Mental Health Cover in Insurance

To be or Not to be?

INCHES Healthcare

December 2018

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Introduction

An ever-ongoing debate (in the grapevine) is on in the Indian insurance industry on 'whether to cover mental health in health insurance or not?' Of course, similar debates also happen on offering cover for dental health as well.

Those against have no specific objections; just wary of 'What will happen?' 'Will we be able to manage it?' 'Will it be a sustainable product?'etc. There is a concern not only on fraud and abuse but also suicidal attempts. Those in favour for offering the cover are looking at it, more as a business opportunity. The concept of 'need-of-the hour' is missing. Mental health NGOs are also not pushing for it; maybe because of the stigma of accepting and acknowledging that one needs a mental health professional.

With re-strategizing of National Mental Health Program in 2003, Central Government has shown the inclination of bringing mental health to the forefront. IRDA of India is also urging insurers to come up with special offerings towards mental health cover; of course, not mandating it yet!

World Scenario

The World Health Organization (WHO) South-East Asia Region, which contributes one quarter of the world's population, has a significant burden due to mental illnesses. Mental health has been a low priority in most countries of the region. Although most of these countries have national mental health policies, implementation at ground level remains a huge challenge.

Many countries in the region lack mental health legislation that can safeguard the rights of people with mental illnesses, and governments have allocated low budgets for mental health services. It is imperative that concerned authorities work towards scaling up both financial and human resources for effective delivery of mental health services. Policymakers should facilitate training in the field of mental health and aim towards integrating mental health services with primary health care, to reduce the treatment gap.

Steps should also be taken to develop a robust mental health information system that can provide baseline information and insight about existing mental health services and help in prioritization of the

mental health needs of the individual countries. Although evidence-based management protocols such as the WHO Mental Health Gap Action Programme (mhGAP) guidelines facilitate training and scaling up of care in resource-limited countries, the identification of mental disorders like depression in such settings remains a challenge. Development and validation of brief psychiatric screening instruments should be prioritized to support such models of care. This paper illustrates an approach towards the development of a new culturally adapted instrument to identify depression that has scope for wider use in the WHO South-East Asia Region.

Governance and mental health policy provision An effective mental health policy helps in establishing national priorities in planning, organizing and coordinating different components of a mental health system.

Eight out of 11 countries in the WHO South-East Asia Region have a separate national mental health policy; however, implementation of such policies is limited in many low- and middle-income countries. Five out of the 11 countries of the region do not have separate legislation for mental health, while some dedicated legislation includes documents that are more than a century old and do not reflect international standards based upon universally accepted values and principles. Several countries in the region have drafted new legislation that is awaiting approval and enactment. Many countries of the region have high estimated suicide rates (age-standardized rate per 100 000 population ranging from 3.7 to 28.8), and contribute to more than one third of suicides globally.

Only Bhutan, Sri Lanka and Thailand have national suicide-prevention plans. Linking mental health programmes to other health programmes and integrating the services with primary health care can improve the implementation of the policies. Development of effective pilot projects showing the cost effectiveness of these interventions can help in convincing authorities to implement policy.

The National Institutes of Health of the United States of America (USA) has allocated grants to set up a collaborative project called the South Asian Hub for Advocacy, Research and Education on Mental Health (SHARE). The project aims for institutions in South Asia to carry out and utilize research that answers policy relevant questions related to reducing the treatment gap for mental disorders in the region. It will include a randomized controlled trial to evaluate a peer-led intervention for

maternal depression in India and Pakistan. Similarly, a project called the programme for Improving Mental health care (PRIME), which includes two countries in the region (India and Nepal), aims to generate evidence on the implementation and scaling up of integrated packages of care for priority mental disorders in primary and maternal health-care settings.

