PODDAR
FOUNDATION

MENTAL
HEALTH INSURANCE

A Qualitative Review

Research Partner

monk prayogshala

Table of Contents

Website	http://www.poddar.foundation/
Contributors	**Poddar Foundation** Prakriti Poddar Yashi Gandhi **Monk Prayogshala** Hansika Kapoor Sampada Karandikar Kimaya Khanolkar
Stakeholders interviewed	Amrit Bakhshy Jehanzeb Baldiwala Kadambari Kulkarni Dr. Kersi Chavda Dr. Kishore Kumar Dr. Nirmala Srinivasan Pooja Krishnakumar Pooja Nair Pragya Lodha Raunak Jha Rhea Arora Sreya Oberoi Vijay Nallawala Dr. Vikram Patel Zain Calcuttawala *Some interviewees chose to be anonymous

Published by Poddar Foundation and Monk Prayogshala in November 2019

List of Figures

Abbreviations

CBT: Cognitive Behavioural Therapy

DSM: Diagnostic and Statistical Manual of Mental Disorders

ICD: International Classification of Diseases

IPD: Inpatient Department

IRDAI: Insurance Regulatory and Development Authority of India

MHCA: Mental Healthcare Act

MHI: Mental Health Insurance

NAAC: National Assessment and Accreditation Council

NIMHANS: National Institute of Mental Health and Neurosciences

OPD: Outpatient Department

RCI: Rehabilitation Council of India

UGC: University Grants Commission

WHO: World Health Organization

Executive Summary

Mental health disorders substantially contribute to the global burden of disease, including in India. Here, the lifetime prevalence of any mental disorder is 13.7 percent and nearly 150 million Indians are in need of active intervention. However, the provision of adequate mental healthcare is a rising concern in India. One of the primary hurdles in this context is the treatment gap, which is the difference between the true incidence of a disorder and the treated proportion of individuals affected by the disorder, reported to be as high as 83% in India. There are significant contributors to this treatment gap, such as the social stigma, lack of awareness, and insufficient or low quality mental healthcare. Additionally, India is also one of the largest countries subjected to economic burden due to mental health concerns. The proportion of individuals that require professional help and the amount of money required to cover the direct costs associated with the treatment are both high in India.

Considering this current scenario, finances required to avail of mental health treatment consistently are warranted, especially for individuals from the lower socioeconomic strata. Adhering to the provisions in the Mental Healthcare Act, 2017, the nodal insurance regulatory authority in India directed insurance agencies to make provisions to insure mental illness at par with physical illness. In recent times, this is the most direct attempt to reduce the financial burden of individuals requiring professional mental healthcare, thereby an attempt at reducing stigma in a top-down manner and increasing accessibility to mental health services. However, in the absence of clear guidelines for implementation and design of mental health insurance products, this directive poses a challenge to proper execution.

Objectives and Method

This paper seeks to start an explicit dialogue on mental health insurance (MHI) in India by identifying opportunities, barriers, and lines of future action that will aid insurance agencies to effectively implement MHI through elegant products. The three objectives of this paper were:

1. Readiness: To assess the readiness of various stakeholders to provide insurance-based mental health services
2. Design Guidelines: To provide guidelines regarding product design and pricing for mental health insurance products
3. Dissemination: To determine optimal practices for disseminating information about mental health and mental health insurance

In order to develop recommendations for MHI delivery, we conducted semi-structured interviews with multiple stakeholders and relied on both primary and secondary sources of literature. The six stakeholder categories were: mental health professionals, individuals with lived experience and caregivers, activists, corporates, insurance agencies, and policymakers. Based on the discussions with stakeholders in mental health and actuarial sciences, an interview schedule was drafted consisting of questions in five domains: Infrastructure (such as the capacity of existing

mental health facilities), Design (MHI product design including illnesses covered and exclusions, if any), Pricing (how premiums can be computed and which mental health treatment modalities to cover, Marketability (general awareness of mental health illness), and Practical issues (such as availability of mental health professionals).

Key Findings and Recommendations

1. **Readiness**

Information from the interviews regarding existing infrastructure and proposed empanelment of facilities as well as practical issues such as availability of professionals helped answer concerns associated with the preparedness of resources to implement MHI. Primary findings were:

- Currently, there are inadequate capacities of mental health facilities (both inpatient and outpatient); this can be remedied by policy-level actions like increasing the number of post-graduate seats in psychiatry and psychology
- A suggestion to empanel recognized mental healthcare facilities at all levels (public and private) under MHI.
- The establishment of an independent body comprising of mental health professionals, actuarial scientists, and policy-makers to ensure optimal implementation of MHI.

2. **Design Guidelines**

Given the novelty of MHI products in the Indian context, discussions about optimal design, coverage of illnesses, as well as pricing considerations were held. Salient findings were:

- All illnesses, including substance abuse, as per the International Classification of Diseases (ICD) criteria were recommended to be covered under MHI.
- It was recommended to extend coverage under MHI to inpatient hospitalisation, pharmacotherapy (medication), and outpatient psychotherapy as the proportion of outpatient to inpatient care is roughly 80:20.
- Standard operating procedures for mental health treatment can be developed using pre-existing research.
- Co-insurance within MHI products may mitigate the risk of fraud as well as improve compliance with treatment.
- In case of pre-existing conditions, the term before which MHI can be sought may be as per existing norms within insurance. However, mental health professionals disputed this latency period citing the immediacy with which mental health concerns need to be addressed.
- Demographic factors such as socioeconomic status, previous history, pre-morbid features, family history, gender, age, and current stress can be considered when developing MHI products.

3. Dissemination

In a country where mental illness continues to be highly stigmatized with low awareness of mental health treatment avenues, the marketability of MHI products was addressed. Key findings were:

- Innovative campaigns and strategies can be designed for raising mental health awareness across diverse populations, like adolescents and corporate professionals.
- It is crucial to involve insurance agencies in mental health awareness campaigns and make them equal stakeholders in this endeavor.
- Holding regular, joint meetings between mental health professionals and insurers can facilitate the reduction of information asymmetry

The global burden of mental illness is only set to increase in the coming decades, with India being a large contributor to this public health issue. This burden also translates into economic and productive losses as a proportion of the national population is unable to cope with the demands of daily life. Against this background, developing sustainable and useful mental health insurance products accessible to all Indians is the need of the hour.

