clear and realistic performance indicators, matches the work to individuals and uses transparent productivity metrics.
Group Salary Continuance (GSC)	Also known as Group Income Protection, is Income Protection insurance secured for a defined group of people utilising economies of scale to reduce operations expenses, allowing for competitive insurance premium rates.
Health Benefits Of Good Work (HBGW)	An approach which recognises that Good Work (defined above) is beneficial to people's health and wellbeing and that long term work absence, work disability and unemployment generally have a negative impact on health and wellbeing.
Impairment	Any loss or abnormality of physiological, psychological, or anatomical structure or function, whether permanent or temporary.
Insurer	A person or company that contracts to pay a benefit to another in the event of illness, loss or damage;

Glossary

Terminology	Definition
Income Protection (IP)	An insurance policy paying monthly benefits to policy holders during periods of loss of earnings due to sickness or injury.
Life Insurance	An insurance policy paying a designated beneficiary a sum of money upon the death of a policy holder.
Mental Health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
Mental Health Condition	A health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria. Interchangeable Terms: Psychological illness, mental illness, mental health disorder.
Mental Health Issues	Symptoms less severe than a mental health condition (i.e. does not meet the criteria for a diagnosis of a mental health condition). Can be a temporary state of mental ill-health or poor mental health that impacts an individual's cognitive, social and/or emotional functioning. If not effectively managed, a mental health issue may develop into a mental illness. Interchangeable Terms: Poor mental health, Mental Health problems, Mental Health difficulties, Mental Ill-health.
Mental Health Claim	An insurance claim where the cause of the claim is related to mental illness or mental health issues.
Morbidity	Departure from a state of physical or psychological well-being, resulting from disease, illness, injury, or sickness, especially where the affected individual is aware of his or her condition.
Mortality	Death.
People on Claim	Individuals who have lodged a claim seeking to access their insurance benefits by way of Income Protection/Groups Salary Continuance and/or Total and Permanent Disability insurance and whose claim has been accepted. Interchangeable Terms: Person Claiming
Policy	A document detailing the terms and conditions of a contract of insurance.
Presenteeism	The practice of coming to work despite illness, injury, anxiety, etc., often resulting in reduced productivity.
Product Design	The systematic development and generation of life insurance products balancing cost-effectiveness with desirable features and benefits for the consumer.
Protective Factors	A characteristic at the biological, psychological, social level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes
Psychological Injury	A Mental Health Condition related to or triggered by a specific event e.g. trauma or bullying.

Glossary

Terminology	Definition
Psychosocial	The combined influence that psychological factors and the surrounding social environment have on the individual's physical and mental wellness and their ability to function.
Psychosocial Disability	A disability that may arise from mental health issues and disadvantage and affect people both socially and psychologically but not have a medical diagnosis.
Psychosocial Claims	An impairment substantially affecting a person's ability to function related to the psychological and/or social environmental factors. The cause of time off work is attributable to psychosocial issues, and no mental health diagnosis is deemed necessary or attributable.
Recovery	Achieving an optimal state of personal, social, emotional and functional wellbeing whilst living or recovering from mental health conditions.
Risk Factors	Any attribute, characteristic or exposure to an individual that increases the likelihood of developing a Mental Health Condition.
Sub-Clinical	Relating to the stage in the development of an illness or disease before the symptoms are observed and meeting the diagnosable criteria.
Subject Matter Expert (SME)	An individual who is considered an expert on particular subjects.
Total and Permanent Disability (TPD)	An insurance policy paying a lump sum benefit in the event an insured person becomes permanently disabled and unable to work again.
Underwriting	The evaluation of risk and exposure, and the establishment of terms and conditions before the provision of insurance coverage for an individual or groups of people.


Scope

Scope

This is the first piece of research commissioned by the FSC on Mental Health under the Letter of Engagement dated October 2018.

The scope of this paper was agreed with the FSC and KPMG had input from the FSC appointed Steering Committee.

Specific questions raised as part of the scope included the following general hypotheses.

'Identifying and understanding psychosocial factors in mental health conditions which contribute to impairment and absence from work, may inform opportunities to improve identification at underwriting assessment and enhance health services to consumers.'

Our approach was to attempt to answer the following three research questions:

What can be learned from local and international industry experts, peer reviewers and grey literature regarding psychosocial factors, and the subsequent impact on wellbeing and mental health to inform insurance practices?

What psychosocial factors provide reliable and statistically correlated support as prognostic and protective indicators of a propensity for absence and impairment (functional/social)?

How can an understanding of psychosocial factors inform insurance practices to optimise health outcomes for people with mental health and other co-morbid medical conditions?

Approach

Approach

The approach to the development of the paper was to:

A

Part A

Perform a literature review with qualitative research and conduct interviews with a panel of six (6) subject matter experts.

Local and international research and analysis of relevant psychosocial factors impacting mental health conditions was undertaken with a focus on mental health risk and recovery outcomes. The research and interviews considered psychosocial factors that contribute to absence and incapacity and are potentially secondary to the mental health issue, but may have had a primary causative effect.

B

Part B

The analysis and findings from Part A was then distilled into potential strategies for addressing the challenges of covering mental health in life insurance in Australia, for consideration, debate and adoption by the life insurance industry.

These are not recommendations, as its applicability may vary from insurer to insurer; nevertheless, there are useful common findings that can be considered.

Research Methodology

Research Methodology

The approach adopted in this paper was to:

1. **Synthesise research literature on psychosocial factors and their influence on the development and persistence of common mental health conditions; and**
2. **Identify psychosocial factors that may be relevant for the life insurance industry to consider in improving the support provided to people with mental health challenges.**

A steering committee was formed to assist with the oversight and development of research parameters. These included representative from the life insurance industry, mental health sector, and academia. An agreement was reached to adopt a mixed approach:

1. To conduct a review of the available literature to investigate the evidence for the association between psychosocial factors, mental health conditions, optimisation of health outcomes and return to work to inform the life insurance sector; and
2. To conduct qualitative research in the form of interviews with key experts from the relevant fields of disability services, welfare policy, return to work and clinical and organisational psychology.

Research methods and rationale

Literature review

To investigate the evidence for the association between psychosocial factors, mental health conditions and return to work, a review of the available literature was undertaken by searching ProQuest, PsychINFO, PsychARTICLES, Google Scholar databases and the 'grey' literature. There were no date range criteria specified in the search to ensure any articles of historical relevance were captured. The search terms selected were initially broad categories of interest which were paired hierarchically with specific descriptors. Absenteeism was included in the results if there was a link to mental health conditions in the studies. Depression and anxiety were used as specifiers due to their high prevalence in reports of mental illness in the workforce. The following are a list of the search items and specifiers used in the ProQuest search:

1. Psychosocial factors AND prediction AND/OR absenteeism AND/OR mental health;
2. Psychosocial factors AND systematic review AND mental health AND/OR return to work;
3. Workplace psychosocial risk factors AND mental health AND/OR insurance; and
4. Epidemiology AND mental health.

The abstracts of approximately 600 papers were assessed for relevance and included in this review if further reading confirmed their value to the study. The literature review resulted in the recovery of 53 papers which had relevance to mental health issues, psychosocial factors and absenteeism. Six of the papers were systematic reviews and/or meta-analysed after further reading of the singular studies, 18 were included for discussion based on relevance to mental health or absenteeism as outcome variables and psychosocial factors as predictors. Workplace psychosocial factors were predictors in 67 percent of the papers reviewed.

Information was included from these papers if they reported results of studies in which the dependent variables were mental health outcomes, return to work and absenteeism from the workplace and the predictor variable was described as a psychosocial factor or psychosocial risk factor. The papers were only included if they were written in the English language and published after 1995. Systematic reviews of psychosocial factors and their relationship with mental health were also included, and the reference sections of the chosen articles were scrutinised for additional relevant papers. A number of industry-specific reports pertinent to the relationship between mental health and insurance were also sourced from public search engines (Google and Yahoo) and the grey literature. Results of these studies are reported and used to explore the hypothesis that 'psychosocial factors are linked to absenteeism and impairment, and are potentially associative indicators of mental health issues'. No papers were identified that were specific to the life insurance sector.

To test for the possible utility of the psychosocial factors in improving the design and delivery of Income Protection (IP) and TPD insurance products, the theoretical information obtained through the above review of the research literature was compared with practical information sourced from the narratives of industry and subject matter experts. This comparison resulted in a condensed list of common psychosocial risk factors that could be used to further inform the life insurance industry and provide tangible evidence for system improvements.

The literature review used key terms that reflected outcome measures applicable to life products (e.g. return to work, absence from work and common mental health issues. The rationale for the selection of outcome measures in the literature review is derived from their intuitive relationship with the provision of income protection insurance. These considerations included:

1. Depression and anxiety symptoms are common presenting problems associated with mental health claims. Thirty-eight percent of mental health claims in the workers compensation sector were identified as anxiety and/or depression related, and of these, 41 percent were classified as a non-specific response to stressors (Safework Australia, 2015).
2. Recurring absence from work can be an early indicator of psychosocial stress (leading to possible chronic mental health conditions), while the duration of absence is a key consideration in the provision of income protection.
3. Psychosocial factors have been identified as influential in motivation and ability to return to work.

Interview of panel of experts

A semi-structured interview format, delivered by remote audio conferencing was chosen as the method to investigate the importance of psychosocial factors in the development and maintenance of mental health issues in a 'real world' context. Audio conferencing was chosen as a preferred method due to the geographical disparity of the interview participants. An overview of the key experts work and relationship with psychosocial factors were assessed prior to an enquiry regarding the respondent's current view on the relevance of psychosocial factors as prognostic indicators for mental health issues and any recognition of specific factors of importance.

The questions were provided on an informal basis and explored further if a more specific focus was required. The interviews were recorded with the verbal agreement of the participants. To ensure confidentiality the audio files and transcriptions were destroyed following interpretation and analysis.

To improve the reliability of results, at least three interviewers attended each session and provided a summary of the key points of the interviews which were included in the analysis. A comparison was made between the summaries provided, transcriptions of each interview and also in reference to the literature review findings. Themes were coded using a qualitative ranking of the commonality of shared experiences and the volume of data proffered in relation to the theme identified. The results are reported as a hierarchy of topic consensus amongst the key informants.

Panel of experts

Six experts were chosen to participate in the interviews by the project leadership group. They consisted of esteemed academics, disability and workers compensation policy advisors and a disability services executive, clinical and organisational psychologists and an experienced international expert on the relationship between return to work and life insurance. These experts were also selected on the basis of their previous clinical or practical work involving either the biopsychosocial or a psychosocial model, and their extensive work in the fields of return to work, assessment and management of mental health conditions, psychosocial applications and disability service provision. All of the selected group have also worked with the life insurance sector either within Australia or other international organisations.

Introduction

Introduction

Mental health and mental illness

It is estimated that 1 in 5 (20 percent) of the Australian population has experienced a 'common mental disorder' in the past 12 months (AIHW, 2018). Mental health conditions have a wide-ranging interactional impact on individuals, families, communities and society. A mental illness reduces the likelihood of someone completing school, accessing work, and maintaining a good quality of life.

According to the World Health Organisation (2018), mental health is "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".

Conversely, mental illness is defined as "a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people". Mental illness as it is defined is diagnosed according to a set of standardised criteria. The term mental disorder or mental health condition is often used interchangeably with mental illness.

A mental health problem also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness. Mental health problems are more common and can be experienced temporarily as a reaction to the stresses of life, but are not always diagnosable health conditions. Mental health problems may develop into a mental illness if they are not adequately addressed.

Mental health is one of the major health issues of our time

Mental illnesses cause a great deal of suffering to those experiencing them, as well as their families and friends (Australian Government, Department of Health, 2007). Furthermore, these problems appear to be increasing. According to the World Health Organisation (2003), depression will be one of the most significant health problems worldwide by the year 2020. Depressive disorders are now the leading contributor to the global burden of disease, while anxiety disorders rank 6th as measured by Years Lost to Disability. The financial cost of these common mental health problems is sobering. The per annum loss in productivity attributable to anxiety and depressive disorders globally is 12 billion workdays – or 50 million work years at the cost of $US1.15 trillion / $AU1.46 trillion (Chisholm et al., 2016).

The average reduction in life expectancies as a result of mental illness have been variably reported, with a gap of up to 20 years for men and 15 years for women. A metric which is often used to describe the individual impact of the disease is the Disability Adjusted Life Years (DALY). DALY's are calculated using a measure of the sum of years of life lost and years lost due to disability.

The Australian Institute of Health and Welfare (AIHW, 2016) has reported that in an Australian context, mental illness contributes to 12 percent of the total burden of disease and 24 percent of the years lost to disability (the highest proportion of any disease class).

Based on this data it has become easy to recognise that mental health issues are a significant consideration for government health agencies, employment institutions and compensable insurers including the life insurance industry. Mental Health, however, impacts not only the individual but also their families, relatives and communities. Tension and frustration can lead to relationship strain, which is both a cause and consequence of mental health issues. Family members also experience distress from troubling emotions and uncertainty associated with mental health issues. The World Health Organisation (2003) has reported that individuals with mental illness and their families are also financially burdened by lost employment earnings and the need for informal caregiving, often compounded by the cost of treatment. Families also experience feelings of anguish and isolation that accompanies societal lack of understanding and stigma attached to mental ill health.

There is an upward trend in public utilisation of mental healthcare services and concomitant financial costs to the Australian Government. The AIHW (2018) reports that government expenditure grew from $2.9b in 1992/93 to $9.0b in 2015/16. The utilisation of Medicare-subsidised mental health services has increased from 5.7 percent in 2008/09 to 9.8 percent in 2016/17. Mental health-related GP visits accounted for 12.4 percent of all GP encounters (of an estimated 18 million visits in 2016/17), while there has been an annual average increase of mental health related GP encounters of 4.7 percent since 2011/12, with this possibly being attributed to the introduction of Mental Healthcare plans through Medicare. The recent Health of the Nation Survey conducted by the Australian RACGP(2018), across 1500 General Practitioners indicated 62 percent of the most common ailments dealt with were psychological and an average of six minutes per consultation. The significance of these trends cannot be understated in terms of reflecting the impact of mental health on social support systems.

Relationship between mental health and work

The recognition of the importance of mental health issues is reflected in increased social awareness, reduction in stigma and acceptance of the disablement created by mental ill health. There is a continued evolving institutional engagement and policy response to an understanding of the financial, social and individual impacts of mental health problems and illness. Specifically, the responses by way of understanding factors contributing to mental ill health and therefore, how to support people suffering is a focus for the life insurance sector.

The relationship between mental health, employment and the workplace is an evolving area of research, policy and program initiatives. Organisations and institutions are increasingly recognising and responding to the significant financial costs from lost productivity and employee replacement associated with absence from work attributed to mental health issues.

The National Institute of Mental Health (2013) suggests that the main economic burden of mental illness for most countries does not stem from healthcare costs, but a loss of income due to unemployment, and the indirect costs associated with chronic disability.

