THE
GENEVA
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INSURANCE FOR A BETTER WORLD

PROMOTING PEACE OF MIND:
Mental health and insurance

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The Geneva Association

The Geneva Association was created in 1973 and is the only global association of insurance companies; our members are insurance and reinsurance Chief Executive Officers (CEOs). Based on rigorous research conducted in collaboration with our members, academic institutions and multilateral organisations, our mission is to identify and investigate key trends that are likely to shape or impact the insurance industry in the future, highlighting what is at stake for the industry; develop recommendations for the industry and for policymakers; provide a platform to our members and other stakeholders to discuss these trends and recommendations; and reach out to global opinion leaders and influential organisations to highlight the positive contributions of insurance to better understanding risks and to building resilient and prosperous economies and societies, and thus a more sustainable world.

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ACKNOWLEDGEMENTS

Foreword

Poor mental health is not a new phenomenon, but the surge in mental illness linked to COVID-19 has elevated the problem to a 21st-century epidemic. The challenge is not the high prevalence of mental illness alone: compared to physical illness, there are unique barriers to detection, case reporting and treatment provision. This report dissects these challenges from the insurance perspective, pinpointing where life and health insurers are already adding value and where they can go further.

We see strong evidence that insurers are increasingly prioritising mental health. The number of companies that offer related protection is on the rise. Insurers are also branching out with innovative tools and approaches. On the prevention side, this includes technology that can detect mental distress; on the treatment side, insurers are proactively offering mental-health coaching to customers and employees.

The focus now is on scaling up these efforts, but there are obstacles. A major one is social stigma. People suffering from mental illness are reluctant to admit they have a mental health problem at important junctures. Sometimes they do not realise they are mentally ill themselves.

The result – a shortage of data – makes the true scope of the problem unknown. It is unknown to policymakers when they decide public health policies and budget priorities. It is unknown to employers when they negotiate group health plans for employees. And the extent of the problem is unknown to life and health insurers when they assess mental health risk, build coverage schemes, and rollout new services. Better data is needed to demonstrate demand – this is a prerequisite for increasing access to mental health services and insurance protection.

What we *can* quantify reveals that the cost of the mental health crisis is staggering. An estimated one billion people globally are afflicted, with certain vulnerable populations at higher rates. Poor mental health is expected to cost economies USD 6 trillion dollars each year by 2030 in medical expenses and lost productivity. Health and life insurers pay out around USD 15 billion each year in related claims, essentially in disability insurance.

The mental health crisis is real and urgent, and as our report demonstrates, leveraging the power of insurance is a key part of the solution. I am pleased that The Geneva Association is contributing to the conversation on this important societal issue and helping to guide the insurance industry on its mental health journey.

Jad Ariss
Managing Director

Executive summary

Close to a billion people around the world live with poor mental health and demand for services is growing.

Close to a billion people around the world live with poor mental health. As the world emerges from the COVID-19 pandemic, health systems are reeling from unprecedented and widespread disruption and contending with a substantial escalation in demand for mental health services. Sharp spikes can be observed in cases of depression and anxiety in particular – by far the most common manifestation of poor mental health globally.

Research on the risks of poor mental health from an insurance perspective is relatively scarce. Yet, health and life insurers are at the forefront of absorbing the resulting shocks, with close to USD 15 billion in claims for mental health-related disability insurance paid out each year. It is thus timely to illustrate the broader landscape of mental health, discuss its insurability and how to overcome related barriers, as well as assess new ways to accelerate the development of innovative approaches to insuring mental health across the industry to keep pace with increased need and societal expectations.

Against this backdrop, this report aims to 1) define mental health and the scale of the burden posed by poor mental health; 2) examine the current role of life and health insurance in addressing mental health; and 3) recommend steps to boost insurers' contributions to promoting mental well-being at scale, from prevention to active case management. It does so by combining a literature review with accounts from 16 senior key informants from the insurance industry.

The pandemic precipitated an additional 53 million cases of depression and 76 million of anxiety disorders globally.

Good mental health should not be defined as the mere absence of mental illness or mental distress, but as a holistic state of well-being. In accordance with this concept, the terms 'poor mental health' and 'mental health problems' are used in the report to encompass both mental distress and illness. The pandemic accelerated the uptick in poor mental health globally, affecting different segments of the population unequally. According to a study by the Institute for Health Metrics and Evaluation (IHME), the pandemic precipitated an additional 53 million cases of depression and 76 million of anxiety disorders globally, and two thirds of those affected were women. There is also substantial evidence to suggest that the perils of poor mental health have a disproportionate effect on the young, working-age and ethnic minority population.

Poor mental health impacts the economy, individuals, health systems and insurers. A study published by the Lancet estimates that mental health problems will cost the world USD 6 trillion in poor health and productivity in 2030, up from USD 2.5 trillion in 2010. For individuals living with poor mental health, this translates to wage and employment gaps and curtailed life chances. Poor mental health has also been linked to an increase in mortality, driven in part by heightened physical morbidity. All of this translates to significant insurance claims. In the U.K., for instance, 27% of income protection claims were attributable to mental health in 2020. In Canada, too, insurers (life and health combined) experienced a 75% rise in claims related to poor mental health in 2021 compared to 2019. Furthermore, as the proportion of claims related to mental health grows year on year in many markets, the well-established link between mental and physical health problems may mean that even health plans that exclude mental health could be affected.

> *Poor mental health can lead to significant insurance claims through wage and employment gaps and increased risk of mortality.*

Insight from the 16 key informants interviewed for the report highlights the differing approaches to mental health adopted by insurers and the difficulties they face owing to the external environment and insurance-specific challenges. The former includes stigma and concomitant effects on demand, financing, workforce and clinical practices. For example, a 2017 study by Pang et al. found over a third of young Singaporeans considered poor mental health a sign of weakness. Such social attitudes may in turn influence the prioritisation of mental health in public policy, fuelling further barriers to access. This is exemplified by the fact that in 2020, two thirds of people in Organisation for Economic Co-operation and Development (OECD) countries seeking mental health services reported difficulties with access. Insurance-specific challenges include non-disclosure of mental problems (deliberate or unwitting), designing holistic propositions, and the complexity of underwriting techniques and claims validation arising from the often subjective nature of diagnoses.

The report highlights numerous examples of the ways in which many insurers are innovating to overcome these insurance-specific barriers. According to a survey by Mercer Marsh Benefits, of 226 insurers across 26 countries, the number of global insurers who did not offer any mental health cover in employment benefits schemes for health decreased from 26% in 2021 to 16% in 2022. However, close to a fifth of global insurers are lagging behind. This gap may partly reflect the low demand for mental health coverage from employers. But even when insurers are expanding coverage, there is a tendency to focus on complex, episodic, inpatient or specialist treatments, while commonplace, non-critical depression and anxiety are the biggest and fastest-growing causes of burden. In this context, the report also explores examples of nascent insurance policies aimed at the prevention and management of poor mental health by taking advantage of innovative underwriting techniques, those that draw on medical technologies such as stress index, mental health-tracking apps as well as workplace interventional frameworks, ultimately yielding significant improvements in mental health insurability.

The report also provides recommendations for life and health insurers to build on existing innovation to improve the insurability of mental health at scale using a three-stage incremental framework.

Firstly, while progress is evident in the inclusion of mental health in existing benefits, insurers can go further by adopting a dedicated strategy for mental health, taking into account the fast-moving evidence emerging from global and market-specific research. The report defines this stage as *decide*. This will help with finessing the scope, scale and depth of the coverage insurers may already offer, and tailoring policies specifically to those affected by depression and/or anxiety. Adopting this strategic approach may also help with identifying how existing or new propositions can be better targeted towards prevention and holistic healthcare by embracing new technologies in combination with physical/in-person care, which can be both clinical and non-clinical in nature (e.g. social support such as befriending or volunteering initiatives, measures to improve financial well-being).

> *Insurers can go beyond including mental health in existing benefits by adopting a dedicated strategy for mental health.*

Secondly, overcoming the stigma associated with mental health and the consequent lack of uptake for timely care likely warrants a consorted effort from a wider set of players in the industry to *engage* their customer base. This can be done through group plans, digital tools and outreach to promote uptake of existing or new propositions. Through group plans, insurers can leverage their existing propositions to improve working environments by advising employers on mental health-friendly policies, proactively managing risks and setting clear goals for improving mental health. Similarly, targeted community interventions and campaigns can help to dispel myths and prejudice. All in all, insurers have the opportunity to shape their market by translating an often unvoiced need for better mental well-being to coherent demand from their customers, either individuals or employers.

> *Group plans and proactive community outreach can promote uptake of propositions that address mental health.*

Lastly, current innovations provide a springboard to *optimise* critical insurance functions. This phase can be further broken into three stages or tailored based on an insurer's strategic priorities:

- Adopting a more nuanced approach to risk assessment: Underwriters can reconsider the way they assess risk and, on that basis, expand the insurability of people living with mental health problems. This may include introducing more gradations into eligibility questionnaires (as opposed to binary questions) at the point of application and using publicly available evidence (such as population-level data) to form a holistic view of the applicant. Such innovative approaches have already proven to be effective.

- Leveraging claims data: Claims assessors could be empowered with new tools and training to move beyond simply assessing the legitimacy of claims. Claims data can provide vital information about sources of risk and the point at which they trigger a claimable event (big or small). It would be also be beneficial for mental health to be seen as more than just an afterthought when dealing with a physical health claim given their strong symbiotic relationship.

- Developing an ecosystem: Bringing all of the above facets into one coherent and holistic ecosystem powered by data can transform group plans. For example, under current practice, insurers may be providing a multitude of services to a large corporate client such as onsite or offsite occupational health support, employee assistance programmes, income or disability insurance, and health plans. By consolidating data to create a central hub, these plans can engage in effective triaging to offer the right levels of clinical, behavioural, social or financial support. In turn, there is evidence to suggest that this can reduce the number of mental health-related claims, the average cost of claims and, most importantly, improve user outcome.

1 Introduction

Introduction

Health and life insurers are instrumental in absorbing the risks arising from poor mental health.

Almost a billion people worldwide live with a mental health problem.[1] Collectively, these make up one of the top 10 causes of the Global Burden of Disease (GBD), a technical metric for the loss of good health through mortality or disability.[2] The COVID-19 pandemic has exacerbated the incidence of poor mental health due to social isolation and the effects of social and economic restrictions. According to the IHME, the pandemic precipitated an additional 53 million cases of major depressive symptoms and 76 million cases of anxiety disorder globally, with young people and women disproportionately affected.[3] Current global challenges – geopolitical, climatic and economic – do little to abate the growing prevalence of poor mental health or the risks it poses.

The challenges poor mental health presents to insurance are relatively under-researched. But health and life insurers are instrumental in absorbing the risks arising from poor mental health, especially through disability or income protection insurance and medical plans. In addition, shifting attitudes towards mental health problems have led to a greater demand for mental well-being services. This all warrants an exploration of the broader landscape of mental health, its insurability and how insurers are overcoming related barriers, as well as an assessment of ways to accelerate innovative approaches to insuring mental health across the industry to keep pace with increased need and societal expectations.[4]

The task at hand, however, is complex. Unlike physical health risks, which can be objectively verified, mental health risks can be prone to subjective interpretations. This can obscure the true extent of the risk posed to insurers and insureds and has resulted in significant protection gaps for people with mental health problems, with some paying higher premiums and others being excluded entirely from adequate health and life insurance coverage.[5,6]

With that in mind, the purpose of this report is to take stock of the existing approaches across the insurance industry and to better understand the obstacles to insurability and ways to address them. It defines mental health and the scale of the burden posed by poor mental health, examines the current role of life and health insurance in addressing mental health and related challenges, and recommends practical steps for insurers to boost their contributions through innovations that promote mental wellness, prevention and provide access to treatment and support.

Subjective interpretations of mental health risks can obscure the extent of the risk posed and result in protection gaps.

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1   World Health Organization (WHO), United for Global Mental Health and the World Federation for Mental Health 2020.
2   IHME 2019a.
3   IHME 2021.
4   CRO Forum 2021.
5   Similar issues exist with car or travel insurance. See Archer 2021.
6   Mind 2022.

2 Defining mental health and the scale of the mental health burden

Defining mental health and the scale of the mental health burden

The terms 'mental health problems' and 'mental illnesses' are too often used erroneously and/or interchangeably, and in some instances are viewed as synonymous.