Introduction

Background

Mental health is a growing concern in India and the lack of adequate mental health care is hardly new. The Government of India, in the past, adopted several measures to remedy this. Before independence, mental healthcare in India was regulated by the Indian Lunatic Asylum Act 1858 (with amendments passed in 1886 and 1889) and the Indian Lunacy Act introduced in 1912. During the time of independence, India's mental health infrastructure and the number of mental health professionals were in short supply.[1] Consequently, the first few decades after independence were dedicated towards improving the mental health infrastructure and services in the country. The Indian Lunacy Act failed to take human rights into account and was concerned only with custodial sentences. Thus, the Indian Psychiatric Society deemed the Indian Lunacy Act as inappropriate and later helped to form a mental health bill in 1950. This bill took more than 3 decades to receive the approval of the President, which was in May 1987. Thereafter, it was finally implemented as the Mental Health Act in 1993.

In 1975, a community psychiatry initiative was started by the government (Murthy, 2011), which involved the integration of mental health services with general healthcare. This shift from hospital- to community-based care was intended to reduce the load on hospitals, help early recovery, and prevent chronic handicap among mentally ill persons. Following this, the National Mental Health Programme (NMHP) was formulated in 1982 with the aim of developing a national-level initiative for mental healthcare based on the community psychiatry approach. The main aim of NMHP was to ensure that minimum mental healthcare is available and accessible to all, to promote the participation of the community in mental health services, increase awareness, and reduce stigma (Shidhaye & Kermode, 2013). A number of five-year plans were also introduced in an attempt to integrate mental health care and the primary healthcare. In 1996, the Ministry of Health and Family Welfare, Government of India formulated the District Mental Health Programme (DMHP), which aimed at making mental health care available to the disadvantaged sections and rural areas of the society. The DMHP was added to the program in 1996 in order to decentralize the NMHP by providing Community Mental Health Services and integrating mental health with general health services. The most recent revision, the Mental Health Care Act, 2017, is a legislation that supports a strong shift from the biomedical approach to a rights-based one. Some significant features of this act are the right to access mental health services by every person and decriminalizing suicide and prohibiting ECT on minors (Mishra & Galhotra, 2018).

Despite these initiatives by the government in the past, there were and still are multiple challenges to the provision of mental healthcare in India. In 2000, a review of epidemiological

[1] Regardless, even today there is a severe shortage of trained mental health professionals (Kumar, 2011).

studies estimated that the prevalence of mental disorders in India was 70.5 per 1000 persons in rural areas and 73 per 1000 in the urban population (Ganguli, 2000). Another study from Bangalore that specifically examined child mental health reported the prevalence of mental disorders to be 12.5 percent among children aged 0 to 16 (Srinath et al., 2005). The study also showed that there were no significant differences among prevalence rates of mental disorders in urban middle class, slums, and rural areas. In 2015, the National Mental Health Survey, which was carried out across 12 states found that the lifetime prevalence of any mental disorder was 13.7 percent and that nearly 150 million Indians were in need of active intervention. The survey found that between 70 and 92 percent of those in need of mental health care failed to receive any treatment (Gururaj et al., 2016). Moreover, a report by the World Health Organization stated that India is one of the most depressed countries in the world ("*India is the most depressed country in the world | Mental Health Day 2018*," 2018). This indicates that mental healthcare in India has long been in crisis.

Need

Mental health in India is affected by a number of socio-economic factors such as age, education, employment status, standard of living, and financial strain (Bhat & Rather, 2012; Shidhaye & Patel, 2010). A major problem that exists with respect to mental healthcare in India is the treatment gap, which is the difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder. The National Mental Health Survey reported the treatment gap of any mental disorder in India to be as high as 83%. Apart from the social stigma associated with mental illness (Shidhaye & Kermode, 2013), lack of awareness, inadequacy of mental health infrastructure and mental health professionals, one of the major contributors to the treatment gap, especially for low to middle income countries like India, is the economic burden of mental illness (Sahithya & Reddy, 2018). The study also estimated that the global cost of mental illness in 2010 was US$ 2.5 trillion, and that 54% of that burden was borne by low- and middle-income countries. The same study projected that by 2030 this figure would go up by about 240%, to $6 trillion, and the proportion of burden borne by low- and middle-income countries will reach up to 58%. According to them India alone stands to lose US $1.03 trillion before 2030 due to the economic burden of mental health. The treatment of mental illness, thus, involves significant expenditure and puts a financial strain on individuals, their families, and society as a whole. This includes direct costs associated with mental health treatment per se, such as the cost of therapy, medication, and clinic visits as well as indirect costs such as lower earning potential, costs stemming from medical complications associated with serious mental illness, and poor quality of life. Additional costs are incurred due to the side effects of these medications (like elevated blood sugar) as well as their treatment.

In 2006, a study evaluated the cost of long-term treatment of two major mental disorders, bipolar disorder and schizophrenia, in India (Sharma, Das, & Deshpande, 2006). This included direct and indirect costs such as that of consultation, medication, travelling to the treatment centre, expenditure of time in caregiving, among other things. They found the overall cost of treatment to be generally high and even higher for patients with bipolar disorder. Similarly, a review on the epidemiology of psychiatric disorders in India estimated that around 20 crore Indians requires

professional help and that every mentally ill patient requires at least Rs. 500 per month to cover the direct costs associated with treatment (Math & Srinivasaraju, 2010). This totals up to approximately Rs. 10,000 crore required per month (Math & Srinivasaraju, 2010).