Mental health and mental health care in Asia

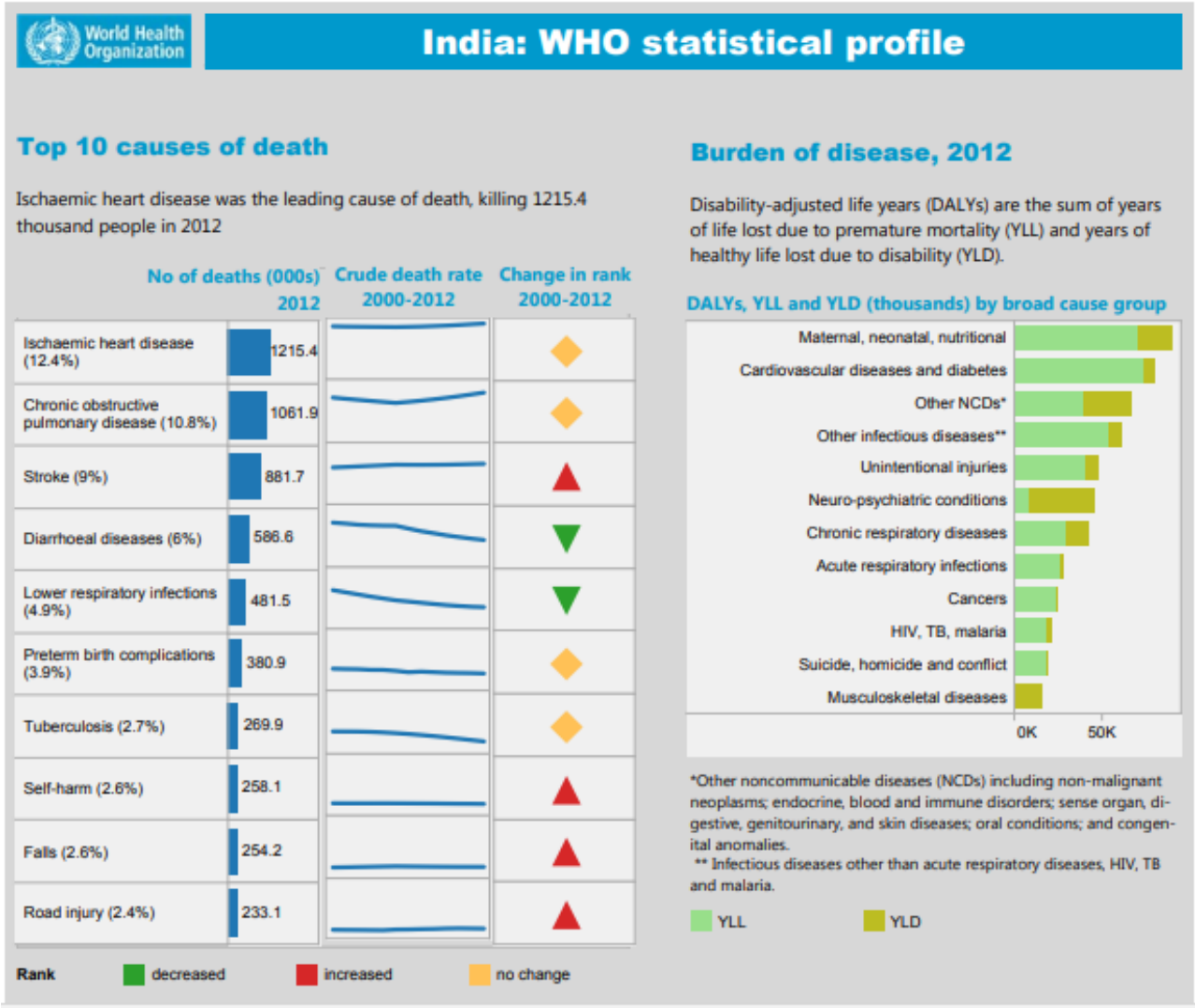
Despite many problems facing psychiatry and mental health care in Asia, there are several strengths that cannot be ignored and indeed are worth preserving, if possible. Among these are the still largely intact family cohesion, that is a resource for support of the mentally ill.

Most mental patients in Malaysia are visited when admitted in hospitals on a daily basis and taken back to their own homes when discharged. Rejection of the mentally ill is still fairly uncommon and occurs in conditions of abject poverty and economic privation. This however may change rapidly with provision of insurance cover or reimbursement systems that are designed to encourage long hospital stays, as in Japan and Korea, where the average length of stay in private hospitals may exceed a year.

Scenario in India – Problem Statement

India is currently home to a population of over one billion citizens. A study conducted by the Word Health Organization in 2015 shows that one in five Indians may suffer from depression in their lifetime, equivalent to 200 million people.
Due to the stigma associated with mental illness, a lack of awareness, and limited access to professional help, only 10-12% of these sufferers will seek help.

Self-Harm contributed to 2.6% of the Top 10 causes of death and Suicide, Homicide and conflict significantly contributed towards sum of years of life lost due to premature mortality (YLL) and years of healthy life lost due to disability (YLD).