2.1 What do we mean by mental health?

The terms 'mental health problems' and 'mental illnesses' are too often used erroneously and/or interchangeably, and in some instances are viewed as synonymous. This is reflected in common usage of the phrases 'mental health issues', 'mental health concerns', 'mental health challenges' and 'mental health conditions' all of which can refer simply to signs of mental distress or else to diagnosable mental disorders. But mental distress is usually a transient emotional state that temporarily compromises function-ality due to increased stress, significant loss or trauma. Most, if not all, will experience mental distress on several occasions in their lives. Mental disorders, on the other hand, are clinical conditions comprising specific symptoms as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).[7]

The American Psychiatric Association (APA) defines a mental disorder or mental illness as 'a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning'. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities. As this definition reveals, mental disorders are viewed through a bio-psycho-social lens, with several factors contributing, either singly or in combination, to the onset and persistence of a given disorder (see Table 1). At the biological level, genetic predisposition, temperament or physical injury/illness may be at play. Behaviourally speaking, risk may be increased by a sedentary lifestyle, poor nutrition or substance use. Social determinants include socio-economic status, level of education and social support, environmental conditions and political structures.

TABLE 1: BIO-PSYCHO-SOCIAL DETERMINANTS OF MENTAL HEALTH

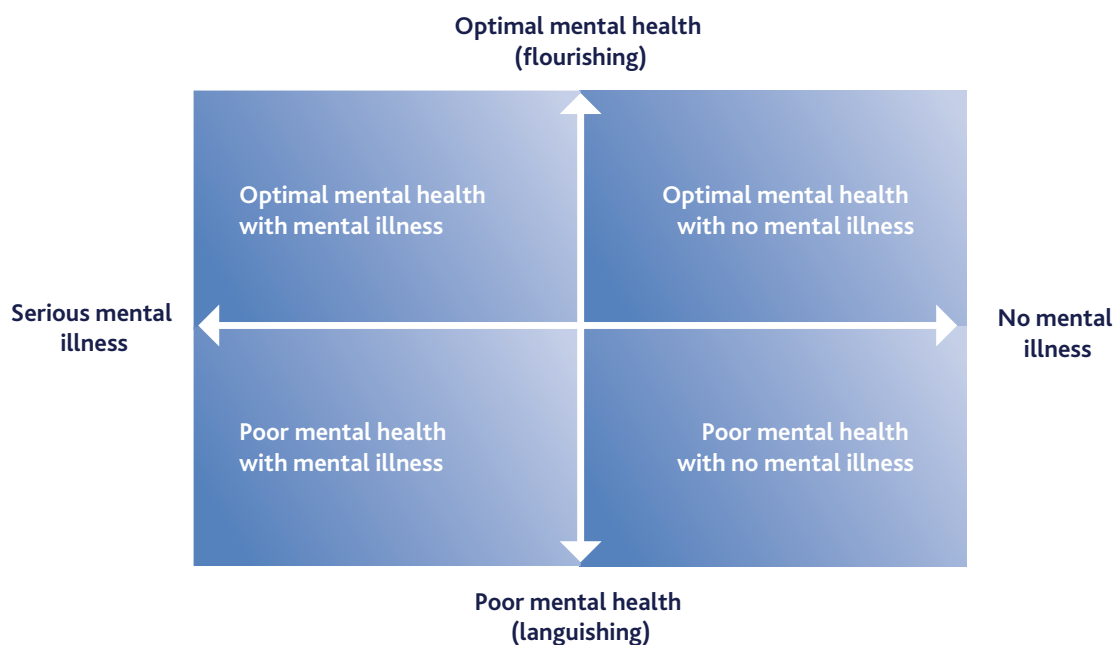| Personal factors	Protective factors	Risk factors
Biological	• Low genetic predisposition • Stable health	• High genetic predisposition • Chronic illness
Behavioural	• Regular physical activity • Balanced/healthy nutrition • Restorative sleep	• Sedentary lifestyle • Poor nutrition • Sleep disturbance • Shift work
Psychological	• Nurturing parenting • High resilience • Education	• Childhood adversity • Low resilience • Limited or no education

Social/economic	• Financial well-being
	  - Living wage
	  - Savings and retirement security
	• Social support
	• Community support
	• Adequate housing
	• Stable political structures
		• Financial insecurity
		  - Poverty
		  - Unemployment/under-employment
		• Limited social connections
		• Unstable housing
		• Unstable political structures

Source: Sam Mikail, Sun Life

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7   APA 2013; WHO 2022a.

The WHO defines mental health as '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'.[8] Mental health is hence conceived as the presence of positive attributes, rather than the absence of negative ones.

Traditionally, mental health and mental illness were considered polarities on a single continuum, implying that good mental health was defined as the absence of psychopathology. By the latter half of the 20th century, however, another perspective emerged whereby mental health and mental illness were conceptualised as distinct but coexisting constructs, each varying in degree at any given time.

Several models for understanding mental health have been proposed; perhaps the most notable among them is Keyes and Westerhof's dual-continua model (Figure 1).[9] Keyes and Westerhof suggest that mental health comprises multiple dimensions of subjective well-being that fall on a pair of axes ranging from 'languishing' to 'flourishing'. A practical example of this could be someone experiencing grief in response to a significant loss and having no underlying mental disorder (placing them on the bottom right-hand side of the quadrant in Figure 1) or someone with a diagnosed bipolar disorder, a condition that causes extreme mood swings, who remains highly functional in everyday life (placing them on the top left-hand side of the quadrant in Figure 1).

FIGURE 1: MENTAL ILLNESS VS. MENTAL HEALTH

Optimal mental health (flourishing)

Optimal mental health with mental illness

Optimal mental health with no mental illness

Serious mental illness

No mental illness

Poor mental health with mental illness

Poor mental health with no mental illness

Poor mental health (languishing)

Source: Keyes and Westerhof [10]

It is therefore essential to view mental health as a dynamic state of well-being that can change over time in response to many factors. For instance, both the WHO (see definition above) and Keyes and Westerhof assert that mental health relies on the ability to realise one's potential.[11] In some instances, a person may fall short of this due to internal blocks, such as fear or past disappointments, but external factors may also be at play, such as limited opportunities, poverty or parentage. Mental health is also determined by the individual's coping capacity, an aspect of functioning that is learned through instruction, role models and experience. The emphasis of the WHO's definition on 'normal stresses of life' suggests that anyone's mental

> *Mental health should be viewed as a dynamic state of well-being that can change over time in response to many factors.*

health can be compromised if exposed to extraordinary stress factors, particularly when this exposure is prolonged. Mental health also derives from the capacity, opportunity and desire to work. Work, whether paid or voluntary, provides opportunities for social connection and socio-economic support, a sense of meaning and

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8   WHO 2001.
9   Keyes and Westerhof 2010.
10   Keyes and Westerhof 2010.
11   WHO 2001; Keyes and Westerhof 2010.

purpose and can form part of one's identity. Workers typically spend over 60% of their waking hours in the workplace, making work a primary vehicle for either contributing to or eroding mental health.[12]

This report adopts the terms 'poor mental health' or 'mental health problems' to encompass both mental distress and illness or disorders. However, this excludes developmental and neurological disorders such as autism and dementia, which differ significantly from mental health problems in their diagnosis, treatment and management, even though they may influence mental health. Table 2 presents a

COVID-19 caused an increase in mental health problems, with young people and women disproportionately affected.

typology of the most common problems, classified into 12 broad categories. These are further broken down into common examples to help readers understand the diversity of manifestations of poor mental health.

TABLE 2: A TYPOLOGY OF MENTAL DISORDERS*

Category	Examples
Psychotic disorder	• Schizophrenia
Bipolar and related disorders	• Bipolar disorder with extreme mood swings
Mood disorders	• Major depressive disorder
Anxiety-related disorders	• Social phobia • Panic disorder
Obsessive compulsive & related disorders	• Obsessive compulsive disorder • Hoarding disorder
Stress and trauma-related disorders	• Post-traumatic stress disorder (PTSD)
Dissociative disorders	• Dissociative identity disorder associated with having multiple personalities
Somatic symptom and related disorders	• Illness anxiety disorder (hypochondriasis)
Substance-related and addictive disorders	• Alcohol use disorder • Gambling disorder
Feeding and eating disorders	• Anorexia nervosa • Binge-eating disorder
Sleep disorders	• Insomnia • Narcolepsy
Personality disorders	• Paranoid personality disorder • Narcissistic personality disorder

The table does not represent a complete list of mental disorders and their categories
Source: Sam Mikail, Sun Life

2.2   The burden of poor mental health

One in eight people around the world live with poor mental health.[13] COVID-19 compounded the problem and revealed disparities in those affected. A study by IHME conducted during the height of the pandemic estimated an additional 53 million cases of depressive and 76 million cases of anxiety, with a perceptible effect on adults less than 50 years old and a disproportionate effect on young people below the age of 25. Over two thirds of the additional cases affected women (Figure 2).[14] Other studies from the U.S. have noted a disproportionate adverse effect on ethnic minority populations due to challenges associated with discrimination and access to care.[15]

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12   Robertson 2017.
13   WHO 2022c.
14   IHME 2021.
15   Simmons University 2022; APA 2017.

Further, when the burden of poor mental health is examined at a disaggregated level by age, self-harm and depression are the third and fourth leading causes of disease burden in people aged 10–24, whereas depression is the sixth leading cause among 25–49-year-olds.[16] Depressive and anxiety disorders remain the most prevalent forms of mental health problem responsible for lost years of good health, commonly expressed using the disability-adjusted life years (DALYs) metric,[17] outpacing problems such as eating disorders or schizophrenia (Figure 3).[18]

FIGURE 2: THE IMPACT OF THE PANDEMIC ON MENTAL HEALTH

🟥 Major depressive disorder   🟦 Anxiety disorder

Cases of mental disorders rose sharply during the pandemic
Cases in 2020

Baseline cases

Additional cases due to COVID-19

193m   **53.2m**

298m   **76.2m**
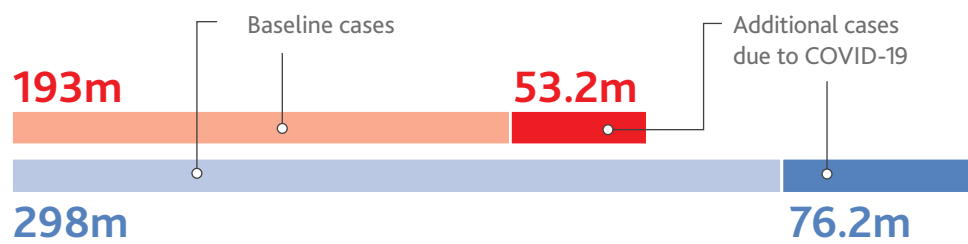
Younger people were hardest hit
Additional prevalence due to COVID-19, by age
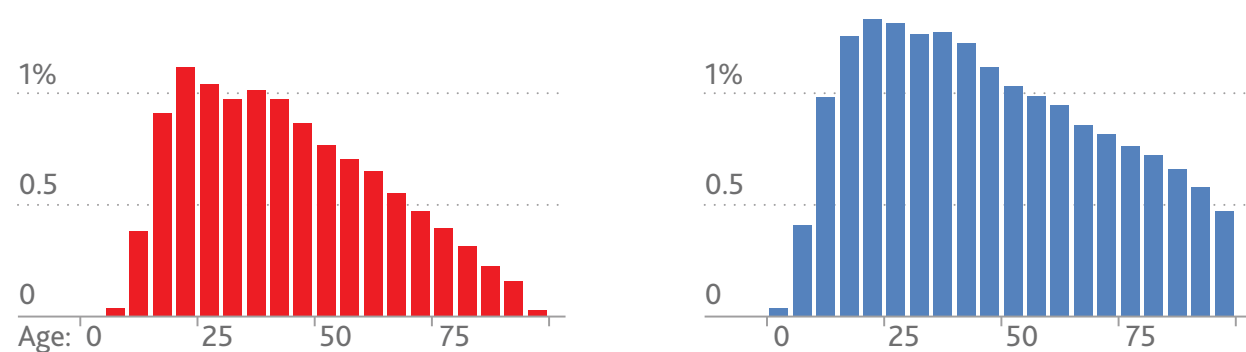
Increases were higher among females than males
Additional cases due to COVID-19, by gender

35.5m   **17.7m**
Female   Male

Total
53.2m

51.8m   **24.4m**
Female   Male

Total
76.2m

Source: Adapted from IHME[19]

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16   Rosero-Bixby et al. 2020.
17   One DALY equals one lost year of full health. WHO (undated).
18   Happier Lives Institute (HLI) 2021.
19   IHME 2021.