It has been proposed that clinically recognised mental disorders, sub-clinical mental health problems and general distress are prevalent in the Australian working population (La Montagne et al., 2014). Loss of productivity associated with mental health issues, regardless of cause is largely due to workplace absenteeism (the tendency and act of being away from the workplace) and presenteeism (attending the workplace regardless of illness) and is estimated to cost businesses in the region of $11 billion every year (AIHW, 2016). Recent estimates by KPMG and Mental Health Australia (2018) put these costs at $2.6 billion and $9.9 billion respectively. In 2014 Beyond Blue reported that 1 in 5 employees will be absent from work annually as a result of feeling stressed, anxious, depressed or mentally unwell. The National Mental Health Commission (NMHC) (2014b) reported that employees with job related stress and mental illness were absent from work for an average of almost 11 weeks a year in Australia.

A number of studies have estimated that investment in mental health in workplace prevention programs could deliver a net benefit not only for employees, but also the businesses which implement them. KPMG and Mental Health Australia (2018) estimated a return to Australian employers which ranged from $1.30 to $4.70 for every $1.00 invested, depending on the initiative being implemented.

Mental health and financial support structures

Increased workplace absence due to mental health issues also places a strain on financial support structures that are provided as a safety net in maintaining income during periods of absence from work. In an Australian context, two important streams of income support in times of unemployment through injury or illness are workers compensation schemes and life insurance income protection products. This broader aetiological perspective, coupled with an increased social focus on achieving good mental health, is contributing to increased mental health claims against life insurance products according to recent APRA (Australian Prudential Regulation Authority, 2018) data. Mental health claims account for $809M or 11 percent of all life insurance claims paid in 2018[1].

The growing recognition of mental health importance is potentially transformational in its impact on policy, system and program development. Institutional and industry responses continue to evolve as evidence based information directs process innovation and system improvements. Unemployment itself is a recognised risk factor in the development and duration of mental health problems and illness. Gaining employment has been found to promote wellbeing, while poor mental health is a well-established consequence of unemployment, associated with increased prevalence of disability plus a higher mortality rate (Murphy & Athanasou, 1999). In a meta-analyses of 237 studies, Paul and Moser (2009) reported a moderate effect size for the relationship between distress and impaired well-being when comparing a group of unemployed people with those who were employed. Longitudinal studies included in the meta-analysis showed that participants' subjective ratings of distress increased if they had experienced a job loss during the research assessment periods.

A number of moderating variables have also been identified as important in the relationship between poor mental health and unemployment. These variables included gender, age, relationship support, career commitment and importantly for life insurance, duration of unemployment and availability of income support. Availability of income support is recognised for reducing subjective stress in those experiencing unemployment. Duration of unemployment has a correlated financial cost burden on income support payments and individual motivation to return to work (Paul & Moser, 2009). Accumulated stress of financial uncertainty and feeling lack of engagement plus loss of purpose and meaning are a common response to prolonged unemployment. From a life insurance and client-outcome perspective, encouraging return to work has multiple health and economic benefits.

Cost of mental health in insurance

In 2013, 'mental disorders' surpassed musculoskeletal problems as the leading cause of long term work incapacity in Australia for workers compensation claims (Harvey et al., 2013). Income support claims for mental health problems are also steadily increasing across all compensation jurisdictions in Australia. Recent data prepared for APRA (Australian Prudential Regulation Authority, 2018) on reported life insurance claims indicates that the industry is experiencing an increasing trend of growing claims costs for Income Protection/Group Salary Continuance (IP/GSC) and TPD products as a result of claims related to mental health, as both a primary and secondary source of impairment.

Mental health claims for IP and TPD products have a significantly higher cost burden than those associated with physical injury. There is evidence to suggest that people on claim with mental health issues, conditions or illness are slower to return to work, while those presenting with a physical disability and comorbid mental health condition have poorer outcomes than

[1] FSC's Life Insurance Industry Data Collection, 2018 – 2021, managed by KPMG

those with physical injury alone (Ellis & Gifford, 2015). Claims relating to mental health are 20-40 percent more likely to result in time off work than those relating to physical injuries and have ten times the absence rate of other claims (McInerney & Gregory, 2013). In this context, it is clear that an increasing trend in accessing income support for absence from work due to mental health conditions require pre-emptive system improvements to ensure the sustainability of income protection and total and TPD products for the life insurance industry.

Worker's compensation and motor accident insurance play a role in financially supporting individuals who experience illness or injury in line with circumstances within their jurisdictions (i.e. workplace accident/illness or traffic accident). The life insurance sector, while covering for illness or injury in these circumstances, also plays a critical role in ensuring the financial security of millions of Australians who are ineligible for support under these schemes. Income Protection and TPD is designed to cover people in all circumstances where illness or injury results in disablement, time off work and lost income (excluding where it relates to active service). As such, life insurance products can be considered a final safety net before social security entitlements. The sustainability of the life insurance industry, therefore, is a necessary consideration to ensure the financial security of millions of Australians and the sustainability of the social security system.

The FSC/KPMG Data Collection[2] for the calendar year 2018 indicates that across all distribution channels:

$750 million

of all claims paid relate to mental health

22 percent

of mental health claims account for TPD and DI combined group and retail by claims paid

Mental health is

No. 1 cause for TPD claims for combined group and retail in 2018

No. 2 cause of claim for disability income

$1 billion (12 percent)

of all sum insured claim causes are mental health related

[2] FSC's Life Insurance Industry Data Collection, 2018 – 2021, managed by KPMG

Insurance and mental health

The current nature of the life insurance product cycle is one of competitive pricing and product design, followed by premium increases and potential definition tightening as common measures to address issues of profitability. This cycle creates issues of sustainability for insurers, and affordability, and often less than optimal outcomes, for customers.

In a competitive market, pricing, individual advice, product utility and customer satisfaction are strong considerations for consumers of insurance. Sustainability of insurance products relies heavily on the ability to control pricing by accurately capturing pooled risk in underwriting, efficient and accurate pricing of group products and competitive product designs that promote the best possible outcomes for customers.

The relationship is mutually reinforcing. Sustainability will ensure the continued availability of a product with high utility value, and positive client outcomes will warrant sustainability.

Insurance is underpinned by risk pooling. Insurers collect premiums from many individuals but pay out relatively few claims because most of the pool members do not need to make claims over the same period. If this balance is somehow distorted, for example by escalating frequency or cost of claims, the viability of the insurance product may be jeopardised, and consumers' access to cover may be affected (Actuaries Institute, 2017). Life insurance provided in superannuation is mostly pooled risk and in most cases advice has not been provided to an individual on types of products needed and their associated cost. In individually underwritten life insurance policies, individual assessment of risk utilises data from prior experiences of claims rates, claims costs associated with identified risks and risks associated with health, work and lifestyle choices.

While pooling of risk underpins insurance, there can be limits to this pooling due to community expectations. Some individuals want a premium to reflect their circumstances and for their premium to not be materially impacted by circumstances that do not apply to them. For example, some individuals living in a low risk "flood" area to be impacted by the risks associated with other people living in high risk "flood" areas if this had a material impact on their premium.

The purpose of income protection products broadly is to support consumers in meeting their financial obligations and costs of living during periods of sickness and injury. TPD benefits serve to provide funds to support consumers in circumstances where they are permanently incapacitated from work. The value of life insurance products, such as income protection and TPD, therefore, is inherently linked to their utility and purpose.

Many people on claim find the experience of engaging with workers compensation schemes highly stressful. KPMG's paper to the Actuaries Institute in 2017, Balancing the Challenges of Mental Health Claims in Insurance, reported that in the Workers Compensation system high levels of stress have significantly impacted higher levels of disability, anxiety and depression and lower quality of life *(Grant et al., 2014)*. High levels of stress were found to be associated with:

- **understanding what is required for the claims process (33.9 percent);**
- **claim delays (30.4 percent);**
- **the number of medical assessments involved (26.9 percent); and**
- **the level of compensation received (26.1 percent).**

Regarding mental health insurance coverage and utility, consumer groups such as Beyond Blue, Mental Health Australia and Choice have previously identified concerns. The recent Parliamentary Joint Committee on Corporations and Financial Service also identified options for greater involvement by private sector life insurers in worker rehabilitation (2018) over three main areas:

1. **Product design**
   definitions and their interpretation;
2. **Product purchase**
   balancing premiums and risk levels; and
3. **Claims determinations**
   issues of timeliness, complexity, fairness.

To ensure a consistent approach to product sustainability and customer outcomes, solutions may need to have application across the life insurance lifecycle – (1) Product Design, (2) Underwriting and (3) Claims Management.

That is:

1. **Product Design that meets customer, regulator and community expectations of insurance coverage relevant to the distribution channel;**
2. **Underwriting approaches/practices that seek to understand the customer holistically while equalising risk; and**
3. **Claims management practices that consider and engage in a manner that is focused and supported to attain fair outcomes to the individual customer.**

Psychosocial focused strategies and mental health

One area in the mental health field which is gaining momentum for widespread policy application in the prevention and treatment of mental health problems is the adoption of strategies with a psychosocial focus and the adoption of biopsychosocial models.

The biopsychosocial model reflects an assumption that mental health is influenced by inherent biological attributes and the psychological and social contexts of the lived environment. While the biological component, which includes individual genetic factors is a relatively fixed characteristic, psychosocial factors are more malleable and modifiable. There is much research evidence investigating the relationship between the development and duration of common mental disorders (depression and anxiety) and stress-inducing psychosocial factors.

Practical examples of the trend toward a psychosocial focus in mental health management and response include:

- Increasing utilisation of psychosocial case conceptualisations, assessments and interventions as standard practice by medical and allied health practitioners. (Jaini & Seung-Hyun Lee, 2015);
- Global Insurance providers are adopting a biopsychosocial approach to claims management. (The Hartford Foundation of Public Giving, 2016);
- Workers Compensation schemes (psychosocial assessment and treatment are embedded in clinical frameworks during claims management);
- Mining industry response to mental health in FIFO workers (identification and amelioration of individual and workplace psychosocial risk factors);
- Organisational Work Health & Safety Psychosocial Workplace Guidelines and Mentally Healthy Workplace strategies, (Site based and aimed at mitigating the impact of psychosocial risks, e.g. job strain, bullying, conflict and increasing management awareness); and
- Employee Assistance Programs (psychoeducation and wellness programs).

Psychosocial focused strategies

For sectors associated with work, health and disability, there are observable shifts from medical models towards the adoption of a biopsychosocial approach so as to understand, identify and manage risks associated with the development and persistence of mental health issues. Over the last three decades, these include de-institutionalisation, national mental health and workplace health and safety policies, the adoption of collaborative case management approaches to care provision and disability, and employment programs aimed at supporting overall health and wellness.

The adoption of a comprehensive biopsychosocial approach to care is varied across industries. Recognising the substantive impact psychosocial domains have on the development and persistence of common mental health problems, as well as other conditions and their associated social, financial and employment impacts, it is clear that strategic change in response to the increasing impact of mental health issues requires reviewing systems and energetic engagement with evidence-based improvements.

It is also argued that optimal client outcomes in relation to case management, particularly in mental health claims (due to longer periods of required support) is pivotal for ensuring product sustainability for insurers.

The life insurance industry recognises the importance of psychosocial factors

The life insurance industry recognises the potential benefits of embracing a biopsychosocial model in response to mental health claims for disability/income support products. The potential benefits of adopting and further embedding a biopsychosocial response model from the research present as compelling, and include:

1. **Better health outcomes for people on claim.**
2. **Aligning products with current trends in healthcare assessment and intervention leading to more customer-centric experience.**
3. **Potential long term savings in claim costs.**
4. **Improved problem identification in the underwriting and claim stages.**
5. **Enriched social contract and positive public perception.**
6. **Possible prevention of secondary development of mental health problems.**
7. **Reduced cost of adversarial litigation.**
8. **Preventing further deterioration of mental health conditions.**
9. **An inherent benefit in applying the model to musculoskeletal claims that have a greater risk of secondary mental health issues.**

It is well established that work is generally good for people's health by providing a sense of purpose, value, autonomy and identity

The life insurance industry has been implementing various policy and program initiatives based on a range of understood and recognised psychosocial factors that impact employment for over 15 years now. As reported in the 2017 Actuaries Institute Mental Health paper, 'the insurance industry has for a number of years promoted the health benefits of good work to both healthcare specialists and in claims management with the person on claim.

Studies have provided strong evidence that employment improves general mental health and reduces depression (van der Noordt et al., 2014) and that work can facilitate recovery from an illness and enhance mental wellbeing (Harvey et al., 2016).

Good work is 'characterised by safe and healthy work practices and it strikes a balance between the interests of individuals, employers and society' (AFOEM, 2013).

SuperFriend has developed a best-practice framework for the management of psychological claims in life insurance, TAKING ACTION, which evaluates the benefits of a psychological and person-centred approach and has been adapted for the Workers Compensation insurance sector (SuperFriend & Safe Work Australia, 2017).

The life insurance industry has recognised that further embedding of a biopsychosocial centric life insurance service is required, an inhibitor to this progress is a lack of life insurance industry focused research.

This paper was commissioned by the Financial Services Council of Australia (FSC) to support their life insurance members with an evidence base rationale to continue to implement changes that focus on psychosocial issues, in order to recognise and support the rising mental health issues impacting the industry.

Why this paper?

This paper acknowledges the rising level of mental health claims in the life insurance industry and reviews qualitative data retrieved from the academic literature to identify the specific psychosocial factors pertinent to the development of common mental health problems.

It considers the prevalence rates of mental health within the life insurance industry and explores the role psychosocial factors may play as a method for life insurers to address mental health issues and conditions.

This data is compared and collated with narratives from international experts in disability service provision, government advisors and frontline allied health professionals to develop considerations for life insurers.

This paper aims to provide a general overview of the epidemiology of mental health conditions and nuanced description of the available evidence. It is designed as a reference for life insurance professionals and health providers to explore the evidence linking psychosocial factors and the epidemiology of mental health issues. It is also a resource specifically tailored to the life insurance industry for accessing ideas for policy, product design, underwriting assessment and case management related to mental health claims from the point of view of a biopsychosocial focus.

This paper complements the work of academics, the worker's compensation industry, SuperFriend, organisational and clinical psychologists and government regulators in their attempts to provide optimal responses to mental health issues. Incorporation of the information presented in this paper may assist in improving outcomes for individuals on claim, enhancing industry reputation with regard to social beneficence and promoting continued sustainability and suitability of life insurance products into the future.

A Part A: Research

Mental Health Models

Introduction

To provide context to the research and understand how this research can support the aims of Part B Implications for the life insurance Industry, this chapter outlines:

- The various models used to describe the factors influencing the development of mental health conditions.
- How these models impact the treatment and management of mental health.

The biomedical model

Several models have been utilised to describe the factors influencing the development of mental health conditions. One such model is the biomedical model. This model is based on the presumption that mental health issues are a consequence of atypical structure or functioning of the brain, and as a consequence, such difficulties are best treated via psychopharmacological interventions (Deacon, 2013). Diagnosis of mental disorders is made with reference to a set of classification criteria based on presenting symptomology sourced from the DSM-V or ICD-10. DSM-V, the diagnostic statistical manual for psychiatric conditions has been adapted in recent years to take into account psychosocial factors. Medical practitioners also utilise these psychosocial factors alongside the biomedical model in clinical practice. They may however not consistently take full account of the causal links between specific environmental conditions and behavioural responses experienced by an individual. It is noted that the use of the biomedical model in isolation would have the potential to generate a risk of over-inflation of diagnosed mental health problems.