With regard to direct costs of outpatient treatment services for schizophrenia, psychosis, bipolar disorder and depression, a study conducted by specialists from AIIMS Delhi and the Jawaharlal Institute for Postgraduate Medical Education and Research in Pondicherry analysed the direct cost of outpatient treatment for these four major disorders (Sarkar et al., 2017). They found that the costs ranged between Rs. 700 to 800 per month, while the average monthly per capita income of the participants was close to Rs. 1700. Such expenses weigh heavily for families with modest income. The total treatment costs are significantly higher among people who are unemployed, chronically ill, disabled, or who frequently visit the hospital. Another study evaluated the economic burden on poor families when a family member needs hospitalization due to psychosis (Rejani, Sumesh, & Shaji, 2015). They assessed expenses incurred during participants' inpatient treatment, which included the cost of medicines, laboratory investigations, food, travel, and other incidental costs. Furthermore, they made a comparison between patients above the poverty line and patients below the poverty line and found that there was no significant difference between the two in terms of the amount of money spent on the treatment.

With such high costs, a substantial number of people suffering from mental health problems, particularly people coming from underprivileged sections of society would require financial coverage in order to continue to adhere to their treatment. However, when it comes to the Indian insurance system, historically, insurance companies did not provide an insurance cover for mental health care (Pattanayak & Sagar, 2016). Furthermore, Indians generally show preference towards life insurance over health insurance. A study by ASSOCHAM and Indiafirst Life Insurance found that respondents preferred policies that provided life cover and returned the premiums at the end of the policy term ("*ASSOCHAM India study*," 2018). Psychological disorders have always featured in the permanent exclusion criteria in health insurance policy documents.[2] This results in a vast majority of mentally ill Indians discontinuing their treatment due to financial considerations adding to the treatment gap. Moreover, most insurance companies focus on only cover the expenses of hospitalization (Shahrawat & Rao, 2012). These policies fail to adequately protect those who are unable to cover high out-of-pocket payments. The rising cost of healthcare and inadequate coverage (only for inpatient services) provided by insurance contributes to the treatment gap.

In this scenario, the Mental Healthcare Act 2017, which came into force on May 29, 2018, called for insurance companies to accommodate mental health expenses into their provisions; this could provide substantial benefits to patients and families by providing affordable healthcare services. According to the Section 21(4) of the Act, "Every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is

[2] Owing to the IRDAI directive, insurance agencies such as Max Bupa, are beginning to revise these exclusion criteria and update policy documents.

available for treatment of physical illness." Such a provision would not only reduce the economic burden of mental illness and empower accessibility to mental health services for all, but also reduce stigma associated with mental health disorders and increase awareness in a top-down manner (Duffy & Kelly, 2019).

The IRDAI, in its circular, dated 16th August 2018, stated that insurers will be required to make provisions to insure mental illness, according to the rules laid down by the Mental Healthcare Act, 2017. However, it did not enumerate the ways in which insurance companies can adhere to the official instruction leaving them unprepared. This paper aims to provide recommendations for the implementation of MHI by presenting a report that outlines the current state of mental health and mental health insurance in India. It also explores and recommends possible solutions that will aid insurance companies in the effective implementation of the Mental Healthcare Act.

[For a list of existing public healthcare schemes in India, see Appendix A.]

Objectives

A chief objective of this paper is to outline the various factors that will need to be considered with respect to the formulation of mental health insurance, such as the kind of mental health treatments that will be covered. For example, an insurance policy may insure a patient in case of hospitalization but not in case of psychotherapy. Insurers will also need to collect data related to mental illnesses and agree on common and consistent definitions of mental ailments that they can adhere to and underwrite policies accordingly. Other factors to take into account would be adequate licensing for mental health professionals in the country and pricing and determination of premiums, co-payments, deductibles or reimbursement on the basis of duration of treatment process and its cost, likelihood of suffering from mental illness, comorbidities etc.

This paper aims to provide psychoeducation to stakeholders as well as potential customers of the current state of mental health coverage by insurance in India. By highlighting various aspects that need to be considered to determine the product design, pricing and underwriting of the policy, the paper will outline a plan of action that is inclusive, beneficial, and adheres to global standards. The final section will make recommendations that each stakeholder can pursue to aid in the implementation of the policy change. Thus, the objectives of the current work are three-fold:

1. Readiness: To assess the readiness of various stakeholders to provide insurance-based mental health services
2. Design Guidelines: To provide guidelines regarding product design and pricing for mental health insurance products
3. Dissemination: To determine optimal practices for disseminating information about mental health and mental health insurance

Methodology

Drawing from insights gained at the "Insure Your Mental Health Conference 2019," the white paper adopted a broad qualitative methodology to connect with multiple stakeholders. We relied on both primary and secondary sources of literature and data to meet the objectives of this paper.

A. Secondary research

In order to develop a comprehensive taxonomy of questions regarding mental health insurance, prior work was consulted in the Indian context (Ahuja & Kapoor, 2019; Kapoor & Ahuja, 2019; Kapoor, 2017, 2018). On the basis of discussions with stakeholders in mental health and the actuarial sciences, the interview schedule (Appendix B) was drafted. This covered five principal areas of interest with respect to mental health insurance (Figure 1):

1. Infrastructure: Concerns regarding the current capacities of mental health infrastructure available to patients as well as the nature of government support for MHI, and directions for empanelment to provide services under MHI were outlined.
2. Design: Technical details regarding the kind of MHI products that can be developed as well as the nature of coverage/exclusions and how pre-existing conditions will be handled was considered here.
3. Pricing: Specific details regarding how insurance premiums would be computed on the basis of various characteristics were included.
4. Marketability: Whether or not the Indian market is ready for the introduction of MHI products with respect to awareness and stigma associated with mental health was considered.
5. Practical Issues: Issues regarding licensing of mental health professionals as well as the overall feasibility of implementation were discussed.