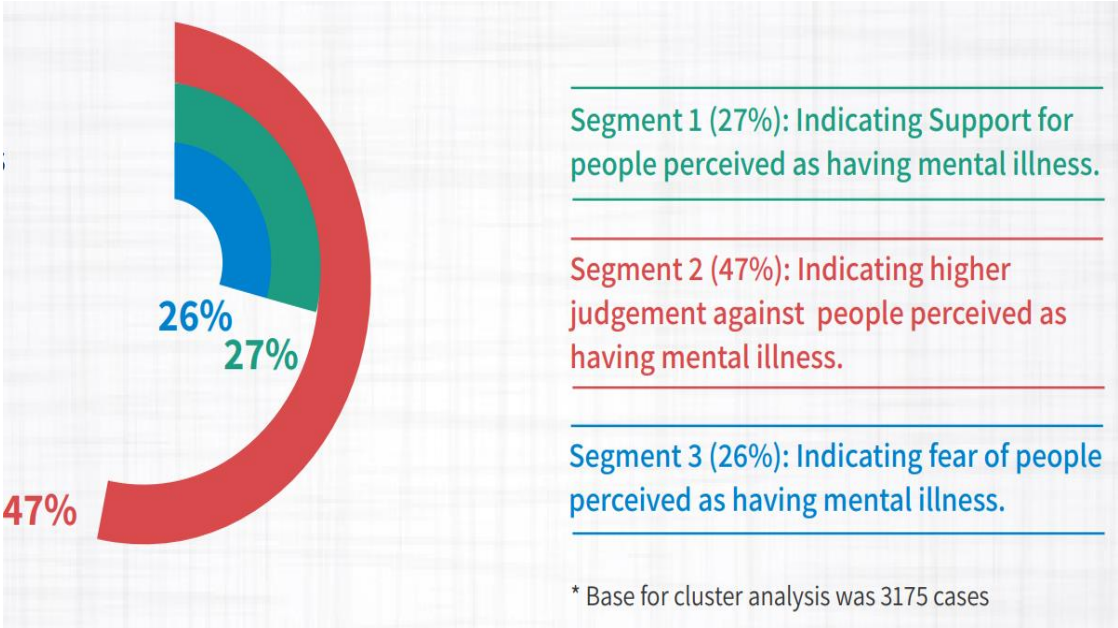


One of the Foundations active in the field of mental health commissioned ***How India Perceives Mental Health: TLLLF National Survey Report 2018*** to help gauge India's mental health landscape with the objective of exploring perceptions surrounding mental health and mental illness in India.

The study further explores the level of sensitivity, attitudes towards mental health, and the level of stigma associated it. The study took place across eight states in India over a span of five (5) months and involved 3,556 respondents.

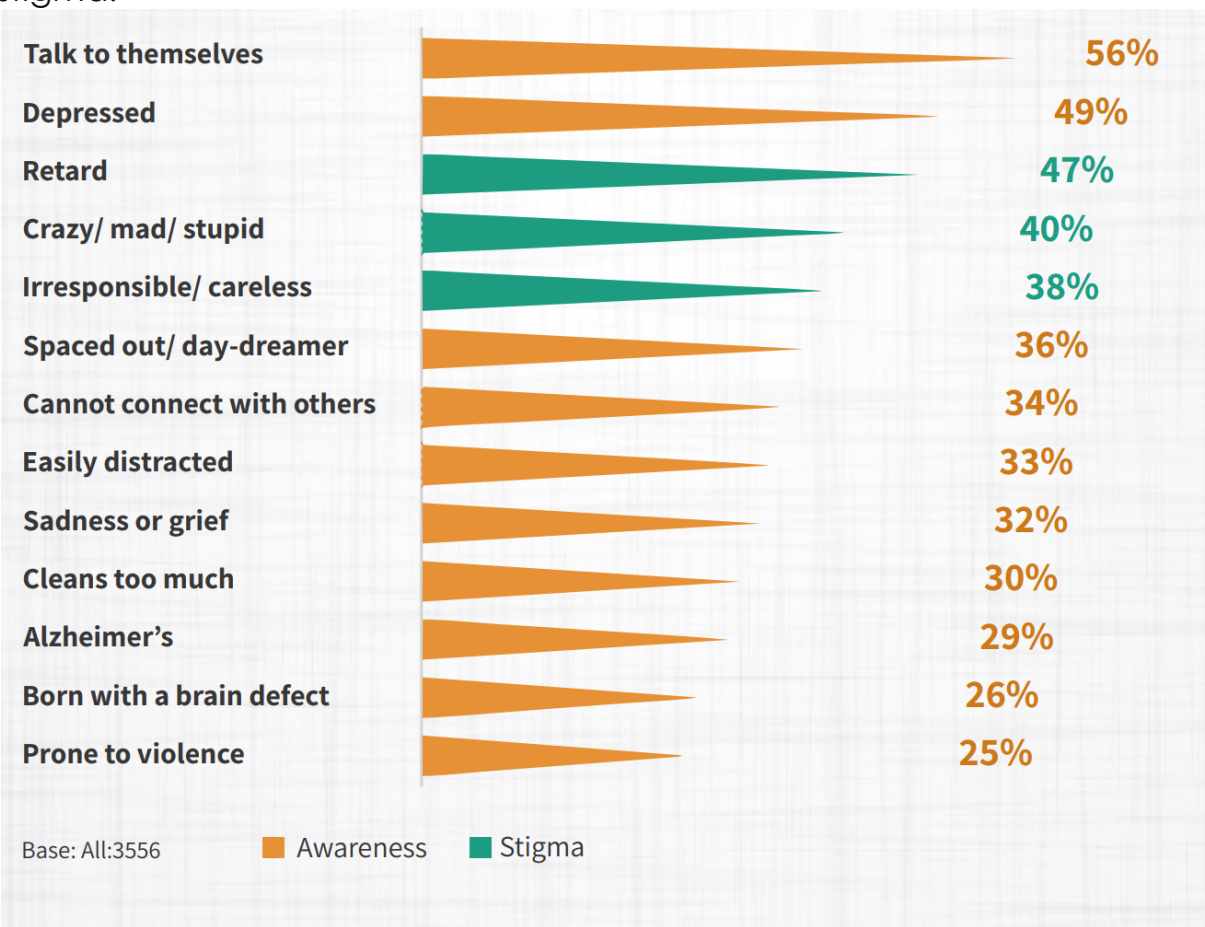
The study revealed three below mentioned broad segments of people based on their attitudes towards mental illness.

