SUBMISSION

Financial Services Council Life Insurance Code of Practice Version 2.0
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Financial Services Council
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Lived Experience AUSTRALIA

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1. Introduction

Lived Experience Australia is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA acknowledges and strongly supports the Code and its goal to ensure that members of the FSC who are bound by the Code:
a) deliver a high standard of customer service throughout their relationship with customers
b) continuously improve the services they offer to customers
c) communicate with customers in plain language where possible
d) seek to increase consumer trust and confidence in the life insurance industry as a whole.

Whilst LEA welcomes the intent of the Code of Practice to ensure ethical practice and protection of customers, there are some aspects of the Draft Code that we wish to highlight as concerns and for your consideration.

2 Comments on whether mental health is appropriately considered

Consideration of the mental health of insurance customers with mental health concerns, or those who may develop mental health concerns in the context of insurance claims and their experience of the claims process, is of central importance to LEA. Over our 20-year experience in mental health advocacy, we have heard of the experiences of many for whom this complex process is both stressful and confusing at times. We have also heard how it can be a traumatic and fraught experience for some customers, given that the claims process usually occurs in the context of significant changes to work and life events for the individuals and their families. Also, customers with mental health concerns must navigate these complex processes at a time when they are likely least able to have the personal resources, strength and capacity to navigate and full deal with this process. Sensitivity to these circumstances is therefore paramount.

LEA would ask that consideration be given to addressing the following concerns:

- Underwriting decisions relating to Mental health, family medical history and genetics (4.18-4.21)

More transparency in how and why this information is being asked about family history is likely needed in this section, given the potential sensitivity for the person, potential trauma circumstances, and family violence history for some.

- Ensuring underwriters are appropriately skilled and trained regarding mental health (4.22-4.23)

There is little information about what that training will entail. It should include Trauma-informed training, not only 'technical competency', 'relevant laws' etc.

- Collecting information regarding a customer's mental health, for claims purposes via:
    - Medical exams (5.18-5.23)

5.21 could acknowledge that costs may include those incurred by a support person/family member (where applicable) in providing transport, time, etc for the person to attend medical exams.
Also, how will the person know that such agreement needs to be made in advance?

- Interviews (5.24-5.34)

5.25 This is where we wondered about the interviewer's skills re psychosocial disability. We see 'cognitive decline or impairment' is mentioned, but this is only one aspect of disability.
5.28 RE 'if you ask us' - We think this information should be offered upfront, not simply relying on the person to raise it. There are already so many layers and processes to comprehend and absorb. Given the average person is highly unlikely to read this code in detail, stating processes in this way means that people won't know what they don't know.
5.29 There should also be something about what the interview won't cover.
5.34 It was good to see this statement, given that the person may feel extremely uncomfortable raising concern with an interviewer with whom they experienced problems with communication.

- Surveillance (5.35-5.38)

This is likely to be a very sensitive area for people with mental health conditions, particularly for those who experience psychosis or delusions. Personally, we would never want surveillance to be used where it is known that the person has paranoia as part of their mental health condition.

Clearly, if there was more in the code about seeking collateral information from the diversity of relevant people who are closest to the person's situation (where relevant and appropriate consent, etc), not just health professionals, then the need for surveillance at the levels suggested here could be averted.
5.38(e) Stopping surveillance – evidence of it negatively affecting the person's health should also be accepted from others who may have much greater understanding of the person's daily life (eg. family and carers, support workers), not only a doctor or psychologist who they may see only intermittently.

- Supporting customers who are experiencing vulnerability due to mental health conditions (6.1-6.14)

6.5 and 6.6 trauma-informed training should also be noted in this section on supporting vulnerability. We wonder whether mitigating family violence risks as a consequence of interactions in relation to insurance matters are covered enough. Currently raised concerns in the media about increasing misuse of technology for stalking, harassment, etc prompt our questions about what might be missing or need more consideration in this section.

6.9 The person may not be able to (or wish to) articulate the extent of their vulnerability. They may not have an understanding of or be aware of what this means from the perspective of others.

6.11 notes extra support as 'a lawyer, consumer representative, interpreter or friend' but should also mention family member, informal caregiver.

Overall comments:
We note that the term 'mental health conditions' does not appear in the definitions information. Also, the term 'psychosocial disability' is not mentioned at all in the document, despite its close relationship with mental health vulnerabilities.
Also, support person is mentioned, and there is some suggestion that this could be an informal support provider. The term 'friend' is used, but nowhere in the document is there explicit mention of family or informal family caregivers who, in many instances may well be playing a substantial instrumental role in supporting the person to attend appointments and navigate processes related to a claim, understand paperwork, keeping records for the person, prompting daily activities, etc.

2.16-2-26 RE Sales
This is an area of concern, given the proliferation of online and phone scams. I have watched my family member many times receive such calls where the conversation was clearly an exploitative one. In this section of the Code re legitimate callers and sales, there is no mention of the potential confusion in distinguishing legitimate callers from scams and also training related to vulnerability and exploitation. Ideally, phone or online contact processes must always be accompanied by a timely paper record of the contact. Our experience is that many people managing significant mental health conditions struggle to keep sufficient records. This issue is relevant to sales but also all other steps in the claims process.

3.2 and 3.3 could be clearer – 'sometimes' is a bit vague and open to being inconsistently applied.

p.11 Box re legal duty – the 2 dot points here seem to lack other steps in the process that need consideration before these somewhat harsh responses are taken. The wording does not seem to be in the spirit of the language of the rest of the Code. These are complex processes for anyone to navigate and the person may struggle to understand the nuances of the layers of information that they must provide.

5.39-40 RE Claim decisions – this is an extremely short section in comparison to other sections of the Code, particularly in relation to when a claim is declined. This has implications for any claimant, but particularly a person with mental health conditions. Receiving this 'bad news' may heighten their risk of suicide or suicidality. It can certainly cause distress and trigger the person's mental health symptoms. There is no mention of duty of care steps that could and should be taken in this section. It is treated as an administrative process only.

5.48 RE closure of a claim and treating it as a new claim – this may be inconsistent with the statements made later at 5.49(c) re the person giving 'extra information'. Given that all information may not be available within the timeframes set for claim processing, and the complexities in navigating the paperwork experienced by the person, this seems somewhat unfair. The new claim start date should take account of the particular circumstances.
5.49(b) We think the person should always have a copy of the documents that have been relied on where a claim has been denied. 'or your doctor if we think that is more appropriate' is somewhat paternalistic and not in the spirit of the rest of the Code's language.

3. Conclusion

Lived Experience Australia thanks the Financial Services Council for the opportunity to consider the Draft Code of Practice and the potential ramifications for people who experience mental health concerns. We hope that these comments are useful in improving the Code and practice.

We would be very pleased to provide any clarification of the issues raised by Lived Experience Australia on behalf of our more than 3500 members and friends across Australia.

4. Contact

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