

Submission to the Productivity Commission

22/1/20

Dear Commissioners,

I am writing this submission as an individual, without any consent from past or present academic or commercial relationships. In my career as a consultant psychiatrist, I have been the chief medical officer of several life insurance companies, advised the Insurance Council of Australia on mental health underwriting in travel policies and have current appointments with two life insurers. I am an appointed dispute resolution assessor for a regulator and maintain a panel of 400 medical specialists who provide medical risk management services, manage a panel of behavioural economists consulting with financial services and I am a current doctoral student of the business school at the University of Sydney. I have graduated from the University of Western Australia. I am a Fellow of the RANZCP and obtained a masters in Behavioural Economics from the London School of Economics. In the course of my clinical work I have assessed over 10000 individuals with mental health claims.

There are two matters that I wish to raise with the Commission. The first concerns the draft recommendation 24.6 and the second an issue that has not been addressed by the commission in its coverage of suicide.

The Commission has accepted an argument that was made by MetLife and the Financial Services Council that insurers be allowed to fund mental health treatments. This argument was not accepted by the Parliamentary Joint Committee for a variety of reasons, some of which were captured in the draft report. While the Commission is well-intentioned, this is a complex issue that is not entirely addressed by the concerns expressed in the Beyond Blue submission. No evidence has been presented that the retail-disability insured have received delayed treatment nor is there evidence that they are undertreated. No evidence has been presented about the level of private health care in the insured. In schemes that include treatment, such as Worker's Compensation or Compulsory Third Party schemes, mental health outcomes are characterised by costly treatment and long durations. Most statutory schemes struggle with the same issues that life insurers confront. The existing evidence suggests that, funded or not, the outcomes are similar. This means that not only would the funding of treatment by life insurers be unlikely to impact outcomes, it would also create increased pressure on policy premiums.

Creating a payment model where the interests of the parties are not perfectly aligned has the potential to create ethical conflicts. If an insurer is to provide treatment funding, it must also be satisfied that the approved treatment is in the best interests of the insured and evidence based. While it may be argued that the insurer does not presently have the skills to do this, should they acquire the skills, the insurer would be drawn into the clinical treatment, carry liability for that treatment and may be awkwardly dealing with conflicts of interest that are not readily resolved.

It is not clear that the insurers, who are currently struggling with problems of sustainability and issues of adverse selection, have clearly thought through the issue of treatment funding.

Should life insurers be given the license to fund treatment, if the experience of statutory schemes is indicative, the end result may present as increased costs, without any of the assumed benefit, therefore increasing pressure on premiums, leading to many customers who need this insurance, being priced out of the market.

The Commission does not appear to have considered the implications of treatment funding on existing private health insurers, where the current recommendation would essentially allow a back-door license for life insurers to enter the private health insurance market. This would create overlapping payment schemes, contrary to other productivity commission recommendations, and confusion over treatment liability. Private health insurers, themselves facing sustainability problems, have strongly objected to new funding models that may have adverse market outcomes.

Given the economic and ethical issues, I would respectfully recommend that while the sentiments of the recommendation are well-intentioned, the arguments require further attention and the unintended consequences may have adverse impacts on those that depend on the affordability of private disability insurance. On that basis I would respectfully recommend that the Commission withdraw recommendation 24.6.

The second issue that has not been addressed is that of life insurance for suicide. Life insurers may argue with the best of intentions that providing cover for suicide protects the beneficiaries if a loved-one takes their life. The usual practice to prevent an extreme moral hazard of this nature, someone taking out a policy with the intent to suicide, is to delay cover

for suicide for 13 months after the inception of risk. The reasoning for this approach is that an individual who takes out a policy with the intention of suicide may have successfully deferred that intention after that time period. However, there is considerable evidence that there is a cluster of suicides after the 13-month period. (e.g. <https://econtent.hogrefe.com/doi/abs/10.1027/0027-5910/a000023?journalCode=crl>). The evidence is repeated by several, credible scholarly studies. The natural conclusion of this statistical cluster suggests that policyholders have waited until the suicide exclusion has been removed.

It appears that despite the good intentions of life insurers who wish to protect the insured and their beneficiaries, some policyholders will suicide based on what may be altruistic financial incentive for the support of beneficiaries. Consider the consequences of adverse economic circumstances in which a troubled family provider may engage in the awful calculation of whether their family is better supported if they were dead or alive.

It is established in the psychiatric literature that there can be motivation for suicide that is generated by both clinical and non-clinical states. Determining motivation for suicide post-mortem is often unreliable and would be exquisitely uncomfortable for the survivors and other parties, therefore policy nuances that limited suicide benefits to customers whose actions were the product of poor mental health would not be practical. As the Commission is committed to the reduction in suicide rates, a recommendation by the Commission to make an amendment to the Insurance Contracts Act to prevent coverage for suicide would mean two things. Firstly, life insurance would be made available for applicants that may be considered a suicide risk. Secondly, it would prevent some suicides, that may be altruistically motivated by financial concern for beneficiaries.

Dr Doron Samuell

M.B., B.S. MSc (LSE) F.R.A.N.Z.C.P.