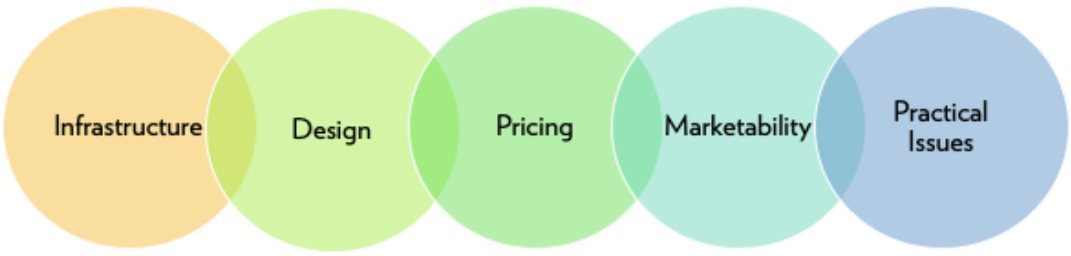

Figure 1: Interview Schedule Themes

B. Primary data collection

After developing and reviewing the interview schedule, a 360-degree stakeholder mapping exercise determined the number of interviews to be conducted. In general, at least two interviews per stakeholder category were scheduled. Personal or telephonic interviews were conducted and informed consent (Appendix C) was obtained for participation in the study as well as for the voice recording of the interviews.

Twenty-two interviews were conducted with various stakeholders. The six stakeholder categories (Figure 2) were as follows:

1. Mental health professionals: This included psychiatrists, clinical psychologists, and counseling psychologists/therapists.
2. Individuals with lived experience: This category included individuals with mental illness who have sought treatment earlier as well as caregivers of those with mental illness.
3. Activists: Disability and mental health activists were interviewed as part of this category.
4. Corporates: Spokespersons from private organizations were contacted concerning their current health policies.
5. Insurance agencies: This included representatives from government (e.g., IRDAI) and private insurance agencies, who are the frontline for the implementation of MHI.
6. Policymakers: This category included certain mental health professionals who are actively involved with mental health policies in India, such as the drafting of the Mental Healthcare Act, 2017.

By interacting with multiple stakeholders, we aimed to achieve a holistic approach to understanding the motivations and practical barriers to adopting and implementing MHI in India. Therefore, with five themes and six stakeholder categories, this white paper presents several perspectives toward mental health insurance in India.

Figure 2: Stakeholder Mapping

Key Findings

To reiterate, the three objectives of this white paper were:

1. Readiness: To assess the readiness of various stakeholders to provide insurance-based mental health services
2. Design Guidelines: To provide guidelines regarding product design and pricing for mental health insurance products
3. Dissemination: To determine optimal practices for disseminating information about mental health and mental health insurance

On the basis of the interview schedule's themes, the first objective (Readiness) was examined via the Infrastructure and Practical Issues themes; Design Guidelines were assessed via questions on Design and Pricing; and Dissemination corresponded to the questions relating to Marketability (Figure 3). The interviews were collated and analyzed with the qualitative software nVivo v12; all interviews were codified into the broad themes and sub-themes from the interview schedule.

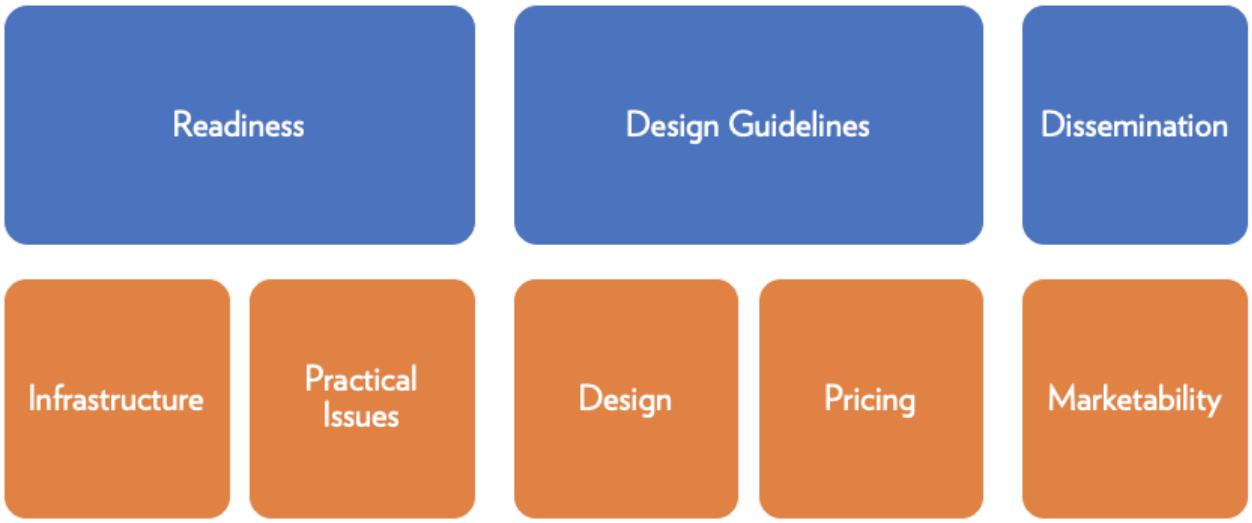

Figure 3: Overall objectives and corresponding data source

A. Readiness

At the policy level, the IRDAI issued the mandate to cover mental illnesses on par with physical illnesses; however, there continues to be uncertainty with respect to the exact manner in which implementation will unfold. It was, therefore, necessary to determine the extent to which service providers and consumers were ready for MHI.

a. Infrastructure

With respect to the existing capacity of inpatient and outpatient facilities in India, there was general agreement that both need to be increased substantially in terms of availability of physical facilities as well as mental health professionals. An important suggestion was to adopt a more decentralised approach toward increasing this capacity; specifically, it was suggested that lay healthcare workers in PHCs (primary health centres) can be trained in mental health first aid to be able to assist with common mental disorders, particularly in rural areas. Another suggestion was to reduce the number of long-stay options (such as within a mental hospital) in order to reduce institutional costs associated with hospitalization. Instead, improving short-term stay options as well as increasing outpatient capacities was recommended, in order to serve a greater number of patients. Increasing primary health care facilities in cities and villages, and also considering mobile facilities for tribal areas was recommended.

Amrit Bakhshy, president of the Schizophrenia Awareness Association, wanted the Government to focus on fulfilling its obligation to provide adequate facilities and infrastructure for persons with mental illness as mandated in the Mental Healthcare Act 2017. This included, among other things, providing primary (at Primary Health Centres), secondary (at District Civil Hospitals, where a psychiatrist is posted with a psychiatry ward, minimum 10 beds), and tertiary level care (at Regional Mental Hospitals) facilities. In order to cope up with the demand for mental health services, Bakhshy wanted implementation of tasking general practitioners with providing primary treatment, with the support of training programs such as being conducted by NIMHANS, a 2-month online training program in treating mental illnesses.