More recently an expansion to the diathesis-stress model has been developed. The phenotypic vulnerability model recognises that adverse and significant life events (e.g. childhood experiences) can overwhelm genetic influence and result in the development of mental health conditions and illness. Expression of the phenotype (e.g. depression, anxiety) from these experiences also creates an increased vulnerability to stressors later in life. This is demonstrated in the next section.

The diathesis stress model

Under this model, stress has been recognised as playing a significant role in understanding how psychopathology develops in individuals. Not all individuals who are stressed, or go through stressful life events, develop a mental health condition or illness. Some individuals are more vulnerable than others to develop a disorder once stress has been introduced, hence the formulation of the diathesis–stress model. Genetic and environmental interactions are recognised as instrumental in the development and duration of mental health conditions.

Current evidence suggests that individuals with a genetic predisposition may react adversely to stressors and could respond more immediately to environmental stressors. This model demonstrates that individuals with a high genetic vulnerability will develop adverse mental health conditions at a lower threshold of stress exposure than those with low genetic vulnerability (see Figure 1) (Barlow and Durand, 2015).

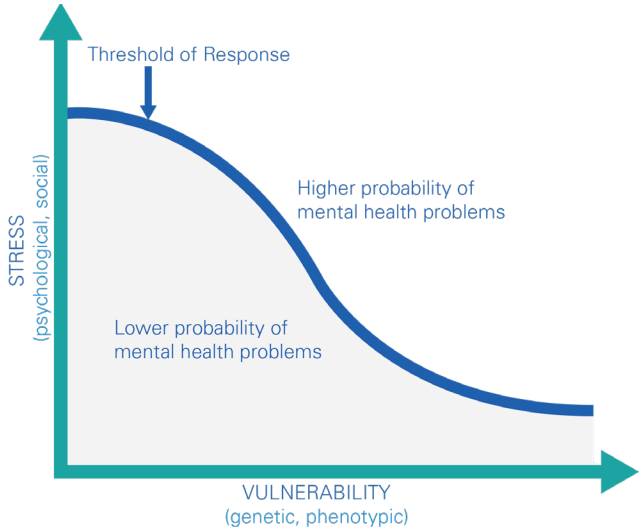


Figure 1:
The relationship between vulnerability, diathesis, and stress, in the development of mental health conditions and illness. Individuals with a lower biological vulnerability to developing mental health conditions or illness are more likely to have an inherently greater threshold of adverse response to psychosocial stressors.

Biopsychosocial paradigm

Intrinsically linked to the diathesis-stress model is the biopsychosocial paradigm which provides a framework for the model. Inherent in the framework is the recognition of the importance of stress emanating from the influence of psychosocial factors.

Psychosocial factors have been described as pertaining to an individual's cognition and behaviour and their inter-relationship with social conditions (Martikainen, Bartley, & Lahelma, 2002). They conceptualise the term 'psychosocial factor' as connected to a description of possible causal influence (e.g. psychosocial influences and risk factors), mediating contexts (e.g. psychosocial environment, psychosocial resources, and psychosocial care) and prescriptive outcomes (e.g. psychosocial stress, psychosocial disability and psychosocial wellbeing).

Psychosocial risk factors are characteristics that increase the prospects that an individual may develop a mental health condition or illness.

Conversely, resilience factors are protective, having the potential to mitigate or reduce the incidence of mental health problems where risk factors are present.

Evidence suggests that psychosocial risk and resilience factors have a crucial role in the prevention and intervention of mental health (Egan, Tannahill, Petticrew & Thomas, 2008). Psychosocial factors may vary according to the developmental stage of the individual. They may be associated with the emergence and duration of mental health issues concurrently or, confer future risk or protective influence on an individual. Broadly, these factors may exist at the intra-personal level (individual-level characteristics), in the social environment, or the context of broader systemic or environmental factors. They may be static (e.g., exposure to childhood abuse or neglect, past psychiatric history) or dynamic (e.g., the absence of social support, the tendency towards negative cognitive appraisals).

The assessment of psychosocial risk factors and interventions focused on ameliorating their impact are important considerations in continued improvements to the provision of healthcare.

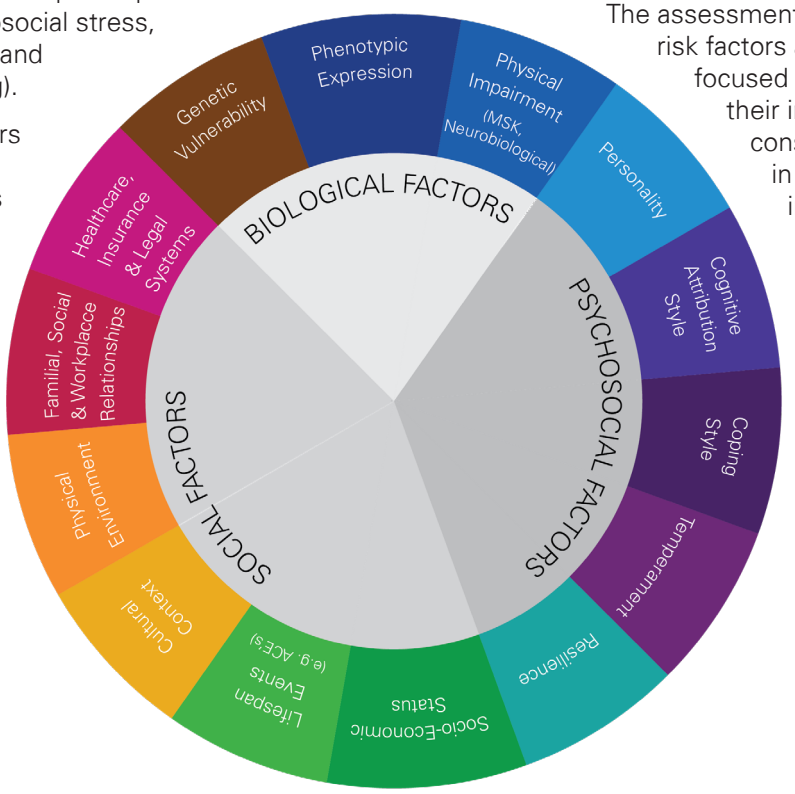


Figure 2:
Psychological and social factors are modifiable variables contributing to an individual's mental health and their overall state of wellbeing. These psychosocial factors interact with each other and have the potential to compound and develop into mental health conditions. The environmental context is the primary source of psychosocial stress.


BIOLOGICAL FACTORS
PSYCHOSOCIAL FACTORS
SOCIAL FACTORS
MENTAL HEALTH
STATE OF WELLBEING

Healthcare models of managing and treating mental health conditions

The different views of mental health conditions, as described above, lead to different models for treating and managing mental health.

Biomedical model of healthcare

A biomedical model of health focuses on the physical or biological aspects of disease and illness. Specifically, the biomedical model of healthcare primarily assumes that;

- illness and associated symptoms arise from an underlying abnormality within the body (usually in the functioning or structure of specific organs), referred to as a disease,
- All diseases give rise to symptoms, eventually if not initially, and although other factors may influence the consequences of the disease, they are not related to its development or manifestations,
- Health is the absence of disease,
- Mental disorders such as emotional disturbance or delusions are separate from, and unrelated to, other disturbances of bodily function,
- The patient is a victim of circumstance with little or no responsibility for the diagnosis or cause of the illness,
- The patient is a passive recipient of treatment, although cooperation with treatment is expected.

A number of advantages of this model have been reported, including contributing to increased life expectancy and effectively returning people to a healthy state. It can lead to advances in medical technologies and improve the quality of life for people with chronic conditions.

The social model of healthcare

The social model of health attempts to address broader sociocultural, environmental and economic influences on health, rather than the injury or illness itself. Where the biomedical model does not focus on those people without a disease, the social model helps to fill this gap.

The social model of health was developed from the recognition that some people have lifestyle influences that affect them, even when there is a trend for generalised population health improvement. An example of this is the link between cardiovascular disease and poor diet and cigarette smoking. Even with an upward trend in improved cardiovascular related health, some people will continue to participate in known high risk activities. These behavioural determinants are often associated with influences such as gender, culture, race or ethnicity, socioeconomic status, geographical location and the physical environment. Responding to these influences through health promotion strategies, including provision of education and economic drivers, is a key aspect of the social model of health.

Since the 1970s, George Engel has been one of the pioneers in arguing for consideration of factors other than medical factors, such as biological, psychological, and social factors in the emergence, maintenance, assessment, and treatment of mental health difficulties (Engel, 1977). A more recent review of the biomedical model highlights the value of engaging with a biopsychosocial approach to healthcare. These observations include that:

1

Biochemical change does not necessarily translate directly into an illness.

2

Biological disorder does not explain the patients' perception of the symptoms, nor does it explain the attitudes and skills that the clinician must have to gather information and process it well.

3

Adopting a sick role is not necessarily associated with the presence of a biological condition alone.

4

The clinician-patient relationship influences medical outcomes and recovery.

5

Illness results from the interaction of diverse causal factors, including those at the molecular, individual, environmental and social levels.

6

Psychosocial variables are more important determinants of susceptibility, severity, and duration of illness than had been previously appreciated by those who maintain a purely biomedical view of illness.

7

The success of biologically focused treatments is influenced by psychosocial factors (e.g. the placebo effect).

8

Unlike inanimate subjects of scientific scrutiny, patients are profoundly influenced by the way in which they are studied, and the scientists engaged in the study are influenced by their subjects (Borrell-Carro, Suchman, & Epstein, 2004).

The biopsychosocial model of healthcare

The biopsychosocial model of healthcare has been developing for over forty years as a result of perceived deficiencies in applying an exclusive medical response to mental health. The biopsychosocial model of healthcare is now being widely adopted by mental health practitioners. It allows for the conceptualisation of mental health issues according to the relative contributions of individual-level and broader, environmental-level risk and resilience factors. George Engel proposed an approach to sickness and disability that aimed to unpack all the issues surrounding the treatment of illness and argued that "the biopsychosocial model is a scientific model constructed to take into account the missing dimensions of the biomedical model." (Engel 1980).

While it could be stated that genetic predisposition towards a certain mental health condition is a necessary precondition for the development of that illness, this is not sufficient for the emergence of that disorder (McCutcheon, 2006). This is predominately because of the principle of equifinality, which suggests that multiple pathways (exposure to stressors, cumulative stress, life-span experiences) may lead to similar outcomes.

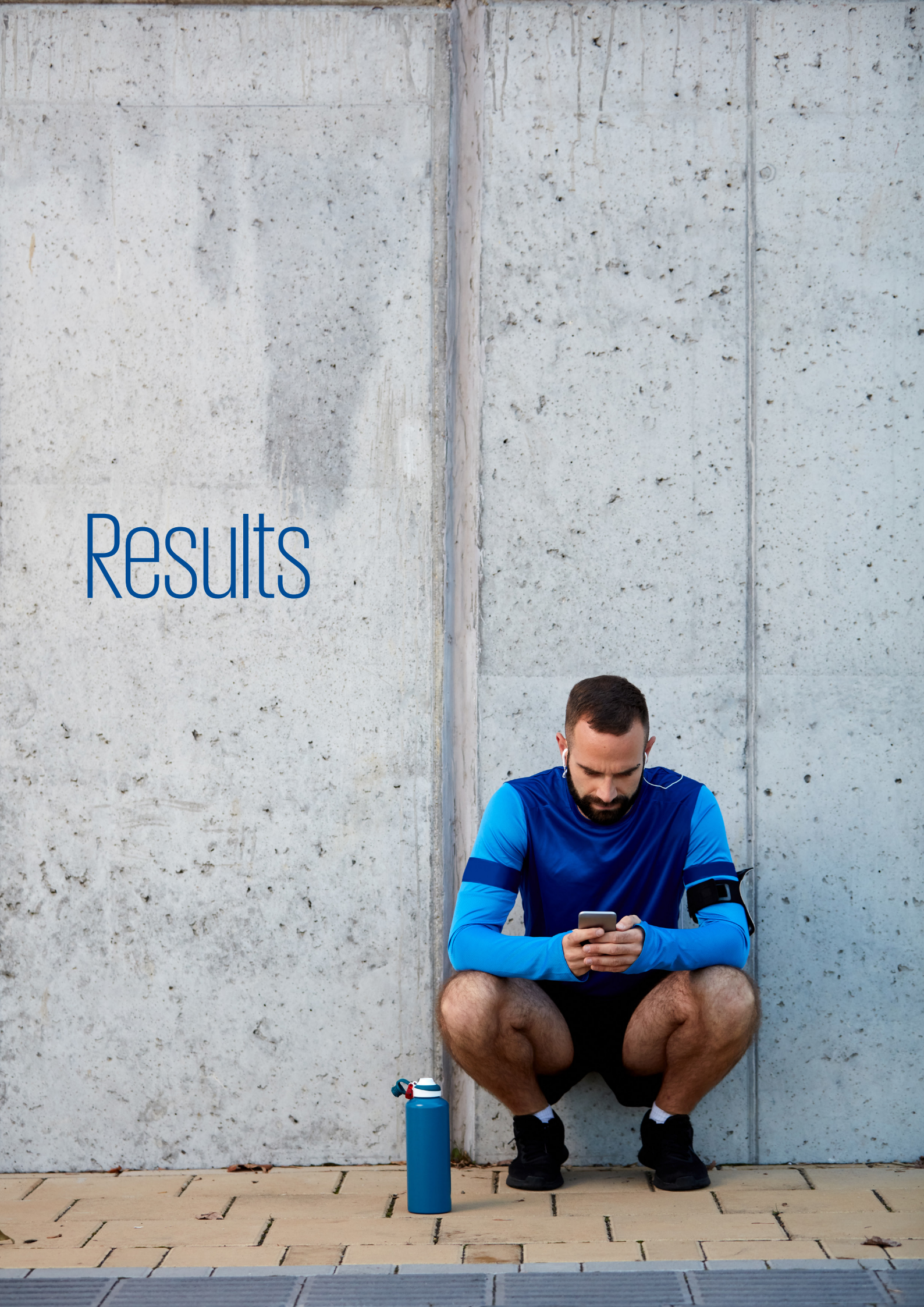
The biopsychosocial model is widespread in its use in contemporary medicine, psychiatry and psychology. It is a framework that reflects the dynamic and complex interplay of factors resulting in the development and maintenance of mental health conditions as well as other conditions.

It permits for multiple treatment targets in the therapeutic context (i.e., psychological interventions may target psychological reinforcing factors such as the tendency towards catastrophising in the case of generalised anxiety, or social reinforcing factors such as parenting behaviours in the context of conduct disorders in childhood). In addition, it aims to de-stigmatise mental conditions by not solely emphasising biological and innate characteristics of the individual in the context of mental health diagnoses.

There has been some criticism of the biopsychosocial model from Ghaemi (2011), who put forward the possibility of artificial distinctions being drawn between biological, psychological, and social domains in the development of mental health problems. Application of the biopsychosocial model in clinical case formulations provides for an inclusive pathway for assessment of psychosocial influences and appropriate interventions.