Support, judgement and fear



People's understanding of mental health

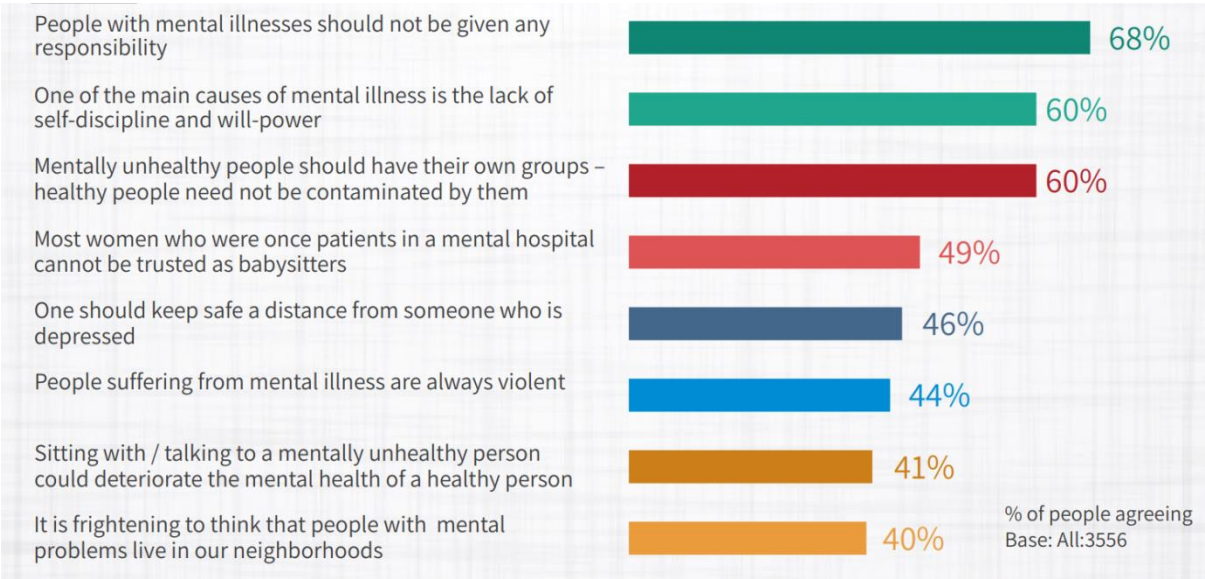
The study showed that while 87% of the respondents showed some awareness of mental illness, 71% also used terms associated with stigma.



This shows that stigma and awareness are two separate issues although interlinked.

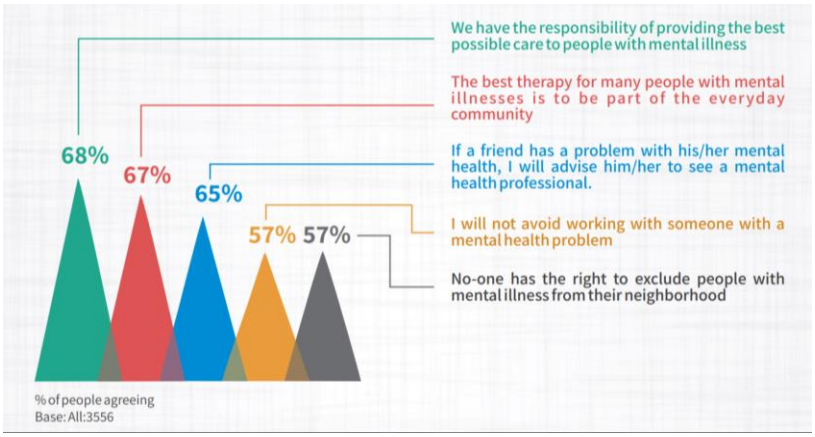
They need to be addressed in parallel in order to tackle the burden of mental illness in India. If individuals continue to view mental illness with apprehension and resistance, it will remain difficult for people with mental health concerns to seek the support they require due to the fear of being labelled or judged.

People's attitudes towards those affected



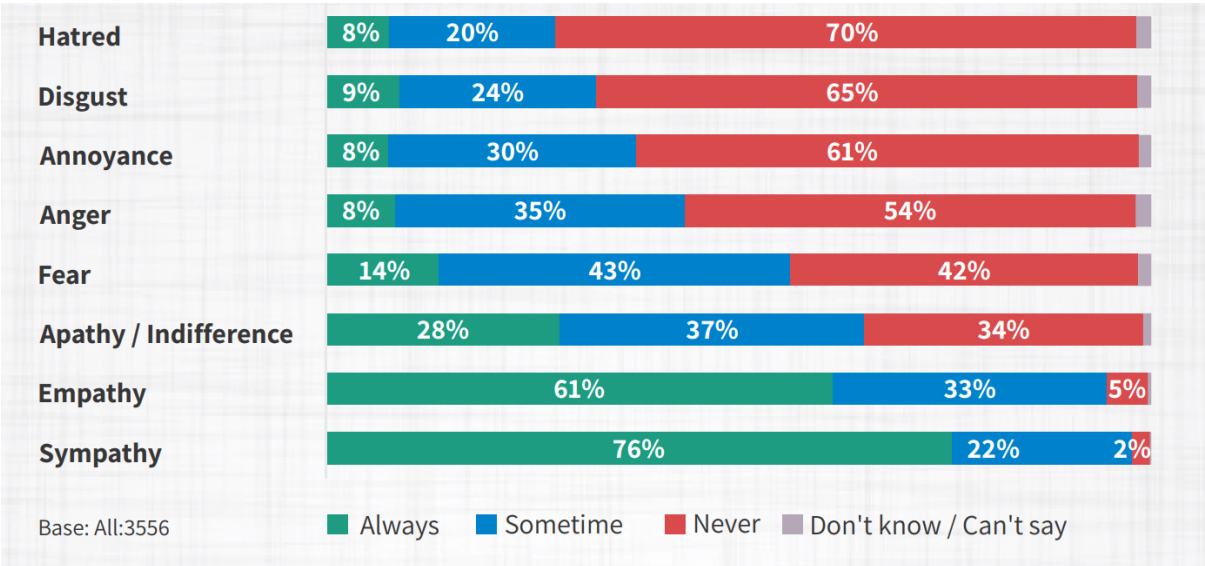
Social inclusion

A majority of respondents appreciate the importance of social support for people with mental illness, but while 68% agree that we have a responsibility to provide the best possible care for sufferers, the number of people who believe no one has the right to exclude people with mental illness from their neighbourhoods is comparatively lower (57%).



What people feel about sufferers

Respondents were asked about their feelings towards people with mental illness. While there exists widespread sympathy towards sufferers, with more than 75% of participants stating they would always feel sympathetic towards them, they also exhibit feelings of fear (14% would always be fearful), hatred (28% feel hatred sometimes or always), and anger (43% feel angry sometimes or always) towards people with mental illness. More than a quarter admitted that they would always be 'indifferent' towards people with mental illness. This admission of the general public to their feelings towards people with mental illness again indicates the prevalent stigma in society.