Vijay Nallawala of Bipolar India offered a similar view regarding equipping primary healthcare centres with mental health professionals (MHPs) or those trained by them, in order to achieve this objective. While talking about the reasons for why the inadequacy exists, he stated,

> “More than 60% of those in need of intervention go untreated for their mental illnesses. Part of the reason could be a) Illness not diagnosed, and b) lack of access to quality and affordable mental health care in rural India.”

One representative of a corporate organisation, who chose to be anonymous, reported that their endeavour was to make line managers mental health champions, by helping them destigmatize mental illness. When explaining the organisation’s take on mental health programs, the interviewee mentioned,

> "Four years ago, we started with offering EAP support for factory workers, and with the salespeople first. Our experience was that there was hesitance to avail of the counselling services. The first year there was less than 1% usage, under half of 1%. We offered it to 5000 people and there were under 100 ready to jump in… We believed they would open up, and talk, and I believe we need far more role models - whether it's within private spaces, or a private company or from outside. Our learning was that when we deployed a new helpline with the right messages from leaders and concentrated efforts on addressing the stigma around mental health, the adoption has been way better, above industry average."

As per the Mental Healthcare Act, an empaneled institution can be under public, private, trust, or co-operative ownership. When speaking to stakeholders regarding the empanelment of various mental health service providers to ensure smooth execution of MHI, a senior clinical psychologist suggested,

> "The first thing that comes to mind is the cost hierarchy like it's more important to have the free services, the lower-paid services first in terms of when you ask in what order. But then it will also depend on what services are offered where. Like some private hospitals may be offering a very specialized service like rehab, post-head injury, which may not be there in say a civil hospital at a district-level. So specialization and cost, those two should be the factors to be kept in mind in terms of empaneling order."

It was also suggested that clinics, and private hospitals with license could be empaneled to share the burden of inpatient and outpatient facilities. Other interviewees were of the opinion that because such few facilities exist in the first place, they should not be discriminated between in terms of the order of empanelment. The need to increase the number of psychiatric wards within hospitals was also suggested. Dr. Kersi Chavda, a senior psychiatrist stated,

"I certainly think that every facility whether it is government or whether it is inpatient or whether it's a standalone clinic or whether it's a psychiatry hospital by itself or whether it's a general hospital which has a psychiatric ward, all of these should come under the, should be allowed to come under the kind of facility that is empaneled under the insurance."

Dr. Vikram Patel stated in this regard that only the providers enlisted by insurance companies should be empaneled, as that would also incentivize providers to actually be empaneled as they will be enlisted. He further gave the example of the US, where there is an in-network and out-network. If one approaches the in-network provider, they pay nothing. If out of network provider is approached then one can seek reimbursement, but they will only pay the rate of the in-network.

Various hospitals only employ psychiatrists and clinical psychologists to assist patients presenting mental health issues. It was suggested that extending employability in the sector to other mental health practitioners such as counseling psychologists would help increase the

capacity of existing facilities. Moreover, such developments should happen for smaller towns as well, and not just big cities such as Mumbai. As the percentage of people requiring inpatient care for mental health issues is a small proportion, efforts should be made to have a widespread network of centres offering outpatient facilities (Government Hospitals, private hospitals or clinics).

A social worker who was interviewed opined that there need not exist a hierarchy within mental health services (government hospital, private hospital, or a clinical set-up), with respect to who goes through the empanelment procedure first. Rather, all eligible bodies should be vetted against certain preset criteria for quality and standards, and those who meet the criteria should be empaneled.

Last, when discussing the role of State and National Mental Health Authorities (instated as part of the MHCA, 2017), it was suggested that the bodies should convene once every 6 months to discuss and review the performance of mental health facilities. This was based on the observation by a senior psychologist who stated that the authorities are sometimes dormant. Their role was described as “supervisory like a watch-dog kind of thing to ensure that services are timely, that they are fair” to ensure appropriate review and reporting standards. There was also a general opinion of establishing a separate regulatory authority (apart from the RCI), consisting of mental health professionals, policymakers, and government officials to ensure optimal implementation of MHI. Jehanzeb Baldiwala, a senior counsellor commented on the matter: “If an insurance company is not covering it (a mental illness) or if I don’t have any mechanism to sort of complain to somebody or do something to get some redrressal, then implementation becomes an issue, right?" Such an authority may also ensure that hospitals and other treatment providers do not misuse the fact that their patients are covered by insurance.

b. Practical Issues

Owing to the gross shortage of mental health personnel in India (the WHO estimates about 0.29 psychiatrists and 0.07 psychologists per 100,000 persons as of 2017; WHO, 2017), another factor that will determine the efficacy of MHI will be the availability of service providers. A senior psychologist suggested that a bare minimum of six professions be included within service delivery for efficient MHI implementation: psychiatrists, psychologists, social workers, speech therapists, occupational therapists, and physiotherapists. To increase the availability of current medical and paramedical professionals, a suggestion was also to increase the number of post-graduate seats in psychiatry and psychology - this indicates the dire need to coordinate across government ministries and existing policies to build a larger personnel capacity capable of addressing the population’s mental health needs. Another important suggestion was for the RCI to include licensing for counseling psychologists and not focus only on clinical psychologists, as the former are preferred in different contexts, particularly in school settings. Citing an example of how nurses have been trained in several countries to offer primary care support, Vijay Nallawala mentioned that physicians and NGO professionals could be trained in a similar fashion, thereby having the peer community play a huge role in providing adequate services.

With respect to empaneling more individuals to deal with the demands of mental health insurance provisions, Dr. Nirmala Srinivasan asserted that a central mental health body should specify guidelines regarding certification of professionals, stating,

> "Some sort of specification should be there either by the Indian Association of Clinical Psychologists or by the Central Mental Health Authority. The Act, for the time being is very clear and it should be followed. And in case of a gap in the Act, the professional body should come forward to identify a certification package and the people they will certify."