FIGURE 3: THE BURDEN OF MENTAL HEALTH PROBLEMS IN DISABILITY-ADJUSTED LIFE YEARS, 2019
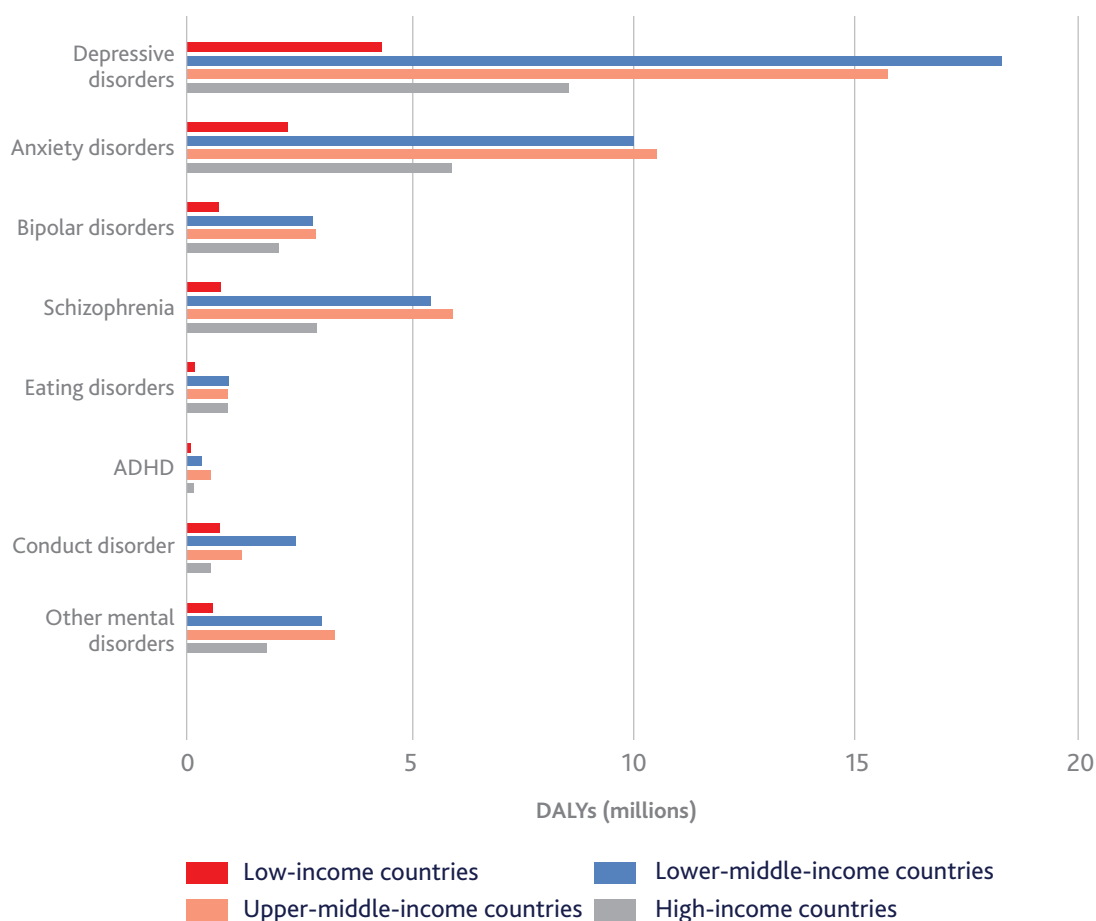
Source: Adapted from HLI[20]

The acceleration of mental health problems during the pandemic was highly correlated with rising infections and restrictions on mobility. Countries and regions with varying levels of income were also unequally affected (see Figures 4 and 5). For major depressive and anxiety disorders, high-income countries were significantly affected in 2020 compared to low- and middle-income countries.[21] This also corresponds to the higher burden of cumulative mortality experienced by the Americas and Europe overall.[22] These regional variations may in part be explained by strict lockdown policies but also possible under-reporting (see section 2.3). However, while mental health in higher-income nations has come under the spotlight as a result of the pandemic, the growing burden on low- and middle-income countries is also palpable.[23,24,25] For instance, in Asia, the prevalence of diagnosable mental health problems has been increasing starkly on a yearly basis, by as much as 20% in Vietnam and Thailand, for example.[26]

20   HLI 2021.
21   Santomauro et al. 2021.
22   Our World in Data 2022.
23   HLI 2021.
24   Accounting for the fact that data collection in low-income countries on mental health may be weak and that the burden may therefore be underestimated.
25   WHO 2022d.
26   Bodeker 2020.

FIGURE 4: CHANGES IN THE GLOBAL PREVALENCE OF MAJOR DEPRESSIVE DISORDER DUE TO THE PANDEMIC

Percentage change in prevalence

■ <10.1%	■ 13.6% to <17.3%	■ 19.2% to <22.1%	■ 25.4% to <29.2%	■ 35.0% to <38.7%
■ 10.1% to <13.6%	■ 17.3% to <19.2%	■ 22.1 to <25.4%	■ 29.2% to <35.0%	■ >38.7%
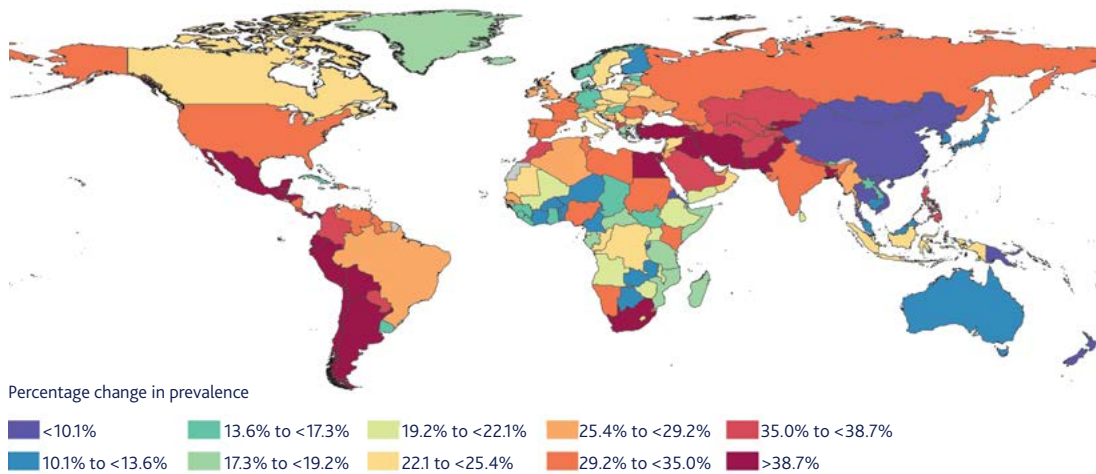
Source: Santomauro et al.[27]

FIGURE 5: CHANGES IN THE GLOBAL PREVALENCE OF ANXIETY DISORDER DUE TO THE PANDEMIC

Percentage change in prevalence

■ <9.7%	■ 14.0% to <16.7%	■ 19.1% to <21.2%	■ 25.6% to <28.8%	■ 32.3% to <36.4%
■ 9.7% to <14.0%	■ 16.7% to <19.1%	■ 21.2 to <25.6%	■ 28.8% to <32.3%	■ >36.4%
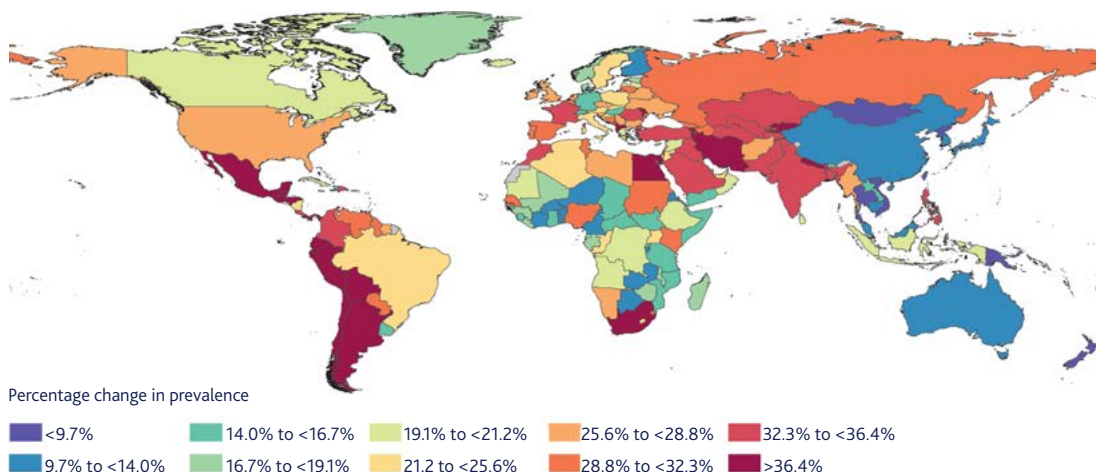
Source: Santomauro et al.[28]

2.3   Just the tip of the iceberg?

While the pandemic has fostered much-needed interest in mental health research and unearthed valuable data, these global figures should be treated with caution. Under-reporting in mental health services is pervasive and many regions lack diagnostic infrastructure: both may lead to substantial underestimation of the scale of the crisis. Likewise, while tools such as the GBD are a useful benchmark on which to base any initial understanding of the crisis, estimates may be undermined by inconsistencies in the way in which data are recorded or interpreted by professionals in various cultural contexts.[29] For instance, global suicides account for 700,000 deaths each year, of which 60% to 98% may be attributable to mental health problems, according to several estimates.[30] In many countries, however, suicides may be miscoded owing to stigma associated with mental health problems, thus making it difficult to ascertain the level of mortality directly caused by mental health problems.[31] Similarly, cultural understanding of mental health adds to the complexity of diagnosis and reporting. In China, for instance, a 2009 study by Phillips et al. demonstrated that adjusting for local interpretation of technical language for describing mental health was pivotal for appropriate diagnosis.[32]

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27   Santomauro et al. 2021.
28   Ibid.
29   HLI 2021.
30   WHO 2021a; Bachmann 2018.
31   Bachmann 2018.
32   Phillips et al. 2009.

3 The cost of poor mental health

The cost of poor mental health

The annual global economic toll of mental health problems was estimated at USD 2.5 trillion in 2010 and is projected to reach USD 6 trillion by 2030.

3.1 The economic toll

The global economic toll of mental health problems, stemming from poor health and lost productivity, was estimated at USD 2.5 trillion per annum in 2010 and is projected to soar to USD 6 trillion by 2030.[33] To put this into context, this represents 6% of global GDP in 2021.[34]

European Union (EU) member states spent an average of 4.1% of GDP, or just over EUR 600 billion, on costs associated with mental health problems in 2015. This breaks down to 1.3% on direct health spending and 2.8% in indirect costs (1.2% on social security benefits and 1.6% due to lower productivity and unemployment).[35] When broken down by country (and following adjustments owing to the U.K.'s departure from the EU), average indirect costs were 25% higher than direct health costs (Figure 6).[36]

Seven years on, the pandemic, Russia-Ukraine war and inflation-induced cost-of-living crisis will no doubt have exacerbated these already stark statistics. Other regions also report a heavy toll. In 2020, the Australian government estimated that absenteeism due to mental health problems alone costed approximately AUD 10 billion each year.[37] Other Australian studies also concluded that mental health problems such as depression increased almost threefold the likelihood of ill health in retirement, dependency on welfare and decreased earning potential.[38] In the U.S., suicide or attempted suicide incurred a cost of nearly USD 70 billion per year in lifetime medical expenditure and loss of work in 2019.[39] These data demonstrate that while the direct cost of mental health problems on health systems is substantial, the indirect costs incurred in other parts of the economy are also significant and warrant attention from a broader range of stakeholders, including employers and insurers.

The direct cost of mental health problems on health systems is substantial but the indirect costs to other parts of the economy are also significant.

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33   The Lancet 2020.
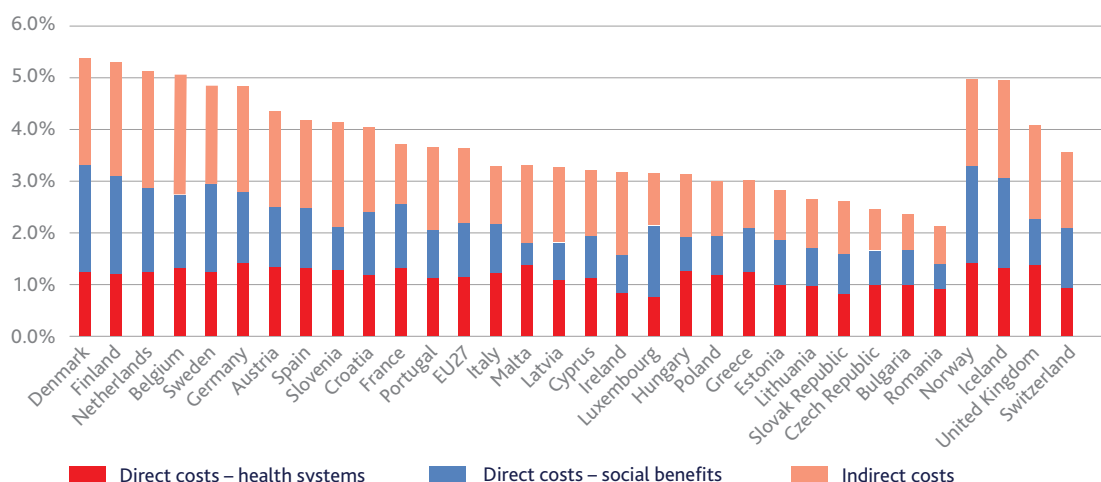34   World Bank 2021.
35   OECD 2018.
36   OECD 2021a.
37   Productivity Commission 2020.
38   Paradise et al. 2012; Doran and Kinchin 2017; Morgan et al. 2012.
39   Centers for Disease Control and Prevention (CDC) 2022a.

FIGURE 6: DIRECT AND INDIRECT COSTS OF MENTAL HEALTH PROBLEMS IN EUROPE

Legend: Direct costs – health systems | Direct costs – social benefits | Indirect costs

Note: OECD estimates based on Eurostat Database and other data sources. Following the departure of the U.K. from the EU, the EU average was updated in 2021

Source: OECD[40]

Beyond the 'productivity problem' discussed above, discrimination against people who live with mental health problems also exerts an economic toll. Data from 25 OECD countries collected five years prior to the pandemic pointed out a 20% employment gap and 17% wage gap between people with and without mental health problems.[41] In Canada, data from people aged 18–54 between 1997–2016 showed that depression led to a 10-year earning loss of CAD 115,000 and CAD 71,000 in men and women, respectively.[42] Likewise, the U.K.'s Equalities and Human Rights Commission found that men and women suffering from depression or anxiety faced pay gaps of 30% and 10% compared to peers, respectively.[43]

The economic perils of poor mental health largely affect young adults and those of working age. A 2022 study by McDaid et al. found that those aged 15–49 accounted for 56% of the GBP 118 billion total economic toll of mental health problems in the U.K.[44] The study also vindicated the claim that a staggering 41% of all costs were attributable to depression and anxiety-related problems, similar to the global findings outlined in section 2.[45] Moreover, longevity trends may continue to pose additional pressures on the working-age population, who are not only faced with navigating the everyday pressures from work and living, but also attending to their elderly dependents over much longer periods of time.[46]

3.2 The non-monetary cost to individuals

Poor mental health can have a significant impact on individuals. Early onset of mental health problems substantially reduces life chances due to lower educational attainment, with ramifications for future social and financial well-being. There is also a growing body of evidence that shows a strong bidirectional connection between poor mental health, multi-comorbidity and mortality.

> *Early onset of mental health problems reduces life chances due to lower educational attainment.*

The CDC estimates that the 37.3 million people diagnosed with diabetes in the U.S. are two to three times more likely to suffer from depression than non-diabetics, but that only a quarter to a half are diagnosed or treated for it.[47] In the U.K., 30% of people with chronic health conditions have a mental health problem, and 46% of people with poor mental health have other comorbidities.[48] Other longitudinal studies have found that poor mental health is correlated with a 29% heightened risk of coronary heart disease (CHD) and a 32% increased risk of stroke.[49]

40   OECD 2021a.
41   OECD 2021b.
42   Dobson et al. 2021.
43   Longhi 2017.
44   McDaid et al. 2022.
45   Ibid.
46   The Geneva Association 2022. Authors: Adrita Bhattacharya-Craven, Richard Jackson and Kai-Uwe Schanz.
47   CDC 2022b.
48   Parsonage (undated).
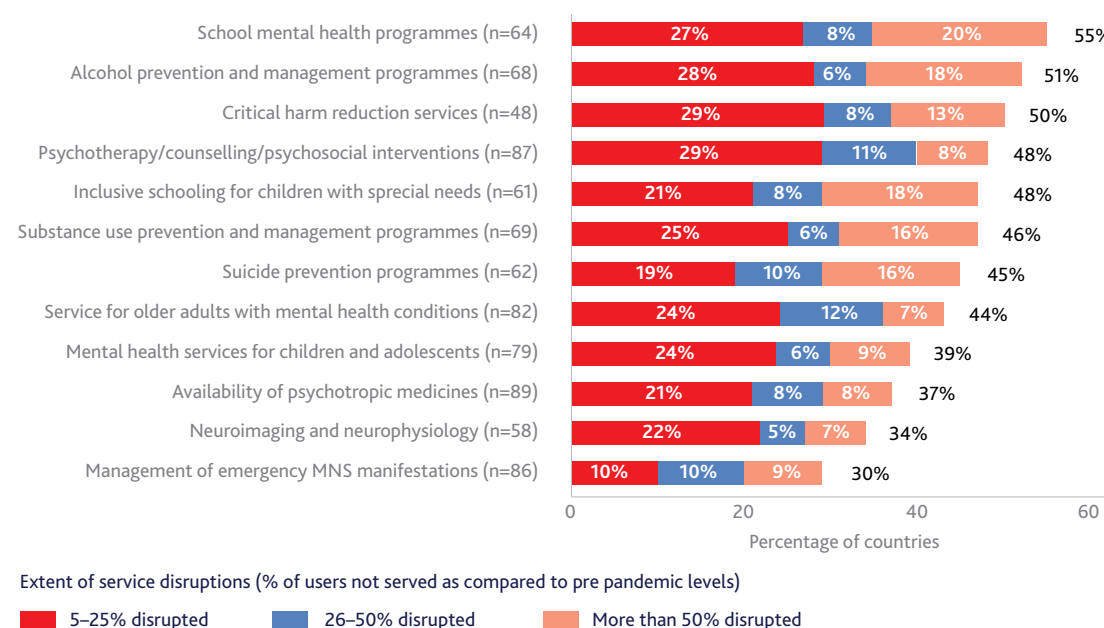49   Valtorta et al. 2016.

Increased mortality and morbidity risks have also been attributed to common risk factors associated with developing mental health problems. These include early-life socio-economic adversity, resulting in the increased likelihood of suffering from cardiovascular diseases (CVD), as well as social isolation and workplace stress, heightening the risk of CHD.[50] In particular, one U.S. study concluded that social isolation led to a 50% increased risk of CVD. Others conclude that mental health risk factors like anxiety, work-related stress, pessimism and social isolation/loneliness are all strongly associated with increases in the incidence of CVD and CHD events as well as related mortality.[51] A meta-analysis by Holt-Lunstad et al. not only confirmed these findings, but also highlighted the disproportionate effect on middle-aged adults.[52] Equally, often overlooked risk factors such as sleep deprivation may not only be indicative of poor mental health: studies have linked it with a 13% increase in mortality.[53]

3.3 The toll on health system capacity post-pandemic

COVID-19 has left health institutions and services weak in many places, as resources were diverted to tackle the immediate effects of the pandemic. As discussed, the prevalence of depression and anxiety has increased worldwide at a time when health and mental health services were experiencing significant disruption. The WHO's mid-2020 survey of 130 countries revealed that 93% of mental, neurological and substance misuse services were disrupted (services that were already in chronic short supply well before the pandemic, see section 4.2 for further discussion), with vulnerable people particularly affected. This included a 67% reduction in counselling and psychotherapy provision, as well as 75% and 78% drop offs in workplace and school provisions, respectively.[54]

While services continued to improve in the later phases of the pandemic, significant shortfalls remain. In the third round of the WHO Global Pulse Survey conducted in 2021, nearly 55% of respondent countries reported continued disruption in school mental health programmes, while 44% reported disruption to mental health services for older adults (Figure 7).[55] Taken alongside the distress arising from chronic or critical illnesses, these figures paint a worrying picture.

FIGURE 7: COVID-19 DISRUPTION TO MENTAL HEALTH SERVICES

Extent of service disruptions (% of users not served as compared to pre pandemic levels)

■ 5–25% disrupted   ■ 26–50% disrupted   ■ More than 50% disrupted

Source: WHO[56]

50   Steptoe and Kivimäki 2013.
51   Levine et al. 2021; Swiss Re 2021a.
52   Holt-Lunstad et al. 2015.
53   Hafner et al. 2016.
54   WHO 2020.
55   WHO 2022b.
56   Ibid.

A multi-country study by Parkinson et al. reveals the extent to which chronic disease management was compromised, leading to instances of delayed diagnosis, misdiagnosis, late treatment and even disruption to routine screening, which in turn resulted in prolonged suffering, pain, anxiety and even death.[57] As such, recent figures from England and Wales have shown non-COVID-related mortality in August 2022 to be higher than the five-year average.[58]

These systemic challenges have been further compounded by the behavioural changes seen during the pandemic. For instance, a recent U.K. research project estimated that increased alcohol consumption to cope with stress during the pandemic may lead to 25,000 additional deaths in the next two decades.[59] Others have noted a worsening of obsessive compulsive disorder (OCD) in existing sufferers;[60] increased risk of PTSD, especially among those who suffered from COVID-19[61] and potentially frontline health workers due to the demands placed on them during the pandemic; and a likely increase in social anxiety among children and adolescents due to a protracted period of loneliness and social isolation.[62] While it is not known how long such behavioural changes will last, it is more certain that, while many health systems try to make up for lost time, the high demand for mental health services will likely continue.

3.4 The cost to insurers

Mental health problems are the most common cause of incapacity for work, with an estimated USD 15 billion in mental health-related disability insurance claims being paid each year.[63] According to research by Swiss Re focused on the Australian market, the proportion of the number of total permanent disability (TPD) claims in group plans due to poor mental health increased from 14.3% in 2015

to 25.4% in 2020.[64] When looking at payouts or the value of claims, the proportion was even higher, with the share of mental health-related claims rising from 20.2% in 2015 to 39.8% in 2020. The study also found that for income protection (i.e. insurance covering non-permanent disability), poor mental health accounted for 14% of all claims, with an average claim duration of four and a half years. Similar phenomena are observed in other countries. In Germany, mental illness-related claims constitute over a fifth of all disability insurance losses.[65] Comparable figures can be quoted for the U.K., where 27% of income protection claims in 2020 were attributable to mental health problems.[66] In Japan, the number of workers' compensation claims due to mental health problems rose by 12.5% in 2021 compared to previous years.[67] In Canada, too, insurers (life and health combined) experienced a 75% rise in claims related to poor metal health in 2021 when compared to 2019.[68]

Although there is a paucity of data on the similar costs borne by health insurers due to variations in product design across different markets, there is some indication that claims rose with the onset of the pandemic, especially among younger cohorts. A report by Clarify Health in the U.S. showed a sharp spike in the number of mental health-related inpatient (IP) admissions in children, especially teenagers; there were 48 mental-health-related admissions per 1,000 admissions in 2021 compared to 30 admissions in 2016, a rise of around 60% (Figure 8).[69] Another report from Canada found that mental health problems were prevalent in over a fifth of all claimants, a proportion that has grown consistently – from 18.1% in 2016 to 20.8% in 2020 – owing to the pandemic as well as broader destigmatisation initiatives that have led to improved uptake of services.[70] The report also noted that while the majority of claims came from those aged 45–54, claims from children, adolescents and young adults were on the rise.

Mental health problems are the most common cause of incapacity for work, with annual related disability insurance claims estimated at USD 15 billion.

57   Parkinson et al. 2022.
58   Office for National Statistics 2022.
59   Angus et al. 2022.
60   Grant et al. 2022; Nissen et al. 2020.
61   Husky et al. 2021; Hong et al. 2021.
62   Morrissette 2020.
63   Swiss Re 2021b.
64   Swiss Re 2022.
65   Munich Re 2016.
66   Zurich 2021.
67   Nippon.com 2021.
68   Canadian Life & Health Insurance Association 2022.
69   Clarify Health Institute 2022.
70   HBM Plus 2021.

FIGURE 8: TRENDS IN THE USAGE OF MENTAL HEALTH-RELATED SERVICES AMONG CHILDREN AGED 1–19 IN THE U.S.

Mental helath-related service	Change 2016–2021
● Inpatient admissions (per 1,000 patients)	61%
● Emergency department visits (per 1,000 patients)	20%
● Outpatient visits (avg. per patient)	5%

■ Emergency department   ■ Inpatient   ■ Outpatient
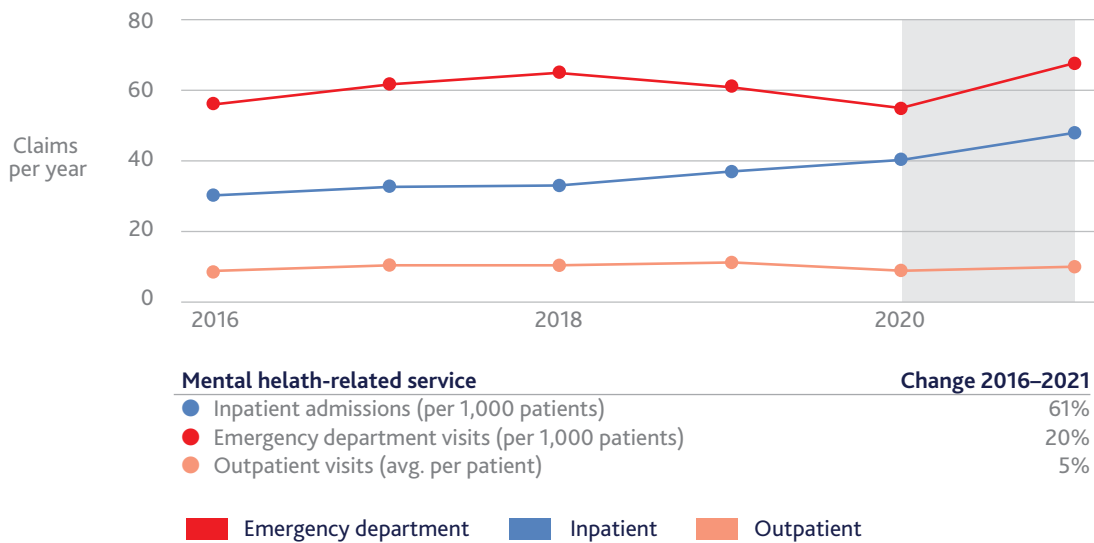
Source: Adapted from Clarify Health Institute[71]

Given the symbiotic relationship between mental and physical health, it may be reasonable to infer that increasing claims for physical health conditions as a result of poor mental health – or vice versa – may pose a significant threat to health insurers. A study of 18,380 individuals with mental health problems in London (using discharge diagnosis) showed that the most common reasons for hospital admission were urinary conditions, digestive conditions, unclassified symptoms and respiratory conditions – the prevalence of which was higher than in the general population.[72] A 2018 survey of 1,000 general physicians (GPs) in the U.K. revealed that 40% of all visits involve a mental health problem.[73] While these examples come from population-level data and are not insurance-specific, they suggest that a significant number of claims incurred in (physical) health insurance have strong links with poor mental health. Furthermore, for health insurers, this interconnection may be linked to poor adherence to treatment regimens leading to a protracted claims period and damaging health behaviours.

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71   Clarify Health Institute 2022.
72   Jayatilleke et al. 2018; Mind 2018.
73   Mind 2018.

4

Mental health and insurance

Mental health and insurance

Mental health in the context of insurance is a relatively under-researched area. This section attempts to fill gaps in the literature by combining global data with contributions from 16 senior underwriting and claims experts.

Mental health in the context of insurance is a relatively under-researched area. This section attempts to fill gaps in the literature by combining global data with contributions from 16 senior underwriting and claims experts from life and health insurance companies as well as mental health experts. The contributors offer global (group-level) as well as regional views from Asia, Australia, Europe and the Americas. The section begins with a high-level outline of the product landscape, followed by an appraisal of the exogenous and endogenous factors faced by insurers when considering the insurability of mental health conditions. It also provides a snapshot of some of the innovations underway to improve mental health risk protection.

4.1 The interface between insurance and mental health

The way in which mental health is handled by insurance varies widely by market and is often shaped by policy environment, demand- and supply-side factors and insurers' own risk appetites. There are some universal characteristics, however, with an especially pronounced role for life and health insurance both at the retail and group levels. This section therefore focuses primarily on life and health insurance, where most direct and indirect costs related to mental health are incurred and where there is significant potential for expanded risk protection.

As illustrated in Figure 9, for life insurers, interaction with mental health occurs mostly through products such as TPD protection, income protection (also known as disability insurance), critical illness protection and mortality protection. For health insurers, mental health coverage may take the form of health plans and employment health benefit schemes. Mental health may also be a key consideration for general and liability insurers when dealing with motor, travel, workers' compensation and professional indemnity policies, though these are not within the scope of this report.

FIGURE 9: THE INTERFACE BETWEEN MENTAL HEALTH AND DIFFERENT LINES OF INSURANCE

- Total permanent disability
- Critical illness
- Income protection/disability
- Mortality protection

- Medical insurance
- Employee benefits schemes for health

LIFE INSURANCE

HEALTH INSURANCE

MENTAL HEALTH

GENERAL INSURANCE

LIABILITY INSURANCE

- Travel insurance
- Motor insurance

- Workplace compensation or other events related to clinical advice

Source: The Geneva Association

In life insurance, **TPD** and **income protection** or **disability insurance** products currently absorb the brunt of the shock stemming from poor mental health. It must, however, be noted that it is not mental health per se that is covered by such policies, but rather the 'policy holder's incapacity to work' because of a mental health condition. While such a clause is often easier to interpret in the context of physical injuries or illnesses, the difficulty of both accurately diagnosing mental health problems and establishing their severity in absolute terms has made this a complex issue. Traditional policy wording in these products has come under scrutiny as a result: unlike physical disabilities, mental incapacity is open to interpretation.

> *In life insurance, total permanent disability and income protection products currently absorb the brunt of the shock from poor mental health.*

To mitigate the risk of moral hazard and fraud for such products, some insurers have put in place a claims postponement clause lasting between three months and a year. Such clauses aim to prevent people from making a claim immediately after purchasing a policy and as a result, have facilitated the provision of protection against conditions such as PTSD, severe depression and anxiety through many TPD, disability and income protection insurance products. However, when examined through the prism of early detection and mental health outcome, such clauses come at a cost, such as inability to detect conditions early leading to poorer health outcomes (see section 4.3 for further discussion).

Critical illness plans have recently started to engage with mental health, with more products offering coverage for mental health problems characterised by severe episodes necessitating hospitalisation or a form of institutional care.

Providers of **mortality protection** need to protect themselves against the possibility that people buy a policy with the intention of taking their own lives shortly thereafter so that their surviving dependents receive a term life insurance benefit. This is why life insurers apply a suicide clause and will typically not pay a death benefit if the insured person dies by suicide within the exclusion period of the first two years of coverage. Many group life policies arranged for by employers do not have such a suicide clause, however.

The interplay between **health insurance** and mental health varies across retail and group plans as well as by market, but it can be broken down into three broad categories. Firstly, mental health insurance provision can be complementary to a statutory health scheme, i.e. one that is publicly funded. In such cases, mental health benefits in voluntary/private health plans build on publicly sponsored services. Secondly, insurers may offer a specific package of benefits where statutory plans are less generous for mental health; in such cases benefits are often limited in order to mitigate the risk of moral hazard. Thirdly, regulatory stipulations in some markets may require health coverage to be comprehensive, even for private insurers. In this case, insurers cannot deprive people with mental health problems of an insurance policy covering other physical illnesses, or otherwise treat mental health differently from physical health.[74]

The products offered by health insurers may also vary by the amount of outpatient and inpatients and the pharmacy benefits they cover. But observations suggest that decisions on what to cover and by how much may not always be taken with due consideration for the depth of coverage needed by individuals and efficiency in the mode of service delivery. This trend is particularly evident in retail plans in parts of Asia that focus on severe inpatient episodes requiring hospitalisation, as opposed to a more balanced package of benefits. This phenomenon is also mirrored by other studies. A survey by Mercer Marsh Benefits (MMB) of 226 insurers across 26 countries found on the one hand that the number of global insurers who did not offer any mental health cover in **employment benefits schemes** for health decreased from 26% in 2021 to 16% in 2022 – representing a significant 10 percentage point improvement. On the other hand, these figures imply that close to a fifth of global insurers are still lagging behind.[75] This may also reflect low demand from employers' to include mental health in benefits that they offer. The survey also revealed that such benefits are inadequate. While two thirds of insurers did offer counselling sessions, in practice these were limited to 10 sessions or fewer, leaving a consumer potentially open to 'hazards' such as incurring high out-of-pocket expenditure or foregoing necessary care altogether. This problem was especially pronounced in insurers operating in Asia, where just 55% offered any counselling at all (Figure 10). Similarly, coverage for pharmacy benefits, mental health literacy or virtual mental health support fared poorly, with less than half of insurers on average focusing on these areas.

The evidence suggests that, until recently, the most common approach across life and health insurance to mental health coverage has been characterised by focus on the number of treatment episodes on offer and the ability of policies to cover expensive cures with specialists, as opposed to a more balanced package of benefits

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74   APA 2014.
75   MMB 2022.

incorporating prevention and management. While changes are afoot (see Box 1), this trend runs contrary to the evidence outlined in section 2 psychological that the most common mental health problems – depression and anxiety – are the growing at the fastest rate, rather than more complex issues requiring hospitalisation or institutional care. Large surveys across Asia vindicate these findings, pointing to an increasing incidence of workplace stress and burnout alongside a lack of financial well-being as common drivers.[76] It can therefore be inferred that focus on clinical interventions alone, either through specialist care or hospitalisation benefits, is unlikely to alleviate the pressures on insurers stemming from poor mental health. There is also a clear social need, as well as a commercial opportunity, for insurers to focus on more common mental health problems.

Focus on clinical interventions alone is unlikely to alleviate the pressures on insurers stemming from poor mental health.

FIGURE 10: MENTAL HEALTH COVERAGE IN EMPLOYMENT BENEFITS FOR HEALTH

Global | Asia | Europe | Latin America and the Caribbean | Middle East and Africa
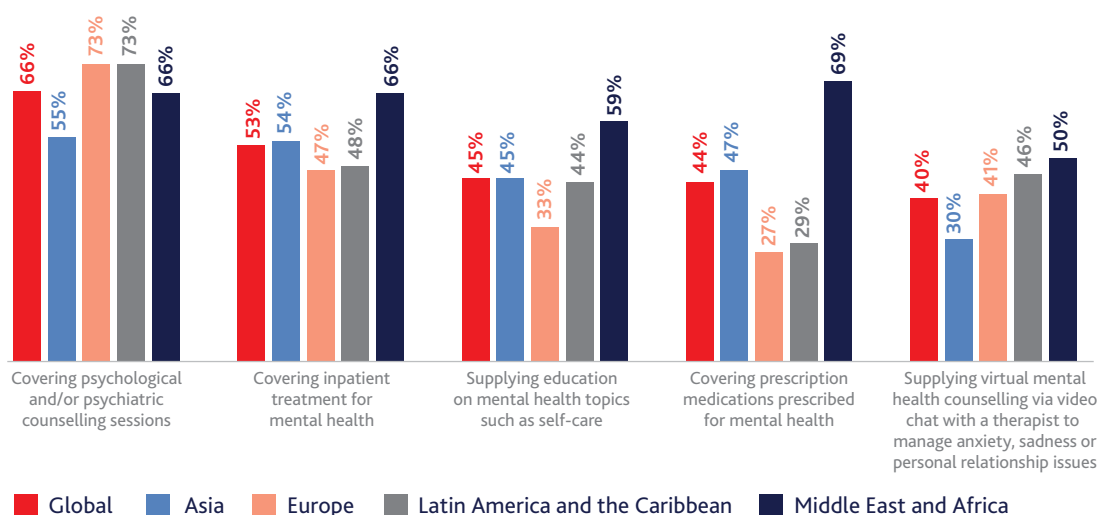
Source: MMB[77]

The COVID-19 pandemic has triggered some favourable shifts towards early and more diverse interventions. Many insurers have embraced (digital) mental health tools, self-help guides, telemedicine, talking therapies and other forms of community interventions with different cost structures and a range of considerations for market replicability.[78,79] Others are beginning to target mental health support towards specific cohorts, such as expectant mothers through maternity plans to address post-partum depression or counselling for policyholders and their families following a cancer diagnosis.[80]

Despite this progress, some limitations persist. Firstly, a number of such interventions exist as value-added products often dependent on voluntary uptake by users. As a result, understanding is currently limited as to how they can be used to gather more systematic intelligence to strengthen risk protection and aid risk assessment. Secondly, they largely focus on developed markets, with a relatively modest presence in emerging economies. Equally, in markets where they do operate,

76   Carmichael et al. 2022; City Mental Health Alliance HK 2020; AIA 2022.
77   MMB 2022.
78   AXA 2022.
79   Notable examples include Swiss Re's work with Wysa combining AI-driven self-help through digital cognitive stimulation therapy (CST); Prudential Financial's work with NeuroFlow combining self-help, care coordination and crisis management; AXA's work with TheraTalk that brings together offline and online access to therapists; and several major U.S.-based insurers' work with 7 Cups to offer a community of online listeners for mental health support.
80   Allianz (undated); Aynjil (undated).

the business case is often predicated on reducing the volume of claims from physical therapy sessions.[81] And finally, while the advent of digital mental health tools is promising, user engagement/adherence and their effectiveness in predicting poor mental health are yet to be fully appraised. The extent to which they can truly reflect needs in a given market and aid service delivery is therefore unclear.[82]

To conclude, while progress is no doubt evident, it is not yet happening at scale. On the one hand, many insurers are starting to acknowledge this and the need to offer more effective solutions to consumers. On the other hand, a coherent framework to assess demand in the context of social stigma and a sufficient policy foundation or infra-structure such as staffing are still absent (see section 4.2). These deficiencies continue to impair the insurability of mental health.

4.2 Exogenous factors affecting the insurability of mental health

4.2.1 Social attitudes and stigma

A 2020 report by the Human Rights Watch (HRW) showed that the practice of 'shackling' the mentally ill is prevalent in 60 countries across Asia, Africa, Europe the Middle East and the Americas.[83] In other, less extreme settings, mental illness is seen as a source of weakness or shame.[84] For example, in Singapore, a survey of over 900 adolescents and young adults showed that over a fifth felt uncomfort-able about openly acknowledging that they had a mentally ill relative, and over a third felt they would be perceived as weak if they were known to have a mental illness.[85] In countries like the U.K., just 54% of people feel comfortable talking openly about mental health at their workplace, despite the fact that workplace burnout and financial stress are among the leading risk factors for poor mental health.[86]

The fear of stigma may also be responsible for the wide-spread under-reporting of mental health conditions, which in turn may also contribute to the unreliable nature of self-reporting in mental health. A population-based longitudinal study of mid- to late-life adults in the U.S. asked participants to report on six mental and six physical health conditions, with four waves of interviews over two decades.[87] The results from the fourth and final wave was compared with the aggregate results from the previous

three waves. The authors found that subjects significantly underestimated the lifetime mental health problems they had suffered when asked at the end of the study. The same glaring discrepancy was not found for physical health conditions. To illustrate: whereas only 4.5% of respondents retrospectively reported experiencing a major depressive disorder in the fourth wave, data from the first three waves generated an average of 13.1%, indicating a discrepancy of 8.6%; for diabetes, the discrepancy was only 2%.

4.2.2 Inadequate and inefficient financing

The economic case for prioritising mental well-being is compelling – every USD 1 invested in mental health can lead to a fourfold return through better health and productivity.[88] Nevertheless, some have argued that negative social atti-tudes towards mental health have dented political prioritisa-tion and, consequently, funding of mental health services.[89] As such, 67% of people seeking mental health services in OECD countries reported difficulties with access in 2020.[90]

Irrespective of a country's level of prosperity, mental health remains under-resourced: significant structural and supply-side constraints have arisen as a result of inadequate funding and an acute shortage of skilled mental health workers. Mental health spending constitutes just 2.1% of global annual median government health expenditure, a meagre USD 7.49 per capita.[91]

Structural and supply-side constraints have arisen due to inadequate funding and a shortage of skilled mental health workers.

The median number of mental health workers per 100,000 people in 2020 was just 13, with stark inequity in their distribution.[92] As Figure 11 illustrates, while the median number of mental health nurses per 100,000 people in Europe is around 25, it is just 0.9 in Africa and South East Asia – some of the most populous parts of the world. Similarly, the density of psychologists is over seven times higher in Europe than the Western Pacific region.

81   AXA 2022.
82   The Lancet 2022.
83   Human Rights Watch 2020.
84   AIA 2022.
85   Pang et al. 2017.
86   The Geneva Association 2022; Business in the Community 2018.
87   Takayanagi et al. 2014.
88   The Lancet 2020.
89   Thornicroft and Sunkel 2020.
90   OECD 2021a.
91   WHO 2021b.
92   WHO 2021b.

Such allocative inefficiencies are also reflected in service design. One 2016 study estimated that 63% of psychiatric beds were situated in large mental health facilities, as opposed to resources being more evenly distributed across primary, community and secondary care settings to enable early detection and facilitate case management.[93] Such policies also often reflect historical trends, when mental health patients were typically confined to 'institutional care systems', leaving the broader societal determinants of mental health overlooked. Similarly, notions of good health and well-being have been compartmentalised further into physical and mental health, limiting the extent to which services can be redesigned and redeployed more holistically.

FIGURE 11: COMPOSITION OF THE MENTAL HEALTH WORKFORCE
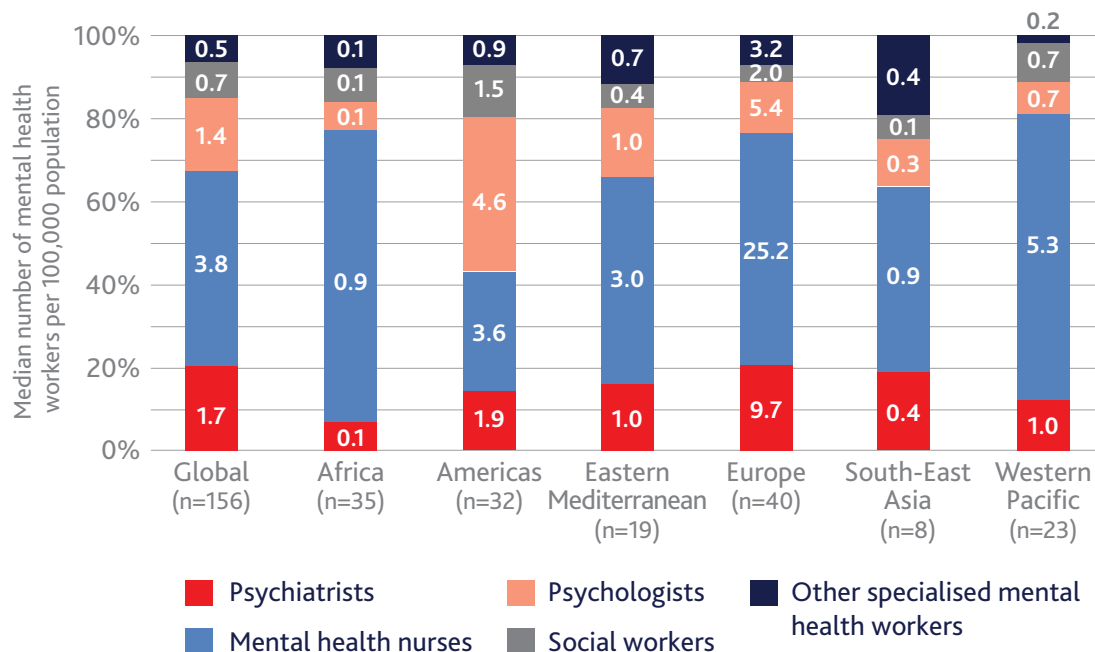
Source: WHO[94]

4.2.3 Implications for insurers and insurability

Given the heterogeneity of health systems and the limitations they face, health and life insurers may reasonably ask: where do we begin? Like products covering physical conditions, insurance plans covering mental health problems are dependent on societal attitudes and the adequacy of existing infrastructure. For insurers, a high level of stigma attached to mental health may translate as a barrier to disclosure and therefore a lack of intelligence regarding demand or risks. Equally, the way in which health systems are organised may impose limits on the availability and nature of service provisions despite best intentions.

In mature health systems, insurers can build on existing statutory schemes and quality assurance mechanisms to design products for mental health.

- In health systems where service delivery structures, clinical pathways (established/standardised care plans with consistency in how conditions are diagnosed, treated and managed) and fee schedules already exist, such as mature systems, it may be relatively straightforward for health insurers to design a health insurance product dealing with mental health by building on existing statutory schemes and quality assurance mechanisms. This can be observed in Europe, Japan and Australia, for example, where the majority of the costs for mental healthcare services are being covered by statutory health schemes.[95] In such settings, life and voluntary health insurance-focused products may also gain traction as people look to protect themselves from the wider (supplementary) risks of poor mental health – as there is a baseline level of awareness and a publicly-sponsored safety net. Under these circumstances, the role of private health and life insurers is very much defined by enhancing state schemes.

- In publicly sponsored systems in which the costs of mental healthcare are excluded from benefits packages or in which service quality is poor (e.g. long

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93   Stuart 2016.
94   WHO 2021b.
95   Mojahedi 2009; Japan Healthcare Info (undated); Services Australia 2022.

waiting times although basic rules and protocols exist), private insurance will doubtless play a larger role if there is sufficient demand for such products. In such cases, insurers may also have greater scope to determine how mental healthcare services should be priced and utilised (e.g. with triaging etc.), as well as to set up quality assurance structures. This requires greater thought about the scale and scope of services from health and life insurers as they stand to absorb more risks than in the preceding scenario.

In less mature systems, insurers need to create and manage their own ecosystem of service delivery.

- In less mature health systems, where services are fragmented and established standard clinical pathways, fee schedules or price caps on professional charges do not exist, insurers will be challenged to ensure that the utilisation of services is medically necessary and that the cost of treatment incurred is reasonable. In these settings, insurers will need to create and manage their own ecosystem of service delivery, which could take considerable time to develop.

4.3 Endogenous factors impeding mental health insurability

In addition to the macrotrends (e.g. social attitudes, resources and health system organisation) that determine how far health systems can provide a conducive environment for insurance to offer protection against poor mental health, a number of insurance-specific factors also impede progress. This section provides an overview of some of the common challenges faced by insurers as a result of historical operating models that do not always translate well to understanding the risks of mental health. It also provides snapshots of some of the novel ways in which insurers are overcoming these challenges to improve the insurability of people living with mental health problems based on publicly available information and insights from 16 key informants.

4.3.1 Consumer awareness and engagement

In insurance, non-disclosure is the most common manifestation of social stigma around mental health problems. It is often driven by the fear of penalisation and anxiety about sharing sensitive data that might stay on official records. Equally, a lack of awareness of mental health problems in the general population has made unintentional non-disclosure another obstacle, as many people are not able to discern chronic mental health problems from general distress until symptoms worsen. The extent of the challenge emerging from non-disclosure

is conveyed by the fact that the rate of increase in mental health-related claims is higher than the rate of increase in the number of customers declaring existing mental health problems at the point of purchase, something that is perhaps much harder to anticipate than in other lines of insurance business (elaborated on in the following sections).

Consumer engagement with mental health interventions is also complicated by the need for anonymity. For example, 'faceless' telemedicine is preferred over video calls or in-person visits in some markets. In other markets, a salesperson and a potential consumer are faced with a sense of awkwardness at the point of sale, when the former is tasked with collecting granular information about mental health as part of overall health data. However, there are some promising indications of improvement in the level of disclosure thanks to destigmatisation efforts, leading to better responses, especially from the young.

> *"There is stigma associated with seeking help in general and also hesitations about consulting your insurer for it."*
>
> **Olivia Turan, VIG**

4.3.2 Uncertainties in product design

Several factors obstruct insurers' ability to integrate holistic mental health propositions systematically with existing products, some of which have been touched upon in the preceding sections. These macrofactors have also curtailed insurers' collective bargaining power with healthcare providers to agree on efficient purchasing/reimbursement arrangements. As a result, in some Asian markets, for example, mental health benefits have tended towards the digital rather than physical in the hope of bypassing such limitations while still endeavouring to improve access to services.

Such an approach comes with the challenge of ascertaining how products will be received by consumers, and of establishing the right mix of digital and physical benefits to address need while ensuring better outcomes and long-term returns on any investment. While some progress is in evidence in some developed countries (as discussed in section 4.1), developing countries lag behind. In many developing countries, mental health services are provided by insurers on a time-bound, campaign-by-campaign basis, as opposed to being a permanent benefit. Regulatory stipulations often also play a role in determining the services insurers can legitimately offer. For instance, in some markets like Australia, life insurers may face limitations on intervening with early clinical support due to health licensing requirements. This imposes barriers upon the extent to which life insurers can proactively take on early measures to improve user as well as claims outcomes.

4.3.3 Rigid underwriting techniques

Risk assessment around mental health is a key challenge since traditional health underwriting models employ simple binary distinctions. They typically fail to sufficiently take into account the nuances of mental health, as described in section 2, and tend to treat mental health conditions simply as the presence or absence of disease. Historically, this has led to mental health being excluded or coverage being denied altogether. Some of these underwriting challenges are described below along with product-specific characteristics.

Firstly, at the underwriting stage, information on mental health is primarily aimed at narrowing the informational asymmetry between the applicant and the insurer. But, as already discussed, mental health problems are harder to diagnose than physical ones due to the potential for differing expert opinions: a general practitioner's diagnosis may be different from a psychiatrist's. Self-reporting of a problem by an applicant may equally be under or overstated.

Secondly, when there is disclosure, underwriters are tasked with establishing the severity of the condition and whether it is indeed a risk or simply a normal, one-off reaction to an adverse life event such as bereavement. It may be possible to adopt a more nuanced approach to risk assessment and ask fundamental questions about conditions such as loneliness, but underwriters are seldom any wiser about the potential of the customer developing a mental health problem in the future.

Finally, there is a dearth of data when it comes to benchmarking mental health conditions across the industry, making it hard to achieve consistency in underwriting decisions. This has also resulted in difficulties with pricing. While some countries have been able to use population-level data as reference points, in other countries the lack of reliable data on prevalence, frequency and severity makes this an even more challenging process.

To complicate matters further, the nature of underwriting differs between mortality and morbidity insurance as well as between group and retail plans. In mortality insurance, though approaches differ by market, the fact that the outcome is certain means that underwriting is less complex. By contrast, in disability or morbidity-related insurance in general, underwriters are faced with the prospect of long-term risk exposure. Here, underwriting is typically more time consuming and elaborate, resulting in higher premiums or even exclusion of mental health benefits.

Underwriting in retail plans tends to be more granular, allowing for longer coverage periods for applicants since insurers have a better understanding of their risk. In group plans, however, the reliance on aggregate history (i.e. the number of claims made previously at the employer level), means that underwriters lack a detailed understanding of their risk exposure, thus limiting coverage to a shorter period.

Innovations are underway to address these difficulties. Where possible, insurers have begun using population-level data to understand and apportion risk more sensitively. For instance, the presence of multi-morbidity in an applicant could serve as a proxy for assessing the future risk of mental health problems through standardised and often automated scoring tools. Others are bringing more nuance

> *Insurers are challenged with getting the right mix of digital and physical benefits to address need and ensuring better outcomes and long-term returns on investment.*

to the application process by asking multivariate questions rather than binary ones. The aim of such approaches is to improve insurability by considering a person's physical, mental and social circumstances holistically, and not basing decisions on one-off episodes of distress or adverse events. This approach also allows for a measured appraisal of the nature, frequency and accumulation of symptoms, as well as broader indicators such as the amount of time taken off work, geographical location and heritage, among others.

Early evidence emerging from such revisions to underwriting techniques is promising. A recent report by Munich Re revealed that by taking a more evidence-based and nuanced approach to underwriting, the insurability of people with mental health problems applying for life insurance products in the German market improved dramatically – from 16% to 56%.[96] For countries with comparable health systems, the authors estimate that over 50% of people with pre-existing mental problems could be offered disability insurance.

> *"It's imperative for insurers that underwriting keeps up with the pace of societal change in attitudes towards mental health."*
>
> **Erin Crump, RGA**
>
> *"As insurers, we don't collect enough data – at least historically. This limits us from seeing the full spectrum of variables that impact on and differentiate risks associated with a history of mental ill-health."*
>
> **Andres Webersinke, Gen Re**
>
> *"In some cases [such as attempted suicide or self-harm] we have to realise that it may be nothing more than a cry for help."*
>
> **Darren Jones, Swiss Re**

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96   Munich Re 2022.

4.3.4 Complex claims validation

Claims managers face some of the same challenges as underwriters, since they are unable to rely on diagnostic test results from laboratories or computerised tomography (CT) scans to determine a poor state of mental health. This raises the possibility of fraud or abuses, but it may also result in genuine cases of poor mental health being rejected.

While the ICD and DSM classifications for mental health conditions provide claims managers with some structure, specific diagnostic criteria may be prone to subjective interpretation. This challenge is further compounded by the aforementioned lack of (standardised) treatment guidelines in many countries, resulting in a wide variety of practices. Claims assessors are therefore tasked with a difficult vetting

Insurers have begun using population-level data to understand and apportion risk more sensitively.

process to ascertain whether a patient is being appropriately treated in accordance with evidence-based best practice, and to limit instances of supplier-induced demand, such as patients being kept in hospital for an unnecessarily long time to their own detriment. These issues have been further complicated by the year-on-year increase in the volume of claims received, especially under disability or income protection plans. Some insurers are overcoming these problems by creating automated decision-making tools to help claims assessors develop a deeper understanding of claims in relation to mental health conditions.[97]

The timing of a claim is another important consideration. Validating a claim can be a lengthy and cumbersome process entailing a retrospective review of financial, occupational and medical documents, especially with the claim postponement periods in disability or income protection products (see section 4.1). While such postponements are designed to protect against illegitimate and fraudulent claims, from a consumer perspective, they may lead to service delays and poorer health outcomes. They may also solidify existing negative perceptions of insurance with regards to mental health.

There appears to be growing consensus among experts that a proactive approach from the outset, through wellness-boosting and preventative measures, is more effective. Some insurers have adopted a middle ground by capping benefits to a defined period (especially for income protection products) as well as laying on mental wellness and early support programmes before a claim is made. The success of such interventions, however, remains to be evaluated.

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97   Mitic and Enslin 2022.

Some insurers are creating automated decision-making tools to help with claims assessment for mental health conditions.

Finally, the nature of mental health claims merits close examination as they can manifest in two ways: primary claims, where a policyholder's primary diagnosis is related to mental health; or secondary, where poor mental health has an exacerbating effect on a primary physical health problem. Musculoskeletal claims (e.g. chronic back pain from an injury) are a common example; the pain may last for a few months or several years, but the claim may be aggravated by a secondary diagnosis of depression. Accounts by experts suggest that case managers across the board are still not adequately equipped to spot the indications for the latter and take necessary action

"Processing claims in mental health is a tough balancing act – it needs to be handled with gloves to differentiate the legitimate from the fraudulent.

Despite international clinical classification systems such as the DSM or ICD, how one arrives at a diagnosis can differ significantly."

Eric Baluya, Allianz

"What is there to differentiate the severe from the moderate to mild? An interview with a psychiatrist might help but opinion may vary from one to another. For instance, a claim may be triggered if the person loses 50% of their ability to work – but who can objectively assess if it's 49% or 56%?"

Alban Senn, Munich Re

"Life insurance policies tend to place the onus on the customer to justify their sickness or illness to have the policy respond with benefit payments, as opposed to rewarding the customer for focusing on wellness behaviours. We have to find ways to incentivise people to do the latter."

Andrew Beevors and Shilpa Ratti, MLC, Australia.

Insurance innovations to improve mental health

Novel technology to enable early intervention and prevention of poor mental health

On the technological front, the use of **stress indexes** from new/emerging/repurposed technology are being investigated by insurers to identify early warning signs and aid prevention of poor mental health. One such technology that has been making waves in the insurance industry is remote photoplethysmography, whereby subtle changes in blood flow beneath the skin can be picked up by camera light sensors and analysed to yield results, including the stress levels of an individual.

If the data from this method are shown to be reliable and adequate, these readings can serve as a proxy to understand who is experiencing mental distress. In turn such technology can be used in mental health well-being programmes, to provide opportunities for insurers to engage with their customer base and provide timely interventions.

Source: NuraLogix[98]

Customised mental health programmes in group plans

Sun Life Canada recently piloted a service internally and with several employer groups that involved inviting employees to complete an online self-directed mental health risk assessment. Employees were then given the opportunity to connect with a **mental health coach** who reviewed the results and offered individualised recommendations for lifestyle changes and mental health support, all aligned with the employee's extended healthcare benefits plan. Early outcomes have been promising: significant improvement was reported by 79% of employees experiencing symptoms of anxiety, 66% of employees experiencing symptoms of depression and 69% of employees experiencing disturbed sleep.

Source: Mikail and Dobler[99]

Creating a mental healthcare continuum: From wellness to management

AIA has adopted the **Learn Act Chat** framework using a simplified risk segmentation matrix to provide personalised recommendations to users. The approach combines **passive intervention** (including self-help tools, articles, podcasts and videos); **guided intervention** (including meditation, mindfulness, gratitude journaling, mood journaling, goal setting and nudges/reminders among others); and **active intervention** (including text chatting with mental health coaches and dedicated sessions with counsellors and psychologists). The programme also provides immediate crisis support through direct hotlines, mental health first aid and opportunities to reach out for help. The services are designed with market-specific needs in mind and are created in collaboration with local/regional partners who deliver clinically validated solutions to the AIA client base.

Source: Myralini Santhira Thesan, AIA

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98   NuraLogix 2021.
99   Mikail and Dobler 2022.

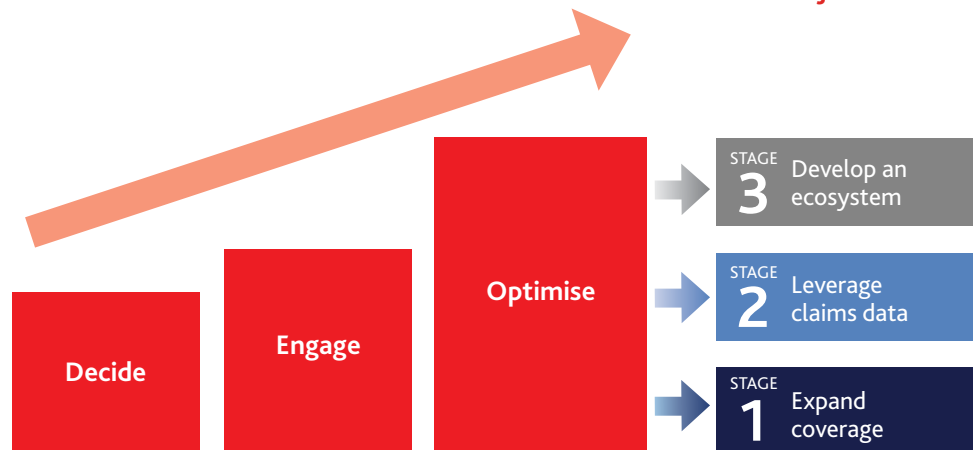# 5 Recommendations and concluding remarks

Recommendations and concluding remarks

This report puts forward a framework to help life and health insurers augment their role in promoting good mental health.

The COVID-19 pandemic has led to profound shifts in the way mental health is perceived by society and businesses worldwide. It has also brought to light the true scale of the mental health crisis. Notwithstanding the barriers to progress discussed in the previous sections, the pockets of innovations underway are insightful and provide a springboard for insurers to go further. Evidence suggests that there is significant consumer demand for insurers to deepen their role. A recent study by Swiss Re of 4,500 people aged 25–70 across seven mature insurance markets found that consumers had noticeable appetite for protection against common mental health problems like depression over complex or rare conditions.[100] The study also showed that consumers valued better guidance on interpreting early warning signs of poor mental health and prevention that went beyond providing a mobile or digital application. For example, this could include the integration of mental health with products physical health products and greater involvement of their employers in their mental well-being.

This report puts forward a framework to support life and health insurers in augmenting their role in promoting good mental health. While it is acknowledged that implementation of the framework is subject to data availability and privacy considerations in certain markets, the principles outlined in this section can be largely tailored to local contexts. The framework (Figure 12) comprises 3 steps: 1) **decide** on a strategic direction for mental health, 2) make a holistic effort to mobilise and **engage** consumers and partners and 3) **optimise** critical functions of the insurance value chain such as underwriting, claims and data analytics.

FIGURE 12: MENTAL HEALTH AND INSURANCE: CHARTING THE JOURNEY

STAGE **3** Develop an ecosystem

STAGE **2** Leverage claims data

STAGE **1** Expand coverage

Decide

Engage

Optimise

Source: The Geneva Association

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100   Swiss Re 2021b.

5.1 Decide on the parameters for the benefits package

Insurers now have the opportunity to finesse their benefits packages by taking advantage of the new and fast-growing global and market-specific evidence on mental health spurred by the COVID-19 pandemic. This entails deciding on the scope (what conditions will be covered), scale (the number of people eligible) and depth (the extent to which a given risk will be covered) of coverage. This report has shown that depressive and anxiety disorders arising from daily living conditions, workplaces, financial worries, major life events etc. constitute the majority of mental health problems. This report does not suggest that depression and anxiety should necessarily be prioritised over other mental health problems, but points out where the burden is felt the most. Insurers are now able to appraise whether their benefits packages are aligned with evidence or need to be recalibrated.

> *Insurers can finesse their benefits packages by taking advantage of the new and fast-growing evidence on mental health.*

In many cases, a recalibration may result in benefits packages that include protective practices by individuals and employers, rather than simply focusing on specialist visits or inpatient episodes. Group policies may support stay-at-work initiatives (in addition to back-to-work ones), which can positively influence productivity and absenteeism. It can also take into account the mental health needs for specific professional groups (e.g. emergency services) and create new propositions that are closely aligned with emerging policies for ensuring psychological safety and health in the workplace. For example, the Canadian Standards Association (CSA) and the Bureau de Normalisation du Quebec (BNQ) collaborated on the development of a set of 13 standards and accompanying implementation guidelines and resources.[101] To date, these standards have been voluntary, but in light of the positive impact they have had on improving employee mental health, work is afoot to make them mandatory in the workplace. This success can act as a reference.

In addition to group plans, there may now also be scope for insurers to pivot the benefits of individual retail policies towards wellness and prevention. This may include guided interventions such as mental fitness programmes, tools for stress or trauma management, and apps and wearables aimed at tracking health activity, which may be used to refer customers to further resources. It may also involve more active interventions such as biannual holistic check-ins with

a case/account manager to spot warning signs, support packages after major life events such as birth, accidents, or the onset of major or critical health conditions, including those leading to palliative care, bereavement and retirement. By incentivising participation in preventative programmes, insurers can also offer premium reductions and rewards to retail and group customers, similar to those seen in physical health plans.

> *There are opportunities to create insurance propositions that balance mental health clinical expertise with social, financial or lifestyle support.*

These considerations go hand in hand with alleviating some of the supply-side constraints. Given the shortfall in qualified mental health professionals, there are opportunities to create insurance propositions that balance clinical expertise with social, financial or lifestyle support. Signing off on a set number of sessions with a psychiatrist or psychotherapist, for instance, would not necessarily result in recovery from a mental health problem if the root cause is loneliness, bullying, chronic sleep deprivation or financial worries. Insurers must accordingly make use of a mix of digital and physical interfaces to facilitate a more holistic ecosystem of care. Such multi-layered and multi-sectoral approaches – including the concept of 'social prescribing' – have already yielded promising results in the public sector.[102]

> *"Covering mental health benefits as part of palliative care is one notable area of opportunity. Here, insurers not only have a chance to address physical distress, but can also help to relieve the psychosocial and spiritual suffering of the patient and his or her family as part of end-of-life care so they are better able to cope with the distress and the accompanying loss."*
>
> **Jaime Herrera, MAPFRE**

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101   CSA and BNQ 2013.
102   See Buck and Ewbank 2020. 'Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellbeing.'

5.2 Engage to improve uptake of services

A recently commissioned survey by AIA across Asia found that just a fifth of those surveyed considered themselves to have good mental health, with financial challenges, household chores, lack of time to relax, pandemic-related social restrictions and the excessive use of social media cited as common drivers of poor mental health.[103] The report also found that a substantial proportion of respondents did not know when and how to access mental health support. The acuteness of such problems, which may vary by culture, generation and setting, will be a significant factor in determining general demand and timely uptake of any existing or new mental health propositions.

Group plans provide a strategic platform to raise awareness and mobilise employers. The U.K.'s 2012 Equality and Human Rights Commission Policy Report found that people living with poor mental health wanted their employers to address three areas: flexible working, more supportive managers and understanding from colleagues.[104] New digital tools and clinical interventions have an important role to play, but a compassionate working environment is clearly also a key aspect. As such, existing group plans can be leveraged to open new opportunities for insurers. This may include advising employers on ways they can create mental health-friendly policies, promote open communication and integrate workers who have suffered from poor mental health and are newly joining/returning to the workforce. Broader outreach in schools and communities can also help to dispel myths and provide tools and guides to improve mental health literacy in a manner tailored to local values and contexts.

Group plans can be used to open new opportunities for insurers, including advising employers on creating mental health-friendly policies and promoting open communication.

It may be some time before the outcomes of such efforts can be assessed, but they will likely reduce the level of risk exposure over time as more people come forward for timely help. They will also help the industry strengthen its market position and play a pivotal role in achieving its social sustainability goals. Further, as employers, insurers have a bigger role to play by examining current working conditions with regards to the exposure of their employees to mental health risks; analysing ways in which such risks are managed and identify room for improvement; and setting clear objectives for themselves (or a client organisation) through verifiable metrics before deciding on an engagement strategy.

"Generally speaking, destigmatisation efforts should continue. It is very likely that this will shrink the size of the problem. People will open up and seek help, and insurers will carry less of a risk than they did 10–20 years ago when people simply bottled it all up. This will improve insurability."

Alban Senn, Munich Re

Measuring mental health in the workplace

Following the COVID-19 pandemic, companies are increasingly under pressure to better support the mental well-being of their people. While insurers play a role through employee benefits offerings, there is a blind spot as business leaders lack the understanding and data to properly evaluate the effective impact of these workplace mental health efforts and benchmark them against global standards. This makes it difficult to gauge success, identify gaps and ensure proper investment.

The ongoing initiative on developing the Mental Health at Work Index, to establish global standards for workplace mental health and promote science-backed best practice across the continuum of protection, promotion and provision of care is therefore very timely. This provides new sources of data and reflects a broader role insurers can play in providing solutions to customer challenges, creating a sustainable impact that benefits not only the business, but society as a whole.

Source: Gordon Watson, AXA

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103 AIA 2022.
104 Equality and Human Rights Commission 2012.

5.3 Optimise operating models

Transforming underwriting, claims management and data analytics functions holds significant promise. Early evidence from innovations described in the preceding sections suggests that shifting the focus away from absorbing one-off, large shocks towards better risk prediction and prevention can help improve insurability, as well as reduce the size of claims. The process may be complex, but results can be achieved through three stages, which can be adjusted to match an insurer's risk appetite and policy environment.

5.3.1 Stage one: Expand coverage

Ongoing innovations in underwriting offer valuable insights into how they may be scaled up, such as moving from binary to multivariate questions. For instance, should a person who has fully recovered from a mental health problem with no relapse for a number of years be offered mental health benefits with no risk loading? Would it be appropriate to exclude an applicant from mental health benefits if they had only encountered a single episode of depression in their lifetime? Should someone be denied coverage or face risk loading for having a mental health diagnosis (e.g. bipolar disorder) even though they remain highly functional? And should someone with a physical condition like tinnitus (constant ringing in the ear) be denied mental health coverage if there are coping mechanisms in place? These questions will need to be considered in combination with individuals' circumstances and life events, such as bereavement and employment status, as well as whether any action is being taken i.e. they are being actively treated. In some cases this may mean that expanding coverage increases the premium paid by policyholders, but a granular assessment increases the chance of enhancing insurability.

Where population-level data is available, insurers can account for the synergies between poor mental health and chronic illness to inform decisions about the severity of the risk exposure. While many underwriting manuals and guidance do exist, enforcing them consistently with these added layers of sophistication would require a degree of automation as well as building internal capacity.[105]

5.3.2 Stage two: Leverage claims data

Claims assessors could go beyond simply focusing on the legitimacy of claims and piece together information about the sources and timing of claims. This may help with monitoring emerging risk factors, identifying gaps in early detection techniques that could have prevented a claim in the first place, and flagging recurrent claims, among other things. Claims could also be trigger points for activating existing mental health-related benefits, such as acute depression therapy/coaching during the diagnosis of cancer or for someone undergoing major surgery. This may not only prevent serious progression of a mental problem but will improve the customer experience. In the same vein, empowering claims assessors and case managers with new tools and techniques can help to ensure that mental health is not just an afterthought when dealing with physical health claims. Such an approach may mean that more insurers steer away from designing products with stringent claims postponement criteria and instead incentivise claimants to come forward much earlier in the process – all the while taking active measures to reduce both the size and duration of claims.

However, the challenges insurers face around moral hazard or fraud should not be disregarded.[106] As systems mature, insurers will have the choice of creating their own controlled environment with quality assured clinical pathways, developing an alliance of preferred providers, training claims assessors and having clear coding and billing practices. While current supply-side constraints limit the extent to which insurers can agree efficient purchasing or reimbursement mechanisms, mixing them with certain progressive incentives such as further professional development would send a clear signal about how providers can stand out in the market through such partnership.

> *"In many cases, people have exhausted all physical tests for diagnosis of an eating disorder thinking it was something else, only then to discover it was a psychological problem after all.*
>
> *Psychological diagnoses need to be evidence-based and considered proactively, not just arrived at by exclusion of other issues."*
>
> **Wolfgang Seidl, Mercer**

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105   Association of British Insurers 2022.
106   Citizens Commission on Human Rights 2008; Grant 2021.

5.3.3 Stage three: Develop an ecosystem

The final phase brings all the previous building blocks together - a tailored and evidence-based package of benefits coupled with better client engagement as well as enhanced underwriting and claims functions - to create an ecosystem that can facilitate a whole continuum of care, powered by data. Group plans in particular could provide an ideal platform for harmonising multiple offerings to create a coherent whole. For example, an insurer may currently be involved in providing a multitude of services to a large corporate client. These services may include onsite or offsite occupational health support, employee assistance programmes, income or disability insurance, and health plans. Any lack of coordination between these aspects may result in insurers duplicating costs, aggravating the service experience of a user who may already be quite distressed, and making it harder to follow a care pathway for the purposes of active case management. As more insurers start to replace this fragmented approach with a focal point, they can engage in effective triaging of users by directing them to the right level of clinical, behavioural, social or financial support. For some, this may mean self-directed exercise on apps; for others it may involve targeted support from a health or finance coach or talking therapist; a social prescribing programme; a high-level clinical intervention; or it may be a combination of these. Such an approach would give insurers the opportunity to consolidate data to inform emerging needs, product design and risk factors from different lines of business, as well as improve coordination between health and life insurance products. A 2021 study conducted at a large financial services company in the U.K. showed that creating such an ecosystem for mental health led to a 41% reduction in absenteeism, 9% reduction in the number of mental health claims, 13% reduction in total costs, 16% reduction in the average cost of claims and, most importantly, 60% improvement in user outcome.[107]

5.4 Concluding remarks

The COVID-19 pandemic, changed geopolitical landscape and cost-of-living crisis all fuel a vicious cycle of uncertainty, distress and economic pressures, with implications for mental and physical health. It is increasingly clear that navigating this emerging and complex landscape of risks requires more than just 'grit' or 'fortitude'; it demands a broad set of interventions that go well beyond the four walls of a psychiatric ward to support people emotionally, physically and financially.

With one in eight people experiencing mental health problems worldwide, we may soon reach a crisis point, with severe social and economic consequences. 'Peace of mind' is implicit in the notion of insurance. Insurers have a golden opportunity to embrace that phrase in every sense and harness the innovations that are already underway to step up their role in promoting and supporting good mental health.

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107   MMB 2021.

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