- The need of the hour is to sensitize and educate individuals about the signs and symptoms of mental illness while normalizing the idea of seeking support for themselves and their loved ones.
- There needs to be more open discussion and dialogue with the general public, and not just experts on this subject, which will in turn help create a more inclusive environment for people with mental illness.

Should India have Mental Health Covered?

Yes. The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), offers a common language and standard criteria for the classification of mental disorders. It is used and relied upon, universally by clinicians, psychiatric drug regulation agencies, researchers, health insurers, pharmaceutical companies, the legal system, and policy makers together with alternatives such as the ICD-10 Classification of Mental and Behavioural Disorders, produced by the WHO.

The International Classification of Diseases (ICD) is the other common manual for mental disorders. It has broader scope than the DSM, covering overall health. While the DSM is the most popular diagnostic system for mental disorders in the US, the ICD is used more widely in Europe and other parts of the world, giving it a far larger reach than the DSM.

However both have standardized psychiatric diagnostic categories and criteria thus making Mental Health conditions as one of the most well defined subject. There are no much vagueness like any medical and surgical Guidelines where each doctor differs.

There is minimal fraud potential because no Indian Customer wishes to proclaim that he or she needs mental health treatment.

In India we have psychiatrist going to patient's house as physicians and other specialities. And then examining and doing things. Hospitalization is minimal. The list of drugs is restricted as compared to Antibiotics and other things.

So there was no reason why rationally it should not have been included. But right from Independence Era that is being going on and today we know it is required badly.

INCHES' Gyan

We at INCHES, commissioned an in-house DeRisking exercise to evaluate the feasibility of offering Mental Health cover in India under supervision of *Team* Psychiatrist. We interviewed several psychiatrists across India; studied the scenario of psychiatric practice; the group of medicines used by psychiatrists; monthly cost of medicines; the availability of these medicines only with a fresh prescription each time etc etc.

The endeavour suggested that with due diligence (adopting following best practices) it is a sustainable solution with both sides achieving satisfaction:

- Add-on product; not part of basic plan
- A plan that offers Disease Management
- Medically exact and ethically compliant policy wordings
- Well-defined exclusions
- Prudent underwriting deploying psychoanalysis questionnaire as well as tele-interviewing
- Twin model – benefit plan cum reimbursement
- Evidentiary treatment (only at hands of qualified psychiatrist)
- Permanent suicide exclusion

Conclusion

With increasing incidence of depression and other adjustment disorders, Indians now, badly, need the cover of Mental Health. As shown above, with due diligence while designing the product, it can become a long-term sustainable win-win solution.

Resources

1. *http://www.searo.who.int/publications/journals/seajph/issues/seajphv6n1p5.pdf?ua=1*
2. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489866/*
3. *http://www.who.int/mental_health/evidence/atlas/atlas_2017_web_note/en/*
4. *https://www.hindustantimes.com/editorials/india-s-mental-health-crisis-a-ppp-between-state-and-private-mental-health-professionals-can-help/story-Q2l1i5PxWRdglbpHh4ObuM.html*
5. *http://www.who.int/bulletin/volumes/96/7/17-203737/en/*
6. *Image Courtesy https://www.weforum.org/agenda/2018/04/5-charts-that-reveal-how-india-sees-mental-health/*
7. *Image By Paget Michael Creelman - Own work, CC BY-SA 4.0, https://commons.wikimedia.org/w/index.php?curid=67346556 from https://en.wikipedia.org/wiki/Mental_disorder#/media/File:Mental_Disorder_Silhouette.png*

About INCHES Intelli-Claims Risk solutions

INCHES is a leader in providing risk solutions based on medical and medico legal insights that helps customers across all verticals of insurance industry to assess and manage risk. Integrating cutting-edge technology and insightful scoring analytics, we provide products and service that address evolving pain points specific to clients ensuring highest standards of security and TAT.

The services cover the entire spectrum of product design, UW & claim process, creating SOPs and requisite training.

Core team:

1. Padmashree Prof Dr Alaka Deshpande – *Director Clinical services*
2. Dr C H Asrani - *Chief visionary & CEO*
3. Dr Sushma Jaiswal – *Executive Director*
4. Dr Salma Rayani Khan – *AVP Legal services*
5. Dr Ashwin Rao Shinde – *Sr Clinical Associate*
6. Dr Satish Kanojia – *AVP - Field services*
7. Dr Bhavini Shah - *Sr Clinical Associate*
8. Dr Dhanashree Mane - *Sr Clinical Associate*
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