Therefore, the primary concern with increasing the numbers of mental health service providers is adequate licensing and professional integrity standards to reduce unintended consequences of such an expansion in the mental health workforce. While the RCI is the nodal body for the licensing of clinical psychologists and other rehabilitative personnel in the country, according to Pooja Nair,

> "I think we need to have... a different licensing body. I don't think the RCI is going to cut it… It's the Rehabilitation Council of India and it is not the Mental Health Council of India."

Yet, other senior psychologists and psychiatrists were of the opinion that instead of replacing the RCI with another agency, the procedures for licensing psychologists and psychotherapists can become more streamlined; for instance, for individuals with a postgraduate degree in psychology from a UGC-recognized and NAAC accredited institute, licensing formalities can become more straightforward. One more suggestion was to authorize universities to provide a license number to students completing a Masters degree there, in order to ease the process of licensing. Further, nearly all agreed that the RCI or a similar body is required to license counselling psychologists, psychotherapists, and similar professionals who are not under the purview of the RCI currently.

In this view, an anonymous social worker stated,

> "I think it should be a professional accreditation body that considers their role much beyond... the remit of RCI…(like) trade certification is definitely something that we can consider."

Similarly, referring to the RCI, Amrit Bakhshy stated,

> "Perhaps they should be a little flexible and provide some relaxation in norms in granting approval of the institutions and registration of mental health professionals. It is ridiculous to say that the country has only 2000 Clinical Psychologists. We know that their number
>
> is much much more; the same is true about psychiatric nurses and psychiatric social workers. RTI should allow some relaxation in institution following their syllabus. RTI can

> ensure that the syllabus laid down by different universities meet the standards laid down by the RTI. They can ensure that the graduates passing out, meet the minimum standards, RTI has laid down. They should approve such universities and colleges and the students who pass out from there, and meet the minimum standards laid down, should be given registration by the RCI."

Further, clinical psychologist Pragya Lodha stressed upon the importance of integrating educational programs with the RCI for standard licensing purposes, stating,

> "I think the RCI really needs to come with a standardized, what would you say… policy or provision for mental health professionals in general. I think if there, in the first place… if there is a licensing system, it has to be a part of every educational program that gives full time MA because half people who are getting trained or are doing MA are licensed and half are not… affiliation (with) all universities who are providing an MA have to have RCI and this has to be an effort from the institutional level because you can't expect students who are graduating out, to keep running behind filing applications, paying so much money for the application, only to not hear from the RCI at all. I think that's extremely unjust. And it's known wide how unnecessarily difficult application procedures are. Additionally, it would be a far smoother system to have RCI mandated courses because that would encourage so many more people to take professional practice ahead and actually lead to managing the existing wide treatment gap."

Dr. Kishore Kumar, director of The Banyan mental health NGO expressed that many individuals with mental health issues are deprived of assistance and are abandoned by their families. Speaking about the reasons as to why the deprivation and denial of rights happens, he said,

> "All of these things happen because the state is not able to respond to their needs in the most appropriate manner at the appropriate time...so if you fail to do this the family may sometimes give up doing the caring responsibility because they are not able to fend for themselves. Poverty is an overwhelming factor and therefore pro active state care is very very important."

The coverage of mental health within insurance schemes would also make it susceptible to issues plaguing physical health coverage, such as the risk of over-hospitalization. In this context, insurance-related stakeholders offer the view that this possibility increases the risk of frauds, and therefore, insurance companies see it as commercially hazardous. However, mental health stakeholders, and those with lived life experiences contend that the fraction of individuals seeking inpatient mental help is far fewer as compared to those seeking outpatient/session-based interventions. Furthermore, based on the Act, it is within the rights of the person suffering from a mental illness to admit themselves to a hospital if need be, which may mean reluctance on their part to get admitted, and the Act itself restricts longer stay in the hospitals. Mr. Nallawala offered the view that hospitalization costs for physical illness far outweigh those incurred for mental

illness, and that surgical interventions in physical illnesses and emergencies form a bulk of claims (in terms of amounts settled). Physical illnesses may therefore take precedence over mental illnesses when it comes to hospitalization. Thus, the risk of over-hospitalization is not a major

concern if assessed in totality. However, in an event where this does pose a risk, one of the suggestions was that increasing focus on outpatient facilities may mitigate the risk.

Another question plagued with much uncertainty in the insurance domain is that of medical proxies, i.e. someone else making a treatment decision for a person because they themselves are incapable of doing so. Raunak Jha of Reliance Health Insurance stated that it would be a difficult aspect to navigate, considering there would not be a way to ensure if they are doing right by the concerned person, and the risk of fraud might increase. She further added that everything is quite nascent in terms of offerings (within policies), and therefore there is no certain answer currently. Even though the IRDAI directive is clear in this regard, that all admissions should be independent, unless conditions exist where it is absolutely unavoidable, more data would be needed to guide agencies regarding how this aspect could be incorporated in their policies.

When speaking of the time taken to get an appointment with a mental health professional, interviewees stated that the waiting times are usually between 2 weeks to 2.5 months. Dr. Chavda stated,

> "If you're looking at a general hospital… they see something like a like 100 patients a day. In a private hospital you might see anything from 25-40/50 and some people even see 60, 70. Certain procedures might take time; for example, if I am going to do something like rTMS, which is recurrent transmagnetic stimulation, there are very few people who have that instrument so you might have to wait for 10, 15, 20 days... Psychotherapists, some very good ones, you have a long waiting period. Psychiatrists by and large I would say within about 10-15 days within about a week."

The general consensus among mental health practitioners and beneficiaries seems to be that private set-ups do not have much waiting times. This may be because a lot of individuals do not opt for going to a private practitioner due to unaffordability. Dr. Nirmala Srinivasan, an activist within the mental health domain, states that when in a government hospital, one may have to wait for 2-3 hours for their turn, but it is around half an hour in private set ups. This view was also supported by the anonymous social worker, who stated that waiting times are usually half to one hour, going up to 2-3 hours if those traveling from far away places have reached early for their appointment. Zain Calcutawalla, who has a personal experience in seeking therapy mentioned that while he recognized his privilege, he preferred going to private practitioners, and has not faced large waiting times for seeking appointments.

Another practical issue in the rollout of MHI concerns the standardization of diagnosis and treatment. Here, SOPs (standard operating procedures) and best practices can help develop protocols for pharmacological, therapeutic, and combined treatment options. Referring to existing

case studies from India as well as collating information from psychiatric hospitals and OPDs in another option for these standards to be established. Similarly, using short-term evidence-based therapies can help justify coverage for greater numbers of clients.

Dr. Vikram Patel weighs in on this issue by pointing toward the World Health Organization's (WHO) guidelines for mental health systems, in order to standardize procedures within the Indian setting, stating,

> "So the quality rights initiative of the WHO actually is an excellent tool kit for doing that so one doesn't have to invent these standards they already exist. But having a mechanism through which these are assessed independently to assure the quality."

Because the IRDAI notice directs parity between physical and mental healthcare, there is a likelihood of insurance agencies to cover only inpatient and hospitalizations costs. However, the general consensus from these interviews is that the proportion of outpatient to inpatient mental healthcare is roughly 80:20. A senior psychologist is quoted as saying,

> "I do not think insurance should be offered only for inpatient. It should be for pan, all kind of conditions… on one hand, you are trying to cut down on inpatient services and if we use only that umbrella to gauge who should get insurance, you are working against yourself. So I think it has to be in- and out-patient."

B. **Design Guidelines**

In the absence of sound design, it is difficult for insurers to make MHI products appealing to present and future policyholders. Numerous insights into the design and pricing of MHI were gained through the interviews, with varied perspectives on which illnesses can be covered as well as how co-insurance would function in this context.

a. Design

In terms of illnesses to be covered, nearly all interviewees were of the opinion that all illnesses, including substance abuse, should be covered under MHI. A Sodexo Corporate representative stressed that depression should be covered, along with anxiety and stress; the latter two mostly because various other conditions such as heart problems could be directly related to them. They also stated that companies would be more open to mental health insurance if it is provided as a package along with general health insurance. An insurance representative was of the opinion that there are various factors such as financial situations, heredity, etc. that may ultimately influence insurance policy, and there is not enough data available yet to surely determine the inclusions, which is why it needs to be waited out. A senior psychologist suggested that coverage should be extended beyond illness to conditions such as low IQ and cognitive impairments among the elderly.

However, some reckoned that until further data is obtained, some illnesses would be difficult to cover. For instance, Personality Disorders ("because there is not so much of a pharmac component"), and factitious and dissociative disorders as adequate prevalence/incidence data are not available for the latter two. Further, while most stakeholders agreed that no pre-existing condition should be excluded from MHI coverage, some estimated higher premiums for those with such conditions as is standard practice within insurance. Pooja Krishnakumar, who is personally seeking therapy for mental health issues, asserted that therapy, medication, and hospitalization for a mental health episode should all be covered by insurance. They further stated that all the conditions should be covered and that severe disorders such as schizophrenia may be covered by an additional package, but common disorders should be covered under basic plans. Raunak Jha stated that if this is treated at par with physical ailments, then pre-existing conditions should not be included as per standard policy, while another insurance officer stated that more clarity would be needed in this respect. However, everyone within this domain agreed that pricing could be determined based on declaration of chronic and pre-existing conditions. In the case of conditions like substance use disorders, like alcoholism, Dr. Kishore Kumar commented that alcoholism is a mental illness as per definitions in the Mental Healthcare Act 2017 and inclusion of which in insurance may cause controversies. Similarly, those with intellectual disabilities have to be covered as they have a high risk of developing mental health problems and medical complications like seizures.

A review of suicide in India found suicide rates to be as high as 82 to 95 per 100,000 population, particularly in rural areas and among women (Rane & Nadkarni, 2014). How to

address suicide attempts and ideation within MHI were also spoken about; one therapist highlighted the fact that when an outpatient is suicidal, there are protocols in place to develop a detailed safety plan for the client, which can be communicated to insurance companies to raise awareness of managing suicidal clients. One important aspect to understand here, as per one of the experts, would be to distinguish suicidal ideation due to a diagnosable mental health issues as opposed to other reasons. Here, Dr. Kumar suggested that suicidal ideation may be due to a personal crisis, and therapy for such crisis should be covered. Dr. Chavda was very clear on this front:

> "It certainly has to be included because you know we will be having a huge amount of kids and adults attempting suicide and to say that you cannot give them insurance because they have attempted suicide is balderdash. Very often they have taken stuff, they need to be in the ICU, they need to be on ventilators, expenses are horrendous. So, this certainly should be allowed to be in the gamut of insurance companies."

The social worker supported covering all mental health issues, irrespective of the category and level, stating:

> "So the minute you bring in the idea of mental illness so to say, I certainly believe that there is a fairly viable testable idea of what mental illness is and you could go with the ICD-10 or ICD-11 criteria and you can certainly have it assessed. So when you enter that arena of a diagnosis, then it means that you clinically require care. So certainly all of them can be covered."

One insurance company representative offered the view that coverage should not be complicated, stating,

> "When the regulator has said that mental health has to be treated at par, so as of today, the way we treat say kidney conditions where the nephrologist has recommended a certain line of treatment, it is admissible and the hospitals and providers that are approved by the government and the hospitalization charges from those providers are accepted so the same will apply for mental health also."

They further mentioned that this would be incorporated in their own mental health products, without any discrimination.

With respect to the system of disease classification that should be followed, mental health professionals suggested a variety of solutions: Dr. Chavda suggested that as the ICD is adopted and accepted by most insurers across the world, this system can be used for diagnosing mental illness by a psychiatrist in order to avail of MHI. Similarly, using ICD classifications as diagnosis guidelines was also supported by an IRDAI representative and an insurance company representative who were interviewed. One psychologist suggested that regardless of the system finally used (DSM or ICD), the patient's diagnosis must be made by a team of mental health

professionals (or at least by a clinical psychologist/psychiatrist) prior to seeking MHI. One expert suggested that as of now, only those with a medical degree, i.e. psychiatrists should provide the diagnosis, as there is no proper licensure procedure in place for other mental health professionals. Another suggested that rehabilitation professionals, psychiatrists, social workers, and psychologists all have to join together to arrive at a consensus about what to do in order to have sound policy in place. Pooja Nair, a therapist advised developing a classification system within India to highlight cultural manifestations of mental illness, along the lines of the Chinese Classification of Mental Disorders. However, considering the presently available guidelines, most of the experts considered ICD to be the reference point for diagnosis given its international applicability, and opposed to the heavy American predisposition of the DSM.

When speaking of specific design guidelines in terms of deductibles and co-insurance, Rhea Arora, an individual with lived experience of mental illness, stated,

> "I think that if it weren't out of pocket, I think a lot more people would be willing to seek help. Like what if you know, tomorrow you wake up and you get a message saying "Hi, magically the policy you have covers this; if you want to go, you can go" and it's not expensive, it won't be added work. I think that would hundred percent help (*sic*)."

However, complete coverage was not recommended by other mental health professionals, who suggested that co-insurance can be determined on the type of illness, its severity, and its treatment; further, this co-insurance ratio should be determined by each insurer. In this respect, a psychologist suggested that a minimum number of sessions should be covered. A suggestion was also made to determine the proportion of co-insurance on the basis of the income-level of the policyholder. For instance, individuals from lower socio-economic classes would be eligible to receive up to 90% coverage for treatment; those from higher socio-economic classes may be eligible for up to 50% cover. Another idea was to have one base cover of Rs. 1 lakh for MHI with add-ons based on genetic susceptibility and coverage extending to inpatient and outpatient treatment. Conversely, the IRDAI representative suggested,

> "In hospitalization policies, treatment of any mental illness including psychotherapy/psychopharma may be covered by insurers as part of their product design ensuring compliance to Mental Healthcare Act 2017. It may be noted that coverage of illnesses / treatments has an impact on pricing. However, a more inclusive product, which is also affordable, is always better."

Within the scope of coverage for hospitalization, Amrit Bakhshy agreed that it was okay for a part of the cost of treatment to be borne by the patient (policy holder) as was the case with those hospitalized for physical illness. Mr. Bakhshy stated,

> "I mean I will be quite comfortable if it is 20 percent, or maximum 25 percent contribution by the policy holder. If they reimburse 75 percent, that I am happy with. If it is less than 75 percent, then I am not interested."

In a similar vein, Mr. Nallawala also stated that it could be in the range of 75% covered by the company, but further stated, “My issue with including outpatient costs is affordability. We must ensure that products don't become so expensive that the core purpose is defeated: so again, optional outpatient coverage could be provided through riders or specially designed products”

With respect to the latency period before which MHI can be claimed in the case of pre-existing conditions, most mental health professionals indicated that this would be extremely difficult to determine as the onset of mental illness is associated with variable genetic and environmental factors. One insurance company representative also mentioned the conundrum of there being a difficulty in isolating temporary versus chronic issues (e.g., feeling low for some time versus depression). That said, there was a general consensus that this latency period could be 2-4 years as per the current practice. Speaking from the design view-point, there was still some confusion about whether a product would be developed solely for mental health, and evolution of related models would depend upon consumer behavior at large.

Another question was regarding preferred disbursement methods, i.e. indemnity versus cash that can be adopted by insurers. Raunak Jha of Reliance Health Insurance Co. Ltd. and two other anonymous insurance representatives agreed that indemnity would be preferred. This is largely because cash benefits are more susceptible to frauds, and generally, insurance companies are pushing for indemnity as a choice for a wider range of products.

b. Pricing

In order to compute premiums for specific disease coverage, prevalence and incidence data is required. Mental health professionals suggested using data from the last National Mental Health Survey conducted by NIMHANS in 2015-16. One also mentioned using the latest data from the WHO Mental Health Atlas for India (WHO, 2017). Two other psychologists indicated that a fair amount of epidemiological data can be obtained from accessing archival psychiatric data from teaching hospitals, and other hospitals and clinics catering to a psychiatric population. It is also imperative to access data from data sources in regional languages.

With respect to the demographic factors that are to be considered when determining the pricing for MHI products, one interviewee mentioned six important features:

> “...previous history, pre-morbid features, family history… then of course gender, age, current stress…”

However, this psychologist was not of the opinion that premiums should differ on the basis of these factors; rather premiums “should be dependent maybe on the kind of services and the cost of those services.” Issuing caution regarding how various aspects are factored in to determine pricing, one expert stated that there is a need to be very careful about adding factors and modelling them in a way that structurally marginalized individuals do not end up paying higher premiums. Dr. Chavda noted that mental health is closely associated with age, family history, and

personal habits (such as consuming alcohol). He suggested using a standardized model for insuring diabetes or another physical illness to provide a model for MHI products. Even in the case of comorbid conditions, interviewees stated that insurers need to be made aware that certain diagnoses go hand-in-hand, such as attention deficit hyperactivity disorder and learning disorders. While the former requires pharmacotherapy, the latter requires educational interventions, highlighting the necessity to provide overall coverage for MHI products. Mr. Bakhshy suggested that domiciliary treatment should be considered for inclusion, by which mental illness, costs of medicine as well as psychotherapy will be covered as this was being done by some insurance companies for physical illness under some group policies. Mr. Nallawala commented -- “when there is a level playing field without consideration of demographics when computing premiums of physical illness, the same should automatically apply to coverage of mental illnesses.”

When asked the most salient demographic factors to be considered when computing premiums, one insurance company representative stated,

> ”A mental health issue can strike anyone at any point in time, at any age and it could be circumstantial, maybe it could be triggered through… any kind of bereavement or any kind of demise in and around the person, it could just trigger just basis family history for that matter. I would think… there is no correlation as such in propensity factors that can be defined at least in India...”

They further added that family history and income levels might have an actual impact on the computations.

All interviewees unanimously agreed that inpatient hospitalisation, psychopharmacology, and outpatient psychotherapy need to be covered by MHI. This view is particularly important, as stakeholders who currently offer mental health insurance do so only for inpatient facilities, i.e. hospitalization. Highlighting the importance of outlining a comprehