



Submission by the Mental Health Council of Australia and *beyondblue* to the Senate Inquiry into the Exposure Draft of the *Human Rights and Anti-Discrimination Bill 2012*

January 2013

Background

The **Mental Health Council of Australia** (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector. Membership of the MHCA includes national organisations representing mental health services, consumers, carers, special needs groups, clinical service providers and community and private mental health service providers, as well as national research institutions and state/territory peak bodies.

beyondblue: the national depression and anxiety initiative is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related disorders in Australia. *beyondblue* is a bipartisan initiative of the Australian, state and territory governments with the key goals of raising community awareness about depression and anxiety and reducing associated stigma. *beyondblue* works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression/anxiety and their carers, to bring together their expertise.

This submission relates specifically to Section 39 (5) of the Human Rights and Anti-Discrimination Bill 2012. Section 39 provides an exception for insurers who discriminate against people on the grounds of age, sex or disability in the following circumstances:

- Where the discrimination is based upon actuarial or statistical data on which it is reasonable for the insurer to rely;
- The discrimination is reasonable, having regard to the data and other relevant factors; and
- If no such actuarial or statistical data is available and cannot reasonably be obtained, the discrimination is reasonable having regard to any other relevant factors.

Section 39 (5) is similar, but not identical, to Section 46 of the *Disability Discrimination Act 2012* Cth) (DDA). Experience with the DDA (outlined below) enables us to anticipate the likely impact of Section 39 in the new anti-discrimination legislation. In particular, we wish to draw to the Committee's attention the experiences of people with a mental illness who seek to obtain insurance or claim against an insurance policy.

Comments on other aspects of the Bill have been provided in separate submissions to the Inquiry by *beyondblue*.

Mental health and discrimination by insurance providers

People with mental illness are subject to discrimination in many forms. Lack of awareness and widespread stigma in the broader community mean that people with mental illness are often not afforded the same respect as other members of society, and have difficulties accessing services that most people take for granted. In 2011/12, around one in five complaints to the Australian Human Rights Commission under the *Disability Discrimination Act 1992* were made by people who reported having a psychiatric disability.

People with mental illness regularly experience discrimination by insurance providers. Consumers have reported instances of discrimination in relation to travel insurance, life insurance, total and permanent disability insurance, income protection and, to a lesser extent, loan insurance. Access to private health insurance poses less of a problem for people with mental illness because it is community-rated.

To date, Section 46 of the DDA has allowed insurers to discriminate against people with mental illness by claiming that their decisions are based on reasonable actuarial judgements or 'other relevant factors'.. The MHCA and *beyondblue* are aware of many consumer experiences which suggest that insurance companies contravene the DDA when they refuse cover to, impose exclusion clauses on or reject claims by people with mental illness. The proprietary nature of actuarial judgements means that it is impossible to determine whether insurers do in fact possess data that would enable a reasonable assessment of risk to be made. We are yet to see evidence that such data exist, and have seen notable evidence to the contrary. For example, a report commissioned by the Investment and Financial Services Association (now the Financial Services Council) in 2006 and written by Gavin Andrews, Professor of Psychiatry at the University of New South Wales and St Vincent's Hospital, Sydney, found that there are major uncertainties in estimating likely future claims for people with mental illness in the absence of data from prior claims. The insurance industry has limited access to such data (at least from Australia) because historically it has not offered cover for mental illness. Furthermore, many consumers report that insurers have not considered their personal circumstances when assessing applications and claims, suggesting that 'other relevant factors' are not taken into account in such decisions.

Some of the practices of the insurance industry contradict their stated policies or protocols. While insurers might assert that they do not reject applicants or claimants solely on the basis of having a mental illness, the experiences of individual consumers make it clear that such discrimination is a common occurrence. Case study examples are included below.

Insurers regularly treat people with mental illness in ways that would be clearly unacceptable for people with physical ailments. A history of one mental illness can mean that people are refused insurance for another, unrelated mental illness; it is hard to imagine someone with a history of (say) stomach problems being excluded from cover associated with a broken leg. Similarly, risk factors for one mental illness are sometimes used to calculate the likelihood of a claim relating to another mental illness. Policy wording commonly refers to symptoms of and risk factors for mental illness (e.g. 'stress', 'insomnia') as proxies for mental illness. Insurers have been known to impute a mental illness in the absence of a diagnosis, such as when someone has seen a counsellor or psychologist. These practices betray a basic misunderstanding of mental illness on the part of the insurance industry and it is inconceivable that there is reliable statistical evidence to support such practices.

Some insurance companies allow people with a mental illness to purchase cover if they have been without symptoms or have not sought treatment for a given time period. Unfortunately, this can serve as a disincentive for people to report mental health problems to a health professional or to change their treatment so that they can qualify for insurance. Apart from leading to under-insurance among the population of people with or at risk of mental illness, such industry practices in fact promote poorer mental health by discouraging early identification and treatment of mental illness. This situation is clearly against the broader public interest.

Case study examples of consumer experiences with insurance

The following examples are based on stories provided to the Mental Health Council of Australia by real consumers. Any information that could identify individuals has been removed, although we have permission to use the information.

Keith sought life, income protection and total and permanent disability (TPD) insurances, but was refused cover by two insurance companies on the basis that he has a history of depression. This is despite having been in paid work ever since he was first diagnosed and managing depression well.

Sally had income protection insurance but forgot to renew her policy. After having an episode of bipolar disorder, Sally's application to reinstate her original policy was rejected, although she has a good employment record. Income protection was also refused by other insurance companies.

Jim's application for travel insurance was rejected outright, and he was not offered the option of cover at a higher premium. The insurance company did not seek supporting information, even though this could have been easily provided by his GP and that additional information is routinely sought in relation to physical conditions. In its response to Jim's application, the insurance company noted that it could not assess the risk of a claim for depression because there are no statistically reliable data on which to make such an assessment.

Geoffrey has mild anxiety and has never had any time off work or taken medication for this condition. He was denied income protection insurance because he accessed psychology services funded through Medicare. The insurance company would not consider his application even with an exclusion for mental health issues, and did not contact his GP or psychologist to obtain any details about his condition. Geoffrey feels that he is now 'branded' since he has had an application for insurance refused and is obliged to disclose this on any subsequent applications he makes.

Deborah has anxiety and depression, and has been managing these conditions through lifestyle changes, counselling sessions and medication. She sought life insurance and income protection insurance through her health insurance provider. She was advised that her premiums would be double the standard price and that any claims for mental health issues would not be covered. Deborah did not take out insurance.

Jennifer has been working for the past 20 years while managing bipolar disorder. Her application for income protection insurance was accepted, but with an exclusion for mental health issues. Jennifer was informed that some insurers require an applicant to be medication-free for five years before offering income protection.

Clive is a highly-paid professional who consulted a psychologist for relationship issues and career advice, but does not have a diagnosed mental illness. When Clive applied for income protection insurance, he was offered a policy only on the basis that he would not be covered for mental illness. The insurance company deemed this necessary because Clive had seen a psychologist.

Tony is a former soldier who saw a counsellor in his first 6 years of civilian employment. When he visited a broker to arrange life and income protection insurance, an insurance company discovered that he had received counselling and asked for access to his case history. In their offer of insurance, the company excluded any future claim that he might have for losses due to mental health problems.

Pat and Denise were planning to go on an overseas trip and purchased travel insurance. Two weeks before they were due to leave, their daughter had her first psychotic episode. When Pat and Denise claimed against their travel insurance policy because they were unable to travel due to their caring responsibilities, the claim was rejected on the basis that their policy excluded any form of psychiatric or psychological condition regardless of whether it was a pre-existing condition or not. Pat and Denise lodged a complaint with the Financial Ombudsman Service and the insurance company. The insurance company did not respond.

Jonathan was refused life and total and permanent disability insurance after the insurance company used actuarial data based on prognosis for Bipolar Disorder 1, despite Jonathan having Bipolar Disorder 2 and a stable recent history including taking no sick leave while with his long term employer. After appealing the decision, the insurance company offered to remove this refusal from his record (so that he would not be required to disclose a prior refusal in future insurance applications) and said that he could apply again after five years without an episode.

Proposed amendments to the Human Rights and Anti-Discrimination Bill 2012

Given the difficulties that people with mental illness have experienced accessing insurance to date, we do not believe that the exemption for insurers under the *Disability Discrimination Act 1992* has operated in the spirit in which it was intended to apply. We therefore propose some amendments to section 36 of the Exposure Draft. The proposed amendments are intended to ensure that:

- the exception does not reinforce discrimination against marginalised groups; and
- insurers are held accountable for the privilege of being exempt from anti-discrimination law in certain limited circumstances.

We believe that our proposed amendments are consistent with the principle at international law that discriminatory behaviour should be considered lawful only if it can be proven that ‘the action was a proportionate means of achieving a legitimate aim’.¹

We do not anticipate that our proposed amendments would have the effect of creating additional regulation or unnecessary burdens for the insurance industry. Much of what we propose reflects the obligations that insurers currently have under the *Insurance Contract Act 1994* (Cth). The key obligations in the context of this submission are:

- the duty to act in good faith (Part II, in particular sections 12 and 13); and
- the requirement to provide reasons for being refused a policy, or being offered a policy at higher premiums or with exclusions, when they are requested in writing by a person that has been affected by the decision (Part IX, in particular section 69 (giving information to insured parties), section 74 (policy documents to be supplied) and section 75 (reasons for cancellation)).

¹ We refer to the submissions by the Public Interest Advocacy Centre, the Human Rights Law Centre and the National Association of Community Legal Centers & Kingsford Legal Centre to the Senate Legal and Constitutional Affairs Committee on the Exposure Draft of the *Human Rights and Anti-Discrimination Bill 2012*.

Given the responsibilities of insurers under the *Insurance Contract Act*, we would argue that objections by insurers to the Exposure Draft's provision requiring them to produce data upon request may be overstated.

1. The requirement to produce statistical or actuarial data

The MHCA and *beyondblue* welcome the inclusion of subsection 39(5)(a)(iii) in the Exposure Draft. This subsection properly requires insurers to ensure that the evidence they rely on in order to invoke the exception is available in a readily accessible format that can be provided to consumers upon request. This is entirely appropriate given that insurers are required to show that they have reasonably relied upon such data.² Section 39(5)(a)(iii) in the Exposure Draft reflects similar requirements that are contained at sections 37 and 54 of the *Age Discrimination Act 1994* (Cth) (ADA) and at sections 41 and 87 of the *Sex Discrimination Act 1977* (Cth) (SDA).

When an insurer refuses to provide cover to someone on actuarial or statistical grounds on the basis of their age, sex or disability, we propose that it must also provide an explanation of its decision to the applicant in plain English, making reference to the evidence of the specific additional risk that the applicant represents and providing information to the applicant on what steps the applicant may take they are not satisfied with the decision.

In addition, where an insurer has relied on 'other relevant factors' (as it is able to do at subsections 39(5)(a)(ii) of the Exposure Draft), the insurer should be required to advise the consumer what factors it considered, why it considers each of these factors to be relevant, and how those factors affected its decision. We submit that section 39(5)(a)(iii) be amended to include these requirements, in addition to the relevant technical information that is now properly required by subsection 39(5)(a)(iii) of the Exposure Draft.

In circumstances where an insurance provider contends that it would be unreasonable for them to provide relevant data to a consumer, the insurer should be required to apply to the Australian Human Rights Commission (the Commission) to explain why providing the data or supporting information would be unreasonable. The Exposure Draft should be amended to ensure that the Commission is empowered to require the insurer to provide a consumer with the data on which it relies, and/or a plain English explanation of the data, and make it an offence to not do so within 28 days. Such an amendment would reflect the current powers provided to the Commission under section 54 of the ADA and section 87 of the SDA.

These accountability mechanisms should apply regardless of whether an insurer provides cover with exclusions for particular conditions (such as mental illness) or denies cover altogether.

2. Refining 'other relevant factors'

If the exception for discrimination with regard to 'other relevant factors' where no actuarial or statistical data are available is retained in the Bill, we propose that section 39 of the Exposure Draft be amended to clarify what 'other relevant factors' are. We believe that this clarification should be

² See subsection 39(5)(a)(i) of the Exposure Draft, *QBE Travel Insurance v Bassanelli* [2004] FCA 396 and the Australian Human Rights Commission Guidelines for providers of Insurance and Superannuation (Revised 2005) which place the burden on the insurer to prove that they have reasonably relied upon the data.

consistent with the principles that have been stipulated by the Federal Court in *QBE Travel Insurance v Bassanelli*³ and state that 'other relevant factors' means:

- All other 'relevant factors', and not just the factors selected for consideration by the particular insurer or person seeking to invoke the exemption;
- Relevant factors that reduce any risk to insurers as well as the factors that increase the risk to insurers; and
- Before refusing cover to someone on the grounds of age, sex or disability having regard to 'other relevant factors', an insurer must take into account the circumstances of the individual applicant. An insurer must not rely solely on general assumptions about people of a particular age or sex or with a particular disability in deciding to refuse cover.

As noted above in relation to subsection 39(5)(a)(ii) of the Exposure Draft, subsection 39(5)(b) of the Exposure Draft should also be amended to require an insurer which refuses to provide cover on the grounds of age, sex or disability on the basis of 'other relevant factors' to provide a consumer with an explanation of its decision in plain English, making reference to the specific factors which it has taken into consideration and provide information to the applicant on what steps the applicant may take if they are not satisfied with the decision.

3. A clear explanation of the purpose of the exception

Explanatory material accompanying the Bill should clearly explain the purpose of the exception. This will provide guidance to insurers and to the community about the circumstances in which insurers can and cannot lawfully discriminate against people on the grounds of age, sex or disability. In addition, and regardless of the proposals above, we propose that the Bill state explicitly that it is not reasonable to refuse to insure a person on the grounds of age, sex or disability simply because of historical practice or the practice of other insurers, however widespread, or to rely on inaccurate assumptions about people of particular genders, ages or disabilities.

4. Compliance

Insurers should be required to advise the Commission how often each year they have declined to provide insurance to someone on the grounds of age, sex or disability on actuarial or statistical grounds. The Commission should then publish the number of refusals made every year by each insurer on its website and/or in its annual report, with reference to the grounds on which cover was refused (e.g. age, sex, type of disability).

³ [2004] FCA 396.