In contrast to the diagnostic model, case conceptualisations that have a psychosocial focus are currently central to clinical psychology. Case formulation developed from a psychosocial perspective enable consideration for causal factors and an individually targeted treatment response. Gaining an understanding of the presenting problem, predisposing factors (e.g. family history), environmental/emotional triggers (precipitating factors), perpetuating factors and protective factors from a psychosocial context are likely to provide enhanced, expedited client focused outcomes. Assessing each case from an individual psychosocial perspective also allows for effective mental health triage, whereby subclinical mental health problems can be differentiated from severe mental disorders and illness.

Results



Results

Literature review

Results presented here are a summary of the research, a full list of the literature reviewed is provided in the appendix. The literature review results are reported in the following sections, reflecting the outcome measures of interest relevant to the life insurance industry, being:

1. **Common mental health disorders – depression, anxiety and substance use disorders.**
2. **Workplace and intrapersonal psychosocial risk factors.**
3. **Impact of intrapersonal factors on mental health**
4. **Absence from work**
5. **Return to work**
6. **Comorbidity and secondary pathology**
7. **Socio-demographic considerations in mental health aetiology**
8. **The concept of odds ratios**

1 Common mental health disorders – depression, anxiety and substance use disorders.

Depression and anxiety were outcome variables of a number of studies sourced from the literature search. Workplace and intrapersonal psychosocial risk factors were found to be associated with the development of common mental disorders (CMD). The results of one study found that high psychological job demands, low job security and a lack of social support were associated with the development of sub-clinical depression and anxiety symptoms (Andrea, 2009).

In another study, the Centre for Epidemiological Studies Depression Scale (CES-D) was used to measure depression symptoms at baseline and after three years in a sample of nearly 10,000 workers. The CES-D is a short self-report scale designed to measure depressive symptomatology in the general population. The results showed that lower depressive symptoms were related to high decision latitude (autonomy and use of inherent skillset), while high job demands and low social support predicted higher levels of depression (Paterniti, 2002). Major Depressive Disorder, Generalised Anxiety Disorder and Alcohol Use Disorder were also found to be associated with poor social relations at work, job strain and effort-reward imbalance (Riviere et al., 2018). It is commonly believed that these workplace factors could be a starting point for General Practitioners and Employers to identify with their people/patients and, to communicate with occupational physicians in order to prevent the onset of common mental health conditions. Additionally, employers are found to play a critical role in providing safe work environments that consider both work design, job control and intervening early if stress or distress is observed. The evidence from these cohort studies is strengthened by systematic reviews investigating the relationship between psychosocial factors and depression and anxiety.

A meta-analysis of longitudinal studies found a relationship between increased risk of depression and effort-reward imbalance (ERI), and organisational injustice and bullying (Bonde, 2008). A strength of this research was an adjustment for demographic co-variables including domestic stressors, personality traits, history of depression and comorbid physical disability. Another systematic review showed that ERI and job strain (the combination of high psychological demands and low decision latitude) were also reported as having a 'causal' association with common mental disorders and unspecified mood disorders according to ICD-10 criteria. A modest association between social support and job insecurity with these outcomes was also reported in this research (Stansfield and Candy, 2006).

Employers play a critical role in providing safe work environments that consider both work design, job control and intervening early if stress or distress is observed.

A more recent systematic review investigated the relationship between work environment and depressive symptoms, assessed one to five years after baseline measurement. The findings showed that there was 'moderately strong' evidence that subjective reports of low decision latitude, bullying and high psychological demands were associated with the development of depressive symptoms over time. It was also suggested in this research that modification of conditions through organisational interventions might mitigate these psychosocial risk factors and reduce the prevalence of depressive symptoms in the workplace (Theorell et al., 2015). This assertion was also posited in research that focused on assessing the influence of workplace psychosocial factors and the development of stress-related disorders (Nieuwenhuijsen, Bruinvels, and Frings-Dresen, 2010). The results of this study found that high job demands, low job control, low supervisor and co-worker support, organisational injustice and high effort-reward imbalance were related to increased occurrence of stress-related disorders measured by the General Health Questionnaire.

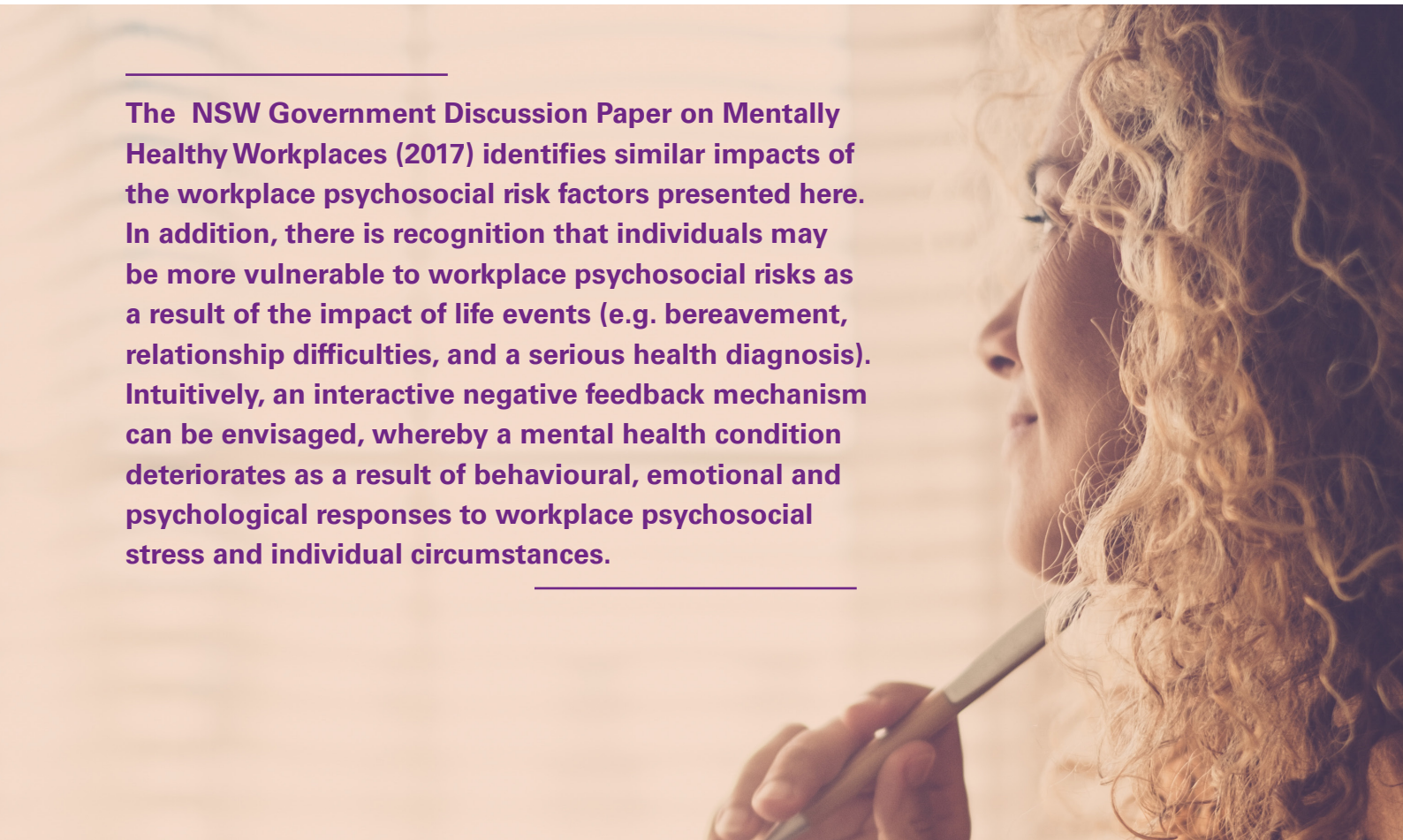
4 Absence from work

There were limited research results solely related to absenteeism and psychosocial factors derived from the literature search. There were only a small number of studies retrieved strictly measuring the link between absence from work as an outcome variable in investigations. In one study, work-related psychosocial factors were found to be predictive of absence from work for three or more days. These factors included job control, job strain, decision latitude, social support and perceived organisational injustice (Duijts, Kant, Swaen, & Zeegers, 2007). In a study of longer-term sick leave absence, bullying in the workplace was a psychosocial risk factor found to be a cause of sickness absence (Janssens et al., 2014).

Absenteeism was also an outcome variable in a systematic review that reported long work hours, high job demands, lack of control, non-participative decision making, poor social support and unclear management were associated with sickness absence (Michie and Williams, 2003). These results were supported by a systematic review of workplace task restructuring which involved increasing control over work tasks and decreased demands. The results showed improved psychological health and disinclination toward absence from work (a surrogate indicator for possible mental health decline).

An important conclusion for these studies was the recognition that workplace factors were amenable to change.

The NSW Government Discussion Paper on Mentally Healthy Workplaces (2017) identifies similar impacts of the workplace psychosocial risk factors presented here. In addition, there is recognition that individuals may be more vulnerable to workplace psychosocial risks as a result of the impact of life events (e.g. bereavement, relationship difficulties, and a serious health diagnosis). Intuitively, an interactive negative feedback mechanism can be envisaged, whereby a mental health condition deteriorates as a result of behavioural, emotional and psychological responses to workplace psychosocial stress and individual circumstances.



5 Return to work

Psychosocial factors are also important negative and positive drivers of occupational rehabilitation and return to work (RTW). It has been argued that many recipients of disability benefits are not completely incapacitated and retain some capacity for work (Aylward, 2015). Many people on claim have diagnosed health conditions and a belief that they are unable to work, often reinforced by medical advice, benefit systems and employers resisting return to work until full recovery is achieved. These assertions were supported by a meta-analysis of cohort studies that found the time taken to return to work positively correlated with visiting a medical specialist and disengagement from the employer (Nigatu et al., 2017).

Psychological influences in return to work include subjective experience of beliefs about the workplace and perceived ability to return to work. Shared beliefs, attitudes, and expectations about illness, and return to work possibilities expressed by family, employers, medical professionals and individuals, may also interact and be reinforcing to those experiencing health concerns. Optimism around return to work expectations, strong resilience, consistent and early contact from the employer, work-oriented values and adaptive coping strategies were also found to be associated with positive RTW outcomes (Aylward, 2015; Cancelliare, 2016). Contra-indicative factors in RTW include risk avoidance, psychological distress, low mood, emotional dysregulation and uncertainty. While the research identifies some relationships of psychological and social influences in return to work, the relative impact and importance of these psychological factors varies between individuals and over time.

Psychological factors that have been found to have an adverse influence on RTW include the perception of work demands, low job satisfaction, lack of social support by co-workers and employers, attribution of health conditions to work, and low expectations about a return to work. Frustration, depression, anger, confusion and support system complexity can also negatively impact the process of returning to work. Higher self-efficacy has been found to mediate the relationship between mental health and RTW.

Longer duration of mental health and illness, the severity of symptoms and somatic comorbidity is also associated with delayed RTW (Nigatu et al., 2017; Eggert 2010). In a synthesis of systematic reviews, prior history of sick leave, higher physical work demands, unemployment and low self-efficacy were also found to be associated with lag times in RTW (Cancelliare, 2016). This research also reported that RTW coordination and multidisciplinary interventions that included workplace stakeholders were associated with positive outcomes.

6 Comorbidity and secondary pathology

The literature review also resulted in a number of retrieved papers reporting the impact of psychosocial stressors in the secondary development and maintenance of mental health conditions associated with primary somatic complaints. Haftgoli et al. (2010) reported that depression and anxiety commonly co-occurred with physical complaints (e.g. headaches, back pain, thoracic pain or digestive trouble). They found that psychosocial stressors including stress at work/home, financial stress, adverse recent and past life events and social support were frequently associated with comorbid physical and mental health problems.

There is also increasing evidence of the role psychological health plays in the development of musculoskeletal (MSK) disorders. Safe Work Australia (2013) proposed that the relationship between psychosocial factors and MSK conditions increases the importance of mediating the epidemiological role of workplace psychosocial factors.

Also, consideration should be made of the possibility of comorbid mental disorders playing a role as a psychosocial stressor. An example of this is the comorbid occurrence of substance use disorders and depression and anxiety.

These relationships allude to the complexity of psychosocial factors in the development of mental health conditions. The complexity of the epidemiology of mental health conditions is further complicated by consideration of the prognostic influence of socio-demographic conditions.

7 Socio-demographic considerations in mental health aetiology

The association between socio-demographic factors and workplace absenteeism and the development of mental health conditions has also been researched. From the context of workers compensation claims, being older, female, working in small organisations and specific industry sectors predicted increased compensation claims and delays in sustained return to work (Prang, Bohensky, Smith, & Collie, 2016). History of previous sickness absence, socioeconomic status and unemployment were also found to be associated with prognosis of long term disability due to mental illness (Cornelius, Van der Klink, Groothoff, & Brouwer, 2011).

Particularly relevant to this paper is the finding from the aforementioned research that negative recovery expectation (an intrapersonal psychosocial factor) is also positively correlated with long term disability.

At least two recent studies have attempted to develop and validate predictive algorithms for the onset of mental illness utilising a combination of socio-demographic and psychosocial factors.

Wang et al. (2014) employed a number of factors including health history, socio-demographic data, comorbid symptomology, and avoidant personality as predictors in an algorithm explaining the risk of recurrent depression. They concluded that the model may assist the medical sector in assessing the probability of a recurrent episode of depression. Notably, workplace psychosocial factors were not examined in the development of the predictive algorithm.

In a more robust study, Fernandez et al. (2018) used socio-demographics, health behaviour and history, potential life stressors (including financial hardship), psychosocial work characteristics (derived from the Job Content Questionnaire), social support and perceived personal control to develop an algorithm predicting the onset of common mental disorders. They were able to provide evidence for the predictive capability of an algorithm using these parameters; however, it was recognised that subjective reporting of the predictor variables was a limitation to the study.

8 The concept of odds ratios

Important to the utility of the literature review results is the concept of odds ratios. An odds ratio is the measure of an association between exposure to a stimulus and an outcome. It is the likelihood that an outcome will occur given a particular exposure to a stimulus compared to the likelihood of the outcome occurring in the absence of exposure. Odds ratios are calculated from systematic reviews and meta-analyses by comparing the expected frequencies of exposed positive and negative cases with unexposed cases between a treatment and control group. For example, in a population, if an odds ratio is found to be two, an individual is twice as likely to develop an outcome (e.g. depressive symptoms) from exposure to the risk factor (e.g. high job demands). An odds ratio can be used to determine whether a particular exposure is a risk factor for a particular outcome (Szumilas, 2010). Odds ratios can also be utilised to calculate the importance of various risk factors for an outcome.

Theorell et al. (2015) found a summarised odds ratio for risk of depression from exposure to job strain and psychological demands from a meta-analysis was 1.78. Individuals exposed to job strain and high job demands were almost twice as likely to develop depressive symptoms as an individual chosen at random in the population. From a societal context, it could be expected that an attributable risk of 11 percent is a potential quantifiable sum where 25 percent prevalence of these workplace psychosocial factors exist. However, it must be acknowledged as a limitation with this potential risk sum that the possible interaction of job strain with psychosocial factors outside the workplace could contribute further to the outcome. Risk calculation is a critical component for provision of insurance, and therefore, odds ratios may have a worthwhile application to the industry. As a raw score, they provide some evidence of the influence of psychosocial factors in the probability of developing a mental health problem. However, there are limitations in the use of odds ratios as generalised indicators for the life insurance industry due to a varied population groups.

Summary

The following table summarises from the literature review the psychosocial factors that appear most pertinent for the life insurance industry.

Outcome Variable	Workplace Psychosocial Predictors	Intrapersonal Psychosocial Predictors
 **Depression and Anxiety**	Psychological Demands, Poor Social Support, Job Insecurity, Low decision Latitude, ERI, Job Strain, Organisational Injustice, Bullying, Conflict	Maladaptive Coping Style, Negative Cognitive Appraisal, Neuroticism, Poor Perception of social support, Adverse Life events (e.g. relationship breakdown)
	Authors (Date)	
	Paterniti, Niedhammer, Lang, and Consoli (2002); Andrea, Bultmann, van Amelsvort, and Kant (2009); Mahmoud (2011); Enns and Cox (2005); Sherbourne, Hays, and Wells (1995); Bonde (2008); Stansfield and Candy (2006); Theorell et al. (2015); Nieuwenhuijsen, Bruinvels, and Frings-Dresen (2010); Butterworth et al. (2011)	
 **Absence from Work**	Job Control, Job Strain, Decision Latitude, Social support, Organisational Injustice, Work Demands	Poor Coping Strategies, Poor Illness Perception, Poor Perceptions of the Workplace
	Authors (Date)	
	Grossi, Soares, Angesleva, & Perski (1999); Dujits, Kant, Swaen and Zeegers (2007); Michie and Williams (2003)	
 **Return to Work (Engagement & Disengagement**	Lack of Co-Worker / Manager Support, Physical work Demands	Low Resilience, Maladaptive Coping Strategies, Low Optimism, Low Work-Oriented Values, Risk Avoidance, Psychological Distress, Low Mood, Emotional Dysregulation, Uncertainty, Perception of the Workplace
	Authors (Date)	
	Aylward (2015); Cancelliare (2016); Eggert (2010); Nigatu et al. (2017)	

Table 2: Summary of psychosocial factors associated with pertinent life insurance industry outcome variables from the literature review. Figures in brackets beside psychosocial factors are odds ratios reported from systematic reviews.

Key Panel Findings

Key psychosocial factors identified

The six key experts identified a number of individual psychosocial factors as consistently influential in the onset and development of mental health problems and returning to work. These are listed below by prevalence with the number of interviewees citing the factor circled.

6 Social support or perceived lack of support

Social support is a psychosocial factor shown to have an important role in maintaining and promoting health. Social support is differentiated into three broad types: tangible, instrumental and emotional support.

Tangible and instrumental social support is often characterised by pragmatic physical assistance, financial assistance, and information availability. Emotional support refers more to the feeling of group belonging or the feeling that one is connected to and cared for by significant others.

Social support is also acknowledged as an important moderator in counteracting the effects of loneliness (Tomaka, Thompson, & Palacios, 2006). Loneliness has been recognised as "the next public health epidemic of the 21st century" (Lim, 2018), and is characterised by negative subjective perceptions of a person's relationships (e.g. their relationships are not meeting their needs). The absence of loneliness has been described by the alternative term 'social connectedness'.

Social support can contribute to cultivating feelings of social connectedness. Lack of social support is strongly linked to onset, prevalence and persistence of disease. Social support has been recognised as a buffering factor in the development of mental health problems and gives individuals a feeling of belonging, being loved, cared for and respected and provides a network for communication. Sources of social support include family, friends, community, healthcare services, employers and organisations (Harandi, Taghinasab, & Nayeri, 2017).

5 Cognitions around return to work

Psychological adjustment to injury or illness (cognitive adaptation) and the way an individual evaluates their situation (cognitive appraisal) are important factors in returning to work. Maladaptive cognitions can include illness denial, fear of or perceived inability to engage in regular activities, fears related to the workplace and faulty thinking around one's situation (Prudential, 2017).

4 Workplace leadership/ management

Leadership and management engagement with psychological health programs and lack of recognition of their importance is a psychosocial risk factor recognised throughout the interviews. Line manager conflict was also identified as a determinant of workplace stress and even a barrier in returning to work.

3 Adverse childhood experiences

There is strong research evidence to suggest that adverse childhood experiences (ACE's) also impact on many areas of health and social functioning later in life. A questionnaire has been developed to assess exposure to adverse childhood experiences in the first 18 years of life in the categories of abuse (physical, sexual, emotional), household challenges (violence, substance abuse, criminality, parental separation) and neglect (emotional and physical). Differing levels of exposure to ACE stressors have been shown to result in a graded dose-response whereby outcome intensities (e.g. depression, health-related quality of life, substance abuse) increase with (dose) levels of exposure to stress (Centre for Disease Control and Prevention, 2016)

2 Perceived organisational injustice

Refers to an employee's perception of fairness in the workplace and how an organisation responds to its role in maintaining reasonable parity between workers. Four dimensions of organisational justice have been identified:

1. Distributive justice (perceived fairness in outcomes, e.g. wages),
2. Procedural justice (perceived fairness in procedures determining outcomes),
3. Informational justice (fairness in the communication of information),
4. Interpersonal justice (biased responses to individuals by the organisation).

Perceived organisational injustice can result in a reduction in employee input (productivity) and disruptive behaviours leading to increased conflict and workplace stress (Afzali, Nouri, Ebadi, Khademolhoseyni, & Rejeh, 2017).

2 Embitterment and Punitveness

Embitterment and punitiveness are related to, and can result from, perceived organisational injustice, leading to negative attitudes and behaviours toward an organisation or employer. Punitiveness is linked to a core belief that there must be accountability for making mistakes. If an employer is deemed accountable by an employee for an adverse outcome, it can be a driver for staying off work and prolonged engagement with financial support mechanisms (insurance and welfare) as a means of punishment.

2 Low workplace morale

Development of low morale in the workplace can be attributed to a combination of factors including uncertainty, lack of growth, leadership change, lack of role clarity and high job demands with low rewards. An environment built on a foundation of trust, recognition, autonomy and respect has been associated with the development of high morale workplaces. Low morale can lead to high staff turnover, productivity loss and can act as a feedback mechanism in increasing workplace stress.

2 Job pressures

Job pressures can be described as a combination of the intensity of physical and psychological demands, job strain, role expectations and workplace environmental conditions. Accumulated stress from high job pressure is a psychosocial risk factor that can lead to mental health concerns.

2 Coping style/coping strategies

Changes in life circumstances can induce stress; a positive experience of stress (e.g. marriage, becoming a parent, finding a new job) and distress or negative stress (loss of a job, divorce, death of a loved one etc.). Coping skills, in response to these life stressors, are employed in an attempt to maintain psychological and physical wellbeing. Coping strategies are the emotional, behavioural and cognitive responses to life changes, and can involve seeking support, problem-solving, adjusting expectations, denial and self-blame. There are many coping styles which people use, often subconsciously, to resolve stressful situations. Response to stress can be active (e.g. focused on problem-solving or focused on emotion management to regulate the emotional consequences of stressful events) or avoidant (e.g. withdrawal from the stressor without resolution, engaging in maladaptive escape behaviours, e.g. substance abuse. An avoidant coping style is a recognised psychosocial risk factor in the development of mental health issues.

2 Previous Trauma

Traumatic events are experiences that put an individual or someone close to them at risk of serious harm or death. In response to the event, a number of physical sensations occur through chemical changes brought about by preparation for 'flight, fight or freeze'. This is a normal evolutionary adaptive way to respond to an emergency; however, shock, denial and feelings of sadness, anger and guilt may persist from a previous trauma or childhood trauma and, lead to serious mental health problems including post-traumatic stress disorder (PTSD) and depression.

Themes identified from panel of expert narratives

From the context of life insurance mental health-related claims, six common threads of ideas were evident in the analysis of the interviews and these were presented as recognised themes. These themes were coded based on commonality, the volume of information provided and application to identifying psychosocial risk factors in the development and maintenance of mental health issues.

Importance of Social Support

The most commonly cited psychosocial factor recognised by the key experts in the development, maintenance and treatment of mental health issues was social support. Support was identified as important across a wide social spectrum including interpersonal relationships (family and community), workplace (colleagues, management, organisational), healthcare and disability services and compensation and insurance systems. The perception of being supported was recognised as influential in staying at work, engaging with rehabilitation and returning to work after injury, while lack of support was identified as a driver for anger and resentment.

Work is important for wellbeing and cognitions about staying at work or return to work are important drivers of recovery

Four of the respondents mentioned the importance of work, and in particular "good work", and its relationship to wellbeing. The components of wellbeing and happiness described in a positive psychology model (positive emotion, engagement, relationships, meaning and accomplishment) were stated as important in motivation for staying at work and returning to work after an absence. These components of wellbeing can also be defined as psychosocial factors influencing mental health conditions. Work is important for wellbeing and perceptions of the workplace are an indicator of the probability of returning to work. However, the theory that work must also be "good" work and not cause harm was also acknowledged when considering returning to, or staying at work. The cognitive attributions attached to a feeling of helplessness are important considerations in promoting a return to work.

The impact of the insurance system on psychosocial stressors

The system and process of providing income support itself can be a source of psychosocial distress which potentially can lead to consolidated and secondary mental health problems. Timelines in receiving financial and healthcare support helps avoid mental health problems in both the life insurance and workers compensation industries. Financial stress as a result of a delayed determination of eligibility was identified as a psychosocial risk factor potentially contributing to the duration and exacerbation of mental health issues. The interviewees also posited that an overly officious focus on the burden of proof undermines perceptions of support which are required for developing goodwill and a return to work focus, and that a distance between customers and insurers can exist where this occurs.

Of interest for the life insurance industry, a review of qualitative data exploring the interactions between injured workers and insurers in workers compensation systems found six themes that "influence the development of secondary injury in the form of psychosocial consequences instead of fostering recovery" (Kilgour, Kosny, McKenzie & Collie, 2015). These are summarised below along with comments from the experts that related to these themes.

Counterproductive actions

This was the strongest theme identified in the interviews and includes the concepts of adversarial relations and legitimacy. If injured workers sense that they are not trusted, it can have a negative impact on their relationship with their insurer.

System organisation

The majority (5) of the experts recognised the skillset and qualifications of case managers as having a substantial impact on the injured worker. Specifically, in the area of case management in assessment and response to mental health issues, mental health expertise, sound administrative capabilities and strong communication practices had an impact. Case management is a complex role requiring training in negotiation, coordination, conflict mediation and psychosocial assessment and intervention. Successful service provision in response to mental health and disability claims was recognised as being a result of a holistic response from an interdisciplinary allied health team (general practitioners, psychologists, occupational therapists, rehabilitation counsellors etc.). Response to mental health needs to reflect up-to-date, evidence-based best practice.

Injured workers limitations

In the workers compensation sector, perceived lack of control over the compensation process and lack of knowledge of the insurance system was also recognised as impacting rehabilitation and recovery from injury.

Perceived claims manipulation

Where people on claim perceived that their insurer was using tactical methods to minimise entitlements and service provision, this was reported as having a negative impact on the relationship and interactions with insurers.

Access to treatment

Where there are delays in an insurer approving a claim, it can mean the injured worker paying for their treatment and experiencing financial stress while waiting for a determination of eligibility. Pursuing a legal avenue to expedite the treatment process had the opposite effect, creating further delays and resulting in increased stress and anxiety.

Cooperative relations

Positive and helpful interactions were also noted in the literature review. Receiving clear explanations and answers to questions, timely payments, prompt referrals to health services, and assistance with employment were recognised as promoting engagement and feelings of support.

The health system may contribute to poorer outcomes

Timely response to healthcare and practitioner behaviours have also been identified as important aspects of health service provision from the interviews and the literature. Research evidence suggests that clinical response to injury and illness fails to address issues around work and disability. As a usual first point of contact following disablement, healthcare professionals are in a unique position to provide a work-focused response to presenting problems (Bartys, Frederikson, Bendix & Burton, 2017). This work-focused approach would benefit from an assessment of psychosocial factors in the initial clinical contact. Evidence of this was reflected in an interview response that a psychosocial module had been incorporated in UK training programs for General Practitioner qualifications, and this is in recognition of the perpetuation of ill health and disability by psychological, social and cultural factors.

The Life insurance industry recently presented to government a proposal for legislation change to enable them to provide payment for early intervention rehabilitation treatment. The opportunity would have allowed Life insurers to work collaboratively with General Practitioners to identify psychosocial factors and respond early with appropriate treatment.

The key experts reported that the general health system can be deficient in providing optimal and early responses to mental health problems. Concern was expressed about the manualised diagnosis of mental disorders leading to potential over-diagnosis/focus of biomedical issues and an under-diagnosis/focus of psychosocial factors. In particular, there was a consensus view that a majority of mental health issues are mild to moderate presentations and common health problems that are often symptomatic of sub-clinical psychosocial stress-related issues.

Socio-political influences

There were also a number of socio-political influences identified from the narratives of the key informants. In particular, government regulation of the life insurance industry was recognised as a hurdle for progression to a biopsychosocial model of health provision. An example of this from an Australian context is the current political lobbying by the life insurance industry to reduce regulatory impediments to providing treatment interventions early in the mental health claims process (Vergara, 2018).

The complexity of the cause of mental health problems

Three of the interviewees believed that the ability to predict mental health issues from a set of psychosocial factors alone was not likely. However, psychosocial factors can be used in risk profiling, adjusting incidence probabilities, and when addressed, can improve RTW outcomes and provide effective interventions by assessing a person's psychosocial context.

Overall Findings

The literature review resulted in a plethora of studies exploring the links between the influence of workplace and intrapersonal psychosocial factors that are of pertinent interest to the life insurance industry. While also noted through the qualitative data process, a further three (3) domains of psychosocial importance were identified from project stakeholders and key informant interviews. That is, the health system, the insurance system and, societal structures (government, culture, and economic system) were acknowledged as presenting unique contributions to psychosocial stress. The key psychosocial factors from the literature review and the interviews are identified in Table 3.

There is a complex interaction of factors that influence the development of mental health conditions. Inherent differences in protective factors (personality, resilience, coping strategies, motivation etc.), socio-demographic variables and genetic/ phenotypic vulnerability all appear to influence the development of mental health problems in any individual, with absolute prognostic capability not possible. However, the research indicates that exposure and response to certain psychosocial factors are associated with an increased chance of developing mental health issues or difficulties, increased absences from work and extended time off work after injury or illness. Therefore, psychosocial factors are a valuable focus area for the life insurance industry.

 **Intrapersonal**	Relationship conflict, social support, neuroticism, optimism, negative cognitive appraisal, negative life, adverse childhood experiences, maladaptive coping style, illness perception, resilience
 **Workplace**	Low job control, high job demands, effort-reward imbalance, organisational injustice, low decision latitude, bullying, conflict, particularly with up-line managers, job insecurity, lack of support
 **Health**	Diagnostic mindset, biomedical model, incentivised disability, diagnostic inflation
 **Societal**	Culture (e.g. mental health stigma), economic framework, Government regulation and legislation (e.g. inability to provide early post-claim intervention)

Table 3: Psychosocial risk factors associated with the development and maintenance of mental health issues and absence from work collated from a literature review and quantitative data analysis.

B Part B
Implications for the Life Insurance Industry

Introduction

Aim of Part B

As noted previously, in essence, Part B is a guide for the life insurance industry to help stimulate further transition to a psychosocial approach. It provides observations and implications for consideration by the life insurance industry and the system that it operates within.

It is noted that the scope of research did not extend to surveying the life insurance Industry on how it currently addresses these themes or its plans in these areas. Therefore, the comments made are general in nature.

To support this discussion, a summary of the key elements of the insurance system, relevant for this paper, is outlined in the diagram below:

These observations in this section are centred on product development and policy, underwriting practices and claims management.

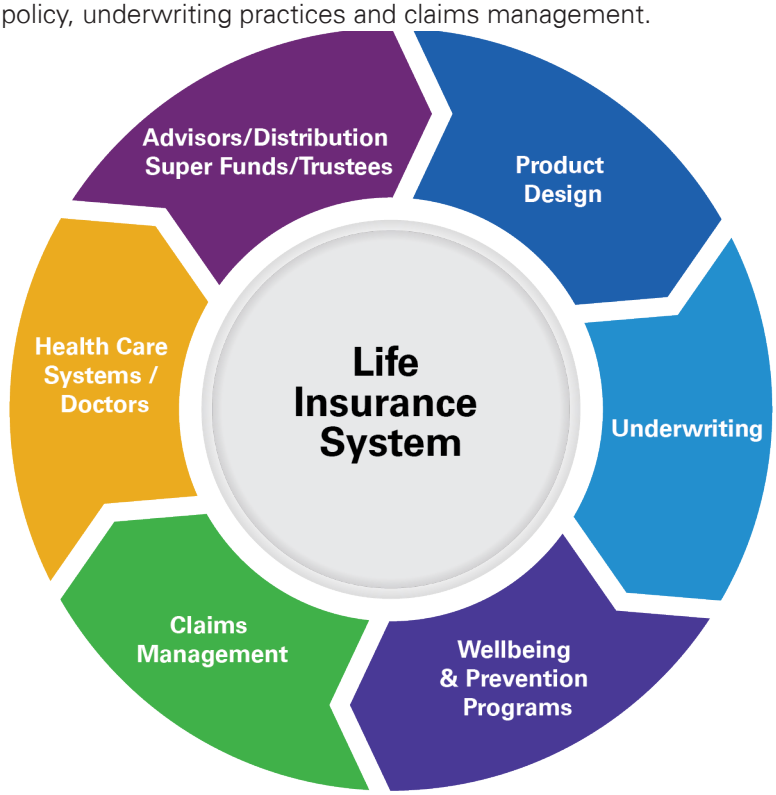
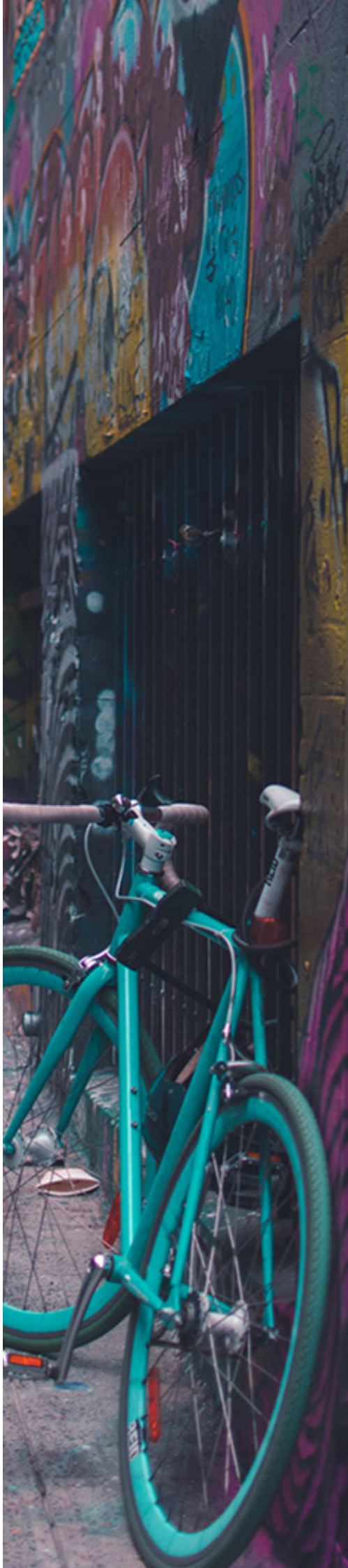


Figure 3: Key elements of the life insurance system



Product Design & Policy

Product Design & Policy

Background

Life products are developed and delivered in predominantly a healthcare environment framed by a biomedical system. This influences many aspects of how policy formation and products are developed in life insurance and underpins how service delivery and customer handling is delivered.

Two specific observations concluded from the evidence in Part A are that:

1. **There are opportunities to further develop a biopsychosocial model in the life insurance system and ensure it becomes fully embedded.**

2. **The healthcare system and its policies have limitations to supporting the life insurance industry with a continuum of psychosocial care to injured and unwell people.**

1 Insurance policy impact to overall system

Much of the research outlined in Part A relating to system stressors focus on physical injury in the worker's compensation sector; however the system stressors identified in this compensation scheme environment are learnings to be adapted for the life insurance industry.

Life insurance product contracts typically require that the Insured's burden of proof of disablement is satisfied for claim eligibility. Learnings from workers compensation studies indicate that overly onerous requirements to show proof of disablement can often result in a negative experience for people that can precipitate stress responses (depression and anxiety) that extend time off work. For example:

- Delays in decision making, excessive document requirements, and financial stresses (due to uncertainty in the insurer accepting the claim) can all have mental effects on customers (Dean, Mathewson, Buultjens, & Murphy, 2018; McEachen, Kosny, Ferrier, & Chambers, 2010).
- If the claims system process continuously reinforces proof of presence/extent of injury or illness, this leads to distrust and perception of being discriminated against (Dean, Mathewson, Buultjens, & Murphy 2018; McEachen, Kosny, Ferrier & Chambers, 2010). A perceived negative experience by a customer has been described as leading to further psychosocial issues being experienced and this can include miscommunication leading to a perception of being deceived or misled, underlining the importance of clear, timely communication.

The situation where a customer is suffering a combination of psychosocial issues and low levels of mental health can magnify any of the mentioned issues. This leads to the following considerations for life insurers:

- Is the current insurance system (e.g. product design, underwriting process, claims management) appropriately designed to deal with customers suffering a combination of psychosocial issues and low levels of mental health without compounding the mental health issues and leading to poor customer experience outcomes?
- Are insurers doing enough to review each step of the insurance system and considering whether their processes, policies and procedures are creating psychosocial issues. If so, what changes should be made to mitigate any issues identified?

2 Current healthcare system limitations

Professor Ian Hickie, in the Sax Institute's Public Health Research and Practice journal (Hickie, 2017) concludes that the best way to deliver higher-quality mental healthcare was through multidisciplinary teams.

"In many cases, however, these are resisted by professional organisations that prioritise fee-for-service, solo-practitioner or single-professional group styles of practice," he stated. "We also continue to prioritise funding into institutional settings when we know that community-based psychosocial, primary and community health services can have the most impact."

Research (Harvey et. al., 2017) recently conducted on the prevalence of mental illness increase in Australia, in particular for more common mental health disorders, (CMD) through 2001 to 2014 suggests that "contrary to popular belief, the prevalence of probable CMDs in Australia was stable between 2001 and 2014. However, the proportion of the working age population receiving social security benefits for psychiatric conditions increased dramatically over the same period.

This conundrum is a major public health problem that should be further examined." (Harvey et al., 2017).

Mental health issues and difficulties have complex epidemiology. An appreciation of the incidence, distribution, and possible control of mental health and other factors relating to mental health, and in turn, the alignment of predictive psychosocial factors of mental health decline are currently areas of research in their infancy.

The World Health Organisation (WHO, 2018) remains concerned that the increased incidence of mental health diagnoses, expansion of treatment options and debate on best practice into preventative measures still requires significant focus if the rising burden of mental health issues is to be controlled.

This worldwide focus is generating differences for what prevention, intervention and treatment options could look like for primary, secondary and tertiary measures to manage mental health[1].

Given the above comments, if the life insurance industry is to embed the biopsychosocial approach further into product design (and claims processes), then further collaboration with the healthcare sector would appear necessary. Possible considerations include:

- Could life insurers be doing more to support a multi–disciplinary integrated approach to mental health? Health professionals, employers and multidisciplinary services working together would ensure issue identification and a continuum of care for the individual/customer, provide co-operative relations and decrease system disorganisation as detailed in Part A.
- The advocacy role of general medical practitioners to support a person throughout their healthcare requirements is a powerful relationship, with the general practitioner well placed to lead multi-disciplinary care solutions. Should the life insurance industry support and collaborate on this further?
- Should insurers be doing more to support community-based psychosocial, primary and community health services? There may be the opportunity for life insurers to work with general practitioners on a change in the process to identify psychosocial factors early in the medical assessment of their presenting patients. With an introduction of adequate workplace and community health services, an extension of support could be offered that prescribes psychosocial conditions and associated treatment.
- Should insurers be doing more to support line managers within employer organisations, accessing more training to detect and respond to early signs of psychosocial issues and protect the mental health of workers through increased resources provided by the healthcare sector and potentially life insurers? This would have the potential to increase the provision of early intervention treatment.

1 It should be remembered however that there are currently legislative restrictions on life insurers providing payment for rehabilitation treatment.

Underwriting

Underwriting

The challenge of using psychosocial factors in underwriting

Underwriting is designed to achieve a range of purposes which include aligning the loadings for risk built in premium rates with the actual risk profile of people applying for insurance.

A key challenge of the insurance industry and society in general is how accurately risk should be priced. By pricing risk more accurately (granularly) some policy holders will receive a premium rate reduction, while others will receive a premium rate increase. At the extreme, refining this process could make insurance unaffordable for some people.

Currently psychosocial factors are not always priced into risk assessment for life insurers. The analysis highlights in Part A that exposure to psychosocial factors do impact risk, which prima fascia suggests that psychosocial factors should be considered in the underwriting process, however, a decision to include psychosocial factors in the underwriting process is a complex decision, involving the consideration of a range of factors including:

- Statistical reliability;
- Community expectations, and affordability of insurance for insurable Australians; and
- Discrimination issues and privacy concerns.

For example FSC Standard No. 11 restricts life insurers from using an adverse result from a genetic test for sums insured that are below certain limits[4]. FSC Standard No.16 outlines principles regarding how information regarding family health history should be used in underwriting decisions.

In addition to the above points, it is noted;

- As explained in Part A, the compounding impact of psychosocial factors is an important consideration for insurers that want to incorporate psychosocial factors into underwriting decisions.
- The analysis also highlights that various psychosocial factors can also be environmental in nature. Predicting exposure to future psychosocial factors would appear problematic.
- The previous section highlights that the impact of psychosocial factors on individuals is hard to predict. For example, some people prefer low levels of social support while others prefer high levels of social support.
- Including psychosocial factors in the underwriting process may discourage individuals from reporting and treating their psychosocial stressors. This is an important consideration for the industry.
- In some cases past and current exposure to psychosocial factors is clear for the policyholder to understand and report. However in other cases this would be less clear. This could lead to a range of issues regarding poor customer experience, and disputes at claims time regarding disclosure issues if this was considered to be introduced in the application assessment phase.

Given the above points, incorporating psychosocial factors into underwriting decisions would appear to involve a number of challenges, with further analysis and research required to understand and address the points above. It is noted that one of the expert interviewees indicated that they were aware that a UK insurer had attempted establishing psychosocial factors for underwriting rules and pricing algorithms, however this had proved to be unsustainable.

[4] The financial limits set in FSC Standard 11 for the different types of personal and group life insurance a person can have in total with all life insurance companies together are $500,000 of death cover, $500,000 of TPD cover, $200,000 of trauma/critical illness cover, and $4,000 a month in total of IP, salary continuance and/or business expenses cover.

Overview

Notwithstanding the above points, the following areas for consideration are noted:

1. **For applicants that have suffered mental illness claims in the past, obtaining a better understanding of the contribution of psychosocial factors to their mental health issues in the past, and the likelihood of these factors reappearing or other factors emerging, may be appropriate.**

2. **Increasing the focus on the identification and management of psychosocial issues within Wellness programs may be appropriate.**

3. **In group insurance, allowing for work place psychosocial factors in the pricing schemes may be appropriate. This may include consideration to providing premium discounts for workplaces that run programs that attempt to reduce work place psychosocial factors and absenteeism rates. There is also a need for more research on the effectiveness of workplace interventions on work and the achievable outcomes for people experiencing mental health issues (van Vilsteren et al., 2015).**

4. **Increasing the collection of psychosocial data at the application phase is needed if psychosocial factors are to to be considered in the underwriting process whilst still being cognisant of the ethical and moral challenges of screening applicants and enabling access to insurance.**

1 Assessment of those that have previously suffered a mental illness

To ensure the objectivity of the underwriting process, it relies heavily on the medical assessments of doctors. However, the discussion above highlights challenges with the treatment of mental health by the health system (e.g. the potential over inflation of mental health issues, and an under identification/ recognition of psychosocial issues). To alleviate this risk and create more equitable assessment of an individual's risk factors, are life insurers doing enough to:

- Identify with applicants and their medical practitioners the contribution of psychosocial stresses to their mental health issues?
- Assess if the psychosocial issue has resolved?
- Assess the ability of the applicant to cope with psychosocial issues in the future
- Understand the cumulative factors to enable insures to distinguish between mental health and psychosocial factors so more access to cover may be possible.

2 Psychosocial issues and recovery from past events

- The research highlights that psychosocial factors can contribute to explaining why one individual recovers as expected post an injury or illness and others do not.
- Are life insurers doing enough to understand how quickly applicants have previously recovered from past events and the contribution of psychosocial factors to their recovery, and factoring this into underwriting decisions?
- It is noted that there are psychometric tools that can measure an individual's exposure to a number of psychosocial risk factors. For example, the Job Content Questionnaire (Ostry et al., 2001) measures a suite of psychosocial risk factors in the workplace, while a number of instruments are available to measure personality type, coping skills, and cognitive attributions. These tools have potential to be modified and applied in the underwriting phase to help understand if psychosocial issues contributed to the duration of past events.

3 Wellness programs

Some insured people participate in wellness programs offered by their insurer. These programs are typically designed to encourage a healthy lifestyle, thereby reducing the potential need to claim on insurance. Are life insurers doing enough to:

- Collect data on psychosocial issues at the application phase and then use this data regarding past/current psychosocial issues to target wellness services to their customers? As noted above various tools exist to collect psychosocial information.
- Incorporate the identification and management of psychosocial issues in wellness programs?

4 Group pricing and encouraging workplace changes

For group insurance products (as mentioned in the previous section) various data could be acquired/analysed that provides insight into workplace risk factors such as persistent conflict, poor attendance, performance management history, previous compensation claims or matters involving harassment in the workplace. This information could then be used to adjust prices, and/or encourage change in the workplace (e.g. no pricing increase if changes to manage workplace psychosocial risks are made).

For example, a more collaborative model between Human Resources (HR)/Employee Assistance Programs (EAP)/Work Health Safety (WHS) providers could contribute to a reduction of psychosocial risks in the workplace and claim costs. Actions could include:

- Centralising/sharing data collection to analyse psychosocial predictors specific to the sector or employer;
- Customising the design and use of prevention wellness programs based on the data;
- Increasing the promotion of EAP counselling services for psychosocial issues;
- Running mental health psycho-education programs;
- Implementing structural responses to known psychosocial risk factors in the specific sector or employer; and
- Providing greater social support to employees. It is well established in Part A that those who are identified as having less coping skills and limited social networks may benefit from social support while they are recovering from mental health issues.

5 Data collection

The analysis in Part A highlights potential benefits of collecting data for underwriting on the following factors:

- Maladaptive coping skills;
- Negative life events;
- Perception of illness;
- Levels of resilience;
- Social support networks;
- Workforce attitudes; and
- Job insecurity.

These factors may provide validity to the specific predictors of longer periods of time away from work and poorer return to health outcomes. Increasing the collection of psychosocial data at the application phase is needed if psychosocial factors are to play a greater role in the underwriting decision process. Positively, some insurers have started to do this.

Claims

Claims

Background

The claims environment is the entry point of the insurance lifecycle which can have immediate benefit from focus on psychosocial risk factors. Prevention, assessment, intervention and optimal management of claims are all pertinent areas of application for a biopsychosocial model of mental healthcare delivery.

Prevention can refer to pre-claim reduction of risk factors, on-claim prevention of extended time off work, and post-claim prevention of relapse and re-engagement with the insurance life cycle. Intervention can occur before a claim is lodged (in the workplace) or as an element of the post-claim systemic response. There are legal impediments that limit life insurers' ability to undertake preventative interventions. While lobbying government for change on this matter, life insurers do not fall under the Health Insurance Act and are precluded from providing medical treatment to customers.

Case management with a psychosocial focus should include pertinent assessment, intervention response and outcome measurement of psychosocial risk factors throughout the life of the claim. An important consideration of the claims management environment is the need for framing strategic responses in a return to work and functionality (not disability) context. The important knowable risk factors at claim reflect those identified in Part A of this paper.

Key topics that the claims model in the life insurance industry could consider are the following areas:

1. **Intrapersonal psychosocial factors are well evidenced as critical to return to work and mental health wellness outcomes and, there are opportunities to manage these factors within claims management.**
2. **The ongoing monitoring of people on claim with mental health issues.**
3. **The collection of psychosocial data.**
4. **Improvements in return to work strategy planning and outcomes through improved relationships with medical practitioners and better differentiation between clinical diagnosis and sub-clinical presentations.**
5. **Development of industry standards regarding the management of psychosocial issues in the claims management process.**
6. **The workplace connection and social support are key areas of focus to enhance psychosocial application in the claims management process and customer relationship.**

1 Psychosocial intrapersonal factors are key determinants to successful return to wellness and work

Key intrapersonal psychosocial factors outlined in Part A specific to wellness and work outcomes were beliefs and perceptions of one's ability to function, coping style and perception of social support. Depression and anxiety were also noted to have a more significant risk on outcomes if there had been a more recent life event, such as a bereavement or relationship separation.

Positive outcomes are further reinforced when the person on claim considers the relationship with the case manager is strong and that sense strengthens over time. The ability to establish a good interpersonal connection with empathy and warmth, tailored to the individual person, rather than specific specialised treatment can produce successful clinical outcomes (Lambert et al., 2001).

There is extensive clinical evidence that beliefs aggravate and perpetuate illness and disability (Main & Spanswick, 2000). The more subjective, the more central the role beliefs play on an individual's cognitive response to recovery or return to work. Beliefs can influence perceptions and expectations, emotions and coping strategies plus motivation and uncertainty. To change belief and attitude an individual must be clearly understood first (Gatchell & Turk, 2002; Waddell & Aylward, 2010).

A shift to understanding at the initial claims assessment phase the beliefs/attitudes and perceptions could lead to better management strategies for emotional and social support of the individual on claim. The following are presented by Aywlard (2010) as suggested areas to address when assessing and managing an individual's beliefs and perceptions:

- Modulate expectations, understand individual values to work;
- Recognise and address the social contexts of ill-health - disadvantage and economic inactivity;
- Promote and educate for emotional/physical well-being;
- Engender clear work focus and vocational goals;
- Encourage behaviour change; and
- 'Living with' not recovering from fatigue/pain.

It is hypothesised that the opportunity exists for:

- The qualified claims professional to extend the initial assessment of the claim further than is currently practised, and include the above identified factors in the first assessment phase while building a relationship with the individual. These key determinants could be built into a more clinical psychosocial assessment of the person's presenting state and history as a means to understanding their potential risk of future mental health decline.
- Insurers to better match the personality, values and beliefs of the claims professional to the personality, values and beliefs of the person on claim.

2 Continuous monitoring

The experience in the life insurance industry for the current levels of mental health claims indicates that there are longer durations of recovery, although this is contrary to the stated biomedical duration for these mental health conditions. Hypotheses presented by the key experts suggest that causes of these longer periods out of work are potentially due to unresolved psychosocial circumstances.

With more continuous monitoring of the changing circumstances and psychosocial profile of a person on claim, the claims professional has an opportunity to intervene with the right resources to support the issue and maintain RTW planning.

This raises considerations for insurers' processes and practices. Is monitoring the progress and profile of psychosocial risks on mental health claims optimal? For example, could more formal regular reviews be made (e.g. at 6 weeks, 3 months and 4 months) to determine potential changes in the determinants of psychological and social health?

3 Claims data

Risk factor identification for potential delayed return to work is a recognised component of high quality claims case management. Recovery expectations and beliefs, mental health status and general behaviour (e.g. substance use) are psychosocial influences that expedite or slow down return to work outcomes. (Iles, Long, Ellis, & Collie, 2018).

Consistent with the previous section, the life insurance industry would benefit from collecting data on psychosocial risk factors as a means to acquiring the evidence base to support the development of tools and practices to identify and manage psychosocial disability. A centralised data collection source could be initiated by the industry to accelerate this research.

Development of a psychosocial pathway of intervention could be then considered in the life insurance industry as a trial to testing and validating the predictive factors, and evaluating outcomes of a psychosocial approach to managing mental health issues and conditions.

4 Return to work model in the life insurance industry

Healthcare practitioners

Client-centered, supportive interactions by healthcare providers and insurance professionals is a critical element for people on claim. Developing a therapeutic alliance is a key factor in the efficacy of medical and psychological interventions. Erosion of trust between the insurer and the person on claim (as well as healthcare providers and the person on claim) can occur if there is an adversarial relationship between insurers and healthcare providers.

As noted in the product design section, the relationship with the individual on claim as a means to providing greater support may benefit from shifting the 'proof and investigation' focus that can often be inherent in the life insurance claims process and reduce the stress associated with the claim assessment process. If the person on claim perceives there to be a cooperative relationship existing between the insurer, employer and medical practitioner; the response is more likely to be collaborative when participating in the return to work coordination planning.

Research evidence suggests that multicomponent interventions targeting stress (psychosocial risk) and maintaining contact to work improve return to work outcomes for injured or unwell workers (Mibkkelsen & Rosholm, 2018)

Potentially the 'relationships' developed in the claims stage are the most critical element. Further review of how it is built into the claims organisation's return to work (RTW) model and the capability framework of the life insurance claims case managers is a suitable starting point for critically evaluating how well life insurers are embedding psychosocial models.

Clinical diagnosis and sub-clinical presentations

Consistent with our observations with underwriting, it is hypothesised that the claims management process could benefit from better identification and differentiation between clinical diagnosis and sub-clinical presentations (i.e. psychosocial factors) for return to work intervention prioritisation. For example, this could involve delineating cases:

- Between predominately mental health claims versus mental illness versus psychosocial claims;
- Segmentation of cases based on level and type of service interventions;
- Provision of suitably qualified claims professionals based on the case profile; mental illness versus psychosocial profile.

The key experts, as detailed in Part A, recognised that a significant issue existed whereby mental health issues or problems are given a mental disorder diagnosis, particularly by general practitioners to satisfy policy requirements.

There was general opinion by key experts that mental health diagnoses are somewhat loosely applied (e.g. self-report of a couple of 'symptoms' can result in a diagnosis). The vast majority of these presenting problems, once labeled 'stress' issues, now attract a disorder diagnosis that leads to potentially ineffective 'treatment', i.e. a prescription to manage their 'mood', not address their psychosocial problem/s.

Key questions put forward by the Productivity Commission into The Social and Economic Benefits of improving Mental Health, 2019 were;

- How could non-clinical mental health support services be better coordinated with clinical mental health services?
- Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

An adjusted triage approach could mirror the current development of a 'stepped care' response to mental health presentations in the Primary Health Networks, an Australian Government initiative to improve the delivery and outcome efficiency of mental health and medical services (Australian Government, 2018).

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional step, but rather offer a spectrum of service interventions. There are four core elements of a step care approach and these consider:

- Groups with different needs, for example, from the population to groups based on needs by severity and complexity;
- Intervention setting by group;
- Evidence based services based on spectrum of need; and
- Matching service types to treatment targets for each needs group to ascertain service delivery.

A triage approach that delineated the difference between mental ill health claims and psychosocial claims could increase focus on the issues impacting the individual and therefore, deliver quicker return to work outcomes.

5 Development of industry standards

Throughout the key expert interview process there was recognition that, to include a psychosocial model, claims professionals would require a diverse and well developed skill-set that currently extends beyond current role capabilities. Recruitment strategies and case management practices within life insurers would need to fully consider the skills, knowledge and qualifications necessary to implement a psychosocial model. Multi/interdisciplinary teams for intervention planning need to be coordinated by appropriately qualified and skilled case managers. Case management is a complex role; mediation and psychosocially focused clinical skills are required.

Practices vary within the life insurance industry with respect to the frameworks used to manage mental health claims.

A key initiative by the industry to set minimum standards for claims handling is the FSC Life Insurance Code of Practice (Code) first introduced on 30 June, 2017. Additional standards of practice could be considered in future versions of the Code or other industry standards (e.g. FSC standards) in relation to the specific handling of mental health claims with clinical and sub-clinical presentations. It is noted that SuperFriend has developed the TAKING ACTION Framework (SuperFriend, 2015), which could be used as reference point in the development of standards. This framework draws on international evidence and local research and endorses a biopsychological and person-centred approach. It also reflects the importance of a biopsychosocial assessment and intervention and the importance and benefits of investing in embedding a case management model that delivers a complete biopsychosocial approach to claims management. Holistic (biopsychosocial) and client (person on claim) centred case management with a RTW focus is also the cornerstone of new emerging models of claims management in the workers compensation jurisdictions and international disability compensation sectors, which could also be leveraged.

6 Key determinants of workplace connection and social support are integral for successful claims management for customers/members

Connection to the workplace (continued communications) and social support (support network and relationships) were identified and well researched as commonly associated with more successful return to good health post absence from work due to injury or illness.

White et al. (2019) recently published that "the "social" component of this model is often neglected. This is problematic as previous research has shown that social factors continue to play an important role in injured workers return-to-work (RTW) process, including workers being at increased risk of secondary psychosocial impairment (e.g., depression, disruption to roles or relationships) when they receive inappropriate care or insufficient support. In fact, social and relationship factors have been shown to be important for the prevention of injury and illness generally, with factors such as social relationships, family ties, and greater social contact, showing protective effects on mortality and morbidity".

Workplace connection

Connection to the workplace is viewed as a critical component of successful RTW. More specifically, contact and good communication, genuine care and concern, organisational trust, validation and belief in injury legitimacy, and relationships in the workplace were all correlated with a strong workplace connection and identified as contributory factors in successful RTW and return to good health. White et al. (2019) states that "specifically, positive supervisor responses to injury predicted better RTW outcomes, suggesting that supervisor attitudes to and interactions with employees may be a key target for intervention within the work community."

From a claims management perspective this suggests that:

- Claims management with a psychosocial focus needs to begin at claim 'contemplation' (workplace). Complaints and previous claims are lagged indictors of potential issues at work. Human resources may miss opportunities to proactively identify a claim being contemplated and intervene with support services. Causes of distress and stress in the workplace can often be related to performance/ poor conduct/absenteeism. Understanding this from both the employer and person on claim allows for collaborative intervention to be then adequately planned and coordinated by the case manager.
- Encouraging connection by the person on claim with their workplace, especially with good quality supervisors, should impact positively RTW outcomes. In addition, this communication should be timely, ongoing, and informative.
- Employers should be encouraged to actively work with life insurers to participate in active RTW planning and continuous communication.
- The above steps should be performed in a non-judgemental manner and with genuine care that allows the injured or unwell person to trust that the employer is advocating on their behalf.

Insurers should consider the extent to which they are successfully implementing the above practices.

Conclusion

Conclusion

Importance of mental health

An awareness of upward trends in financial and social costs of mental illness and mental health issues has provided the impetus for policy development across diverse institutional domains. There is growing public and stakeholder expectation that the importance of mental health is considered and embedded in decision processes, consumer products, organisational culture, government services, industry sectors and workplaces. Essentially, protection of mental health, prevention of mental health difficulties and appropriate responses to mental illness have become intrinsic components of an evolving contemporary model of 'business as usual'. Sustainability of business requires:

- certainty in the analysis of risks posed by mental health problems;
- an understanding of the complex nature of their epidemiology; and
- a commitment to applying appropriate evidence-based responses.

An important consideration in response to the impact of mental ill health is loss of employment. Unemployment which is attributed to chronic disability associated with mental health problems incurs a high economic and social cost. Financial costs of healthcare, opportunity costs in lost productivity and individual and familial distress due to loss of income are salient consequences of extended unemployment due to mental health decline. In this context, income protection and total and permanent disability products are recognised as crucial support mechanisms having significant benefits for government, business, industry, community and individuals. The two main providers of income protection and total and permanent disability support nets are workers compensation schemes and life insurance.

The biopsychosocial paradigm

The results of research findings into the aetiology of mental health issues and continued absence from work have intuitive utility for informing improvements to mental health claims for the life insurance industry. The biopsychosocial paradigm is a widely accepted context which is applied both in describing the theoretical development of mental health problems, and also as a foundation for a related healthcare framework. It is derived from an understanding of the importance of predisposing vulnerabilities and the impact of environmental stressors as a precursor to developing mental health issues. The biological component of the model describes genetic, phenotypic and physical predispositions to developing mental health issues. The psychosocial element is a combination of intrinsic psychological characteristics (perceptions, cognitions etc.) and environmental influences that can assist in understanding absence from work.

What can we learn from the literature?

Utilising continuous comparison between the meta-analyses of the literature review and the key informant interviews, a number of common psychosocial risk factors were identified (see Table 3.) that are often associated with development of mental health issues, absence from work and delayed return to work after injury. The links between these psychosocial risk factors and the outcomes are well established, however using exposure to these factors to derive a reliable prognosis is problematic.

Why is this the case?

The psychosocial factors are not exclusive in their influence and association with the outcomes under investigation. There are a number of psychosocial stressors that were identified (as factors in the development of mental health issues) from the literature review and interviews which were not common to both methods.

- Individual differences in innate and environmental protective factors which help to manage stress and buffer the impact of these factors (e.g. social support, resilience, coping strategies). This is an example of modifiable vulnerability to psychosocial risks.
- Impact of life span development history on response to psychosocial risk factors (e.g. Adverse Childhood Experiences may increase stress sensitivities and response to adult exposure to psychosocial risk factors).
- Dose-response, synergistic effects and cumulative impacts are not well understood.

What we can say is that exposure to the psychosocial factors identified from the research increase the risk of developing mental health issues and are influential parameters in absence from work and delayed return to work after injury. These psychosocial risk factors can potentially be used to develop a psychometric tool to improve risk assessment and provide a more informed assessment and specific intervention focus at claim.

Implications for the life insurance industry

This paper presents in Part B a high level guide for the life insurance industry to help stimulate even further transition to a psychosocial approach. It provides observations and implications for consideration by the life insurance industry and the system that it operates within, as well as the key challenges that a change of approach may present

As the scope of research did not extend to surveying the life insurance industry on how it currently addresses the themes and issues identified in the paper, the comments made are focused on outlining considerations for life insurers to evaluate themselves against and consider, rather than making recommendations.

A large number of considerations are outlined in Part B for life insurers to assess themselves against. These considerations cover policy and product design, underwriting, and claims management and range from:

- How life insurers interact with the medical profession; to
- The collection of psychosocial data at underwriting and claim time; to
- Whether insurers are providing sufficient social support to customers.

The emphasis is on using the research as a guide to evaluate where the psychosocial model can impact changes in the life insurance value chain, to benefit insurers and their customers and the industry.

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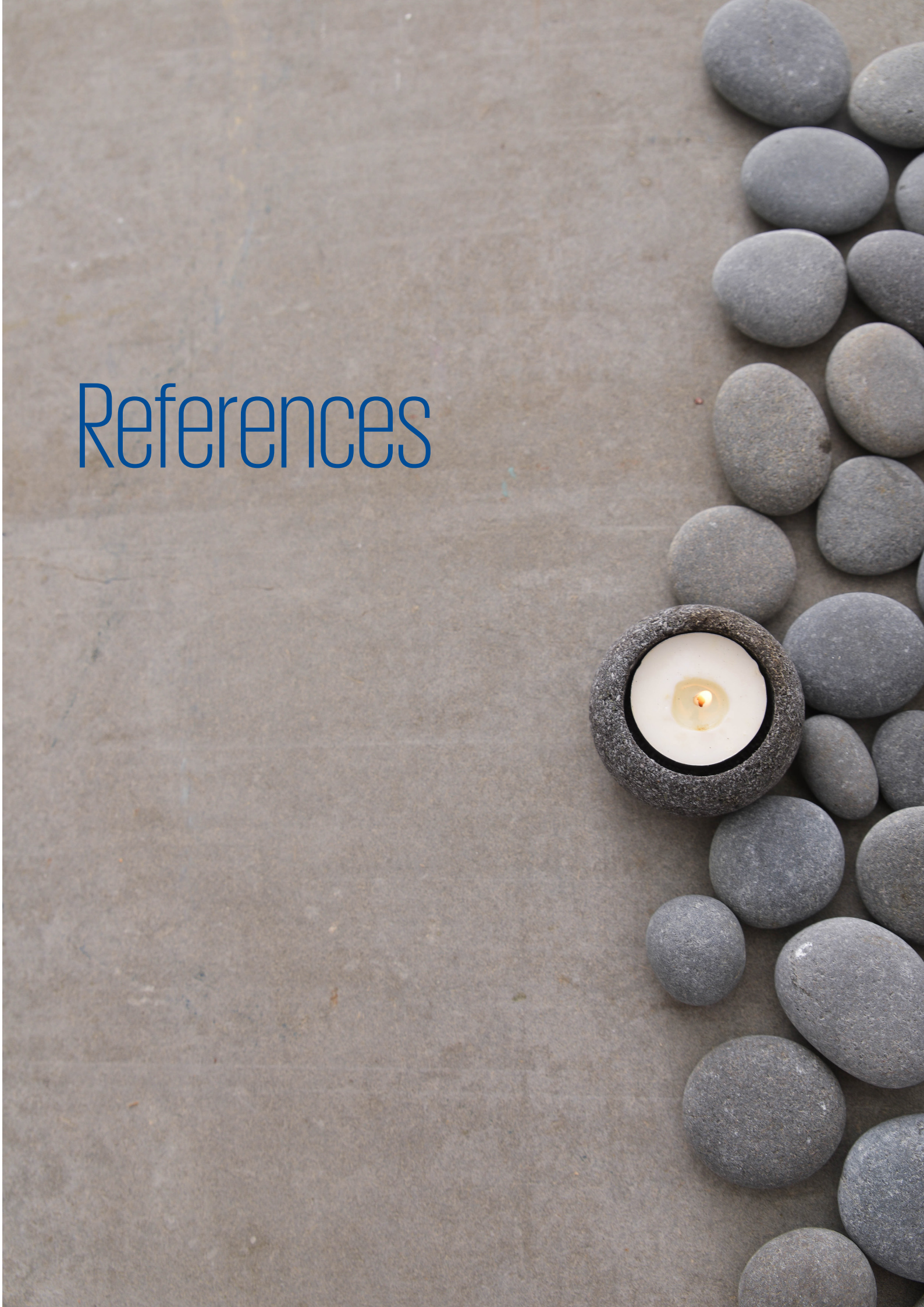

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Curriculum Vitae of Key Experts

Professor Sir Mansel Aylward

Sir Aylward is the Chair and Chief Executive, Life Science Hub, Wales

Professor Sir Mansel is also Chair of the Bevan Commission and Professor of Prudent Health and Wellbeing at the School of Management, Swansea University.

During his distinguished career, Professor Sir Mansel was Chief Medical Officer, Medical Director and Chief Scientist at the Department for Work and Pensions in London. He was the first Chair of Public Health Wales NHS Trust, responsible for the delivery of public health services at national, local and community levels in Wales and former Director of the Centre for Psychosocial and Disability Research at Cardiff University.

He was knighted in the Queen's New Year's Honours 2010 for services to health and healthcare. In 2016, he was elected to fellowship of the Learned Society of Wales.

Ms Joy Reymond

Ms Reymond is the Director and Head of Gender Evaluation Services. In this role, she leads research into the cultural and financial impacts of gender diversity in organisations. Over the last 15 years, Ms. Reymond has held several positions including Senior Absence Management Consultant, Board Member for the Council of Work and Health as well as Director of the UK Rehabilitation Council.

Ms Reymond has over 22 years' experience in the insurance industry, having held the position of Head of Vocational Rehabilitation Services for Unum UK for 15 years. There she oversaw the strategic and operational management of this service, ensuring Unum led the UK market in providing innovative customer experience, preventing long term sickness absence and supporting return to work.

Ms Therese Rein

Ms Rein is the founder of Ingeus, an international employment services agency assisting job seekers, in particular long-term unemployed, enter the workforce.

The Australian Human Rights Commission awarded her the Human Rights Medal in December 2010 for her long-term dedication to human rights, especially the rights of people with disability. In December 2012 she was awarded an Honorary Doctor of the University degree by Griffith University for her services to business, and the award of Doctor of Letters (honoris causa) by the University of Western Sydney in April 2014, in recognition of her service to the Australian community, commitment to human rights, engaging constructively with human rights mechanisms, eliminating poverty and injustice, and the illumination of disadvantage. In 2018, she was inducted into the Queensland Business Leaders Hall of Fame.

Ms Rein has a strong involvement in charity work and is patron of The Australian Common Ground Alliance; UNICEF Maternal and Infant Health Campaign; the Indigenous Literacy Foundation; OzHarvest Food rescue; Ability First Australia; Arts Project Australia; The Bella Program at the Museum of Contemporary Art, Sydney; ACT Junior Talent Squad for Athletes with a Disability; Shakespeare on Oxford Festival at Bulimba, Brisbane. She is a member of the Honorary Board of the International Paralympic Committee.

Mr Justin Simonds

As the Principal Consultant Psychologist at CommuniCorp Group, Mr Simmonds works closely with organisations to prepare and manage the array of complex clinical, legal, ethical and risk scenarios that occur on a daily basis within teams. He is an experienced Clinical Psychologist with 17 years' experience, working across vocational counselling, life and business coaching for individuals and organisations and occupational rehabilitation.

During his time as Psychologist and Head of Organisational Advisory Services, Davidson Trahaire Corpsych, Mr Simmonds oversaw clinical governance and service provision nationally and internationally, consulting to over 1000 organisations across all sectors.

Mr Alex Jenkins

The Director and Principal Consultant at Alex Jenkins & Associates, Mr Jenkins has over 15 years' experience consulting in the areas of employee health and wellness, EAP, mediation and conflict resolution, leadership and team development, injury management and the prevention, mitigation, assessment and treatment of psychological injury in the workplace.

He has consulted with many of Australia's largest public and private sector organisations to design and deliver innovative clinical and organisational solutions.

Dr Peter Cotton

Peter Andrew Cotton (1958-2018)

Dr Peter Cotton's dual qualifications of clinical and organisational psychology enabled his career to simultaneously span research, clinical supervision, strategic and advisory roles across industry and governments, as well as work at the coalface as an organisational and clinical practitioner.

Dr Cotton provided extensive advice to organisations like Australian Public Service Commission and Comcare in their support of the psychological health and safety of federal workers. He worked with national organisations like Beyond Blue, SuperFriend, the CSIRO, the Australian Psychological Society, Safe Work Australia and Medibank in expert advisory roles. Peter also worked extensively with numerous work health and safety organisations, Victorian Transport and Accident Commission and state and territory regulators and insurers. He collaborated with individuals, researchers and workplace mental health organisations to develop and deliver programs and to push forward the science, the practice and the evidence.

In recent years, because of his unique skills, extensive knowledge, practical experience and expertise, Dr Cotton's unique expertise was called on more and more to formally investigate and provide recommendations for specific industries in relation to significant issues about workplace mental health. Dr Cotton undertook independent investigations into mental health within the Victorian Police, the Metropolitan Fire Brigade, and Ambulance Victoria, just to name a few. In undertaking these reviews, Dr Cotton's unwavering resolve was in getting the very best outcomes for the staff and the broader Australian community.

Dr Peter Cotton contributed his expertise to the development of this report before his passing in November 2018.

Curriculum Vitae of Steering Committee

Dr Sally Phillips

Dr Phillips is the current General Manager of Health Services at TAL Life and has over 20 years of experience in the life insurance industry across the South African, UK and Australian markets. During this time, Dr Phillips has held several senior positions at various Life Insurers including the Head of Life Product and Strategy, Head of Insurance Proposition, Underwriting and Claims and Head of Underwriting and CMO.

Ms Margo Lydon

Over the last 9 years, Ms. Lydon has held the position of CEO and company Secretary of SuperFriend, an organisation focused on creating mentally healthy workplaces for 'profit to member' superannuation funds. In this role Ms. Lydon has driven the strategic and operational direction of the organisation to reduce the incidence of suicide and the impacts of mental illness on individuals, employers, workplaces, colleagues, families and friends.

Mr Josh Fear

At the time of this paper's preparation, Mr Fear was the Director of Policy at Mental Health Australia where he served for over 6 years. Mr Fear has considerable experience in the evaluation of large and complex government programs and is also interested in social justice and the non-government sector. He has particular expertise in the health sector, having undertaken many projects on behalf of the Department of Health and Ageing. Of particular note is his work on the National Suicide Prevention Strategy and research into three of the seven National Health Priority Areas - mental health, asthma and diabetes. He is also experienced in researching issues affecting Indigenous people, organisations and groups. He has also undertaken research into Indigenous mental health, the Indigenous health workforce and Indigenous employment.

Ms Joanne Graves

Ms Joanne Graves is the National Rehabilitation Manager at AIA and advocate for the difference rehabilitation can make in the lives of others in the Life Industry. Ms Graves is an Occupational Therapist with a Masters of Public Health and has 29 years of experience in the rehabilitation industry including 16 years working in life insurance and has worked at AIA Australia since November 2011. Previously Ms Graves has worked at ING/OnePath in life insurance, in occupational rehabilitation, has been self-employed and worked clinically in hospitals.

With the goal of improving mental health outcomes, Ms Graves was a member of the Superfriend Insurance Reference Group Sub Committee for the design of TAKING ACTION: A Best Practice Framework for the Management of Psychological Claims and is now involved in the FSC Mental Health Working Group. Ms Graves won the Life Insurance Category for the Women in Financial Services Awards in 2017.

Professor Alex Collie

Professor Alex Collie is Director of the Insurance Work and Health Research Group in the School of Public Health and Preventive Medicine, Monash University. He is an applied public health and social policy researcher, with a specific focus on injury and illness compensation systems and their impact on the work, social and health outcomes of injured and ill people.

He leads programs of research that seek to (1) describe health and work outcomes of people receiving support from Australia's workers' compensation, social security, life insurance and road traffic crash compensation systems; (2) identify factors affecting the health and work function of people involved in these systems; and (3) modify those factors to improve outcomes for injured and ill people and reduce the burden of work disability in the community.

Ms Jane Dorter

With over 20 years' experience in the life insurance Industry, Ms Dorter is the Australian Head of Insurance Claims and Workplace Health at KPMG. Ms Dorter is significantly aligned with Mentally Healthy Workplace program initiatives, and works with key organisations to introduce more effective mental health management for people at work. She is a frequent speaker at industry forums and represents numerous industry and other healthcare sector representative groups on workplace health, mental health, insurance and compensation and claims. She has lead specialist teams in the design, development and delivering several projects an initiatives focused on mental health, including:

- Industry Thought Leadership: bio psychosocial factors impacting time that individuals spend off work and the prognostic indicators of absenteeism.
- Resilience Workshops
- Suicide Prevention Strategies: for industry development.
- Community Support Program development: re-engagement to community-based services.
- Review and development of Wellness Programs.

Mr Nick Kirwan

In his role as Senior Policy Manager, life insurance, Mr Kirwan leads the FSC's policy work on the Code of Practice and the minimum standard medical definitions for trauma/critical illness policies. Mr Kirwan has spent his career in financial services, both in industry and public policy. He spent many years in senior industry roles in the UK before spending eight years as the policy lead for life insurance at the Association of British Insurers and then two years at the ILC-UK, a Westminster think-tank advising the UK Government on public policy matters relating to demographic change.

Mr Jesse Krncevic

At the time of this paper's preparation Mr Krncevic was the Senior Policy Manager, Investments, Global Markets and Strategy at the FSC. Prior to working at the FSC, Mr Krncevic was a Senior Media and Policy Consultant at Primary Communication. He was responsible for developing and implementing government, stakeholder and media relations strategies for organisations in the energy, resource and not-for-profit sectors.

Recently, at the FSC, he spearheaded the strategic direction and execution of the Australian life insurance data collection solution. The industry data solution was established to improve the sustainability, transparency and reputation of the life insurance sector.

He was also one of the proponents for this research to be undertaken.

Mr Krncevic is now Advisor - Policy Development, Australian Prudential Regulation Authority (APRA).

Ms Mel Toomey

Ms Toomey currently holds the role of Senior Policy Manager, Life Insurance, FSC. There she has held policy roles in life insurance, financial advice and the Royal Commission. She has over 11 years' experience in financial services in Australia, both as a senior solicitor and policy manager. She has a deep interest in nurturing positive mental health, both at the individual and community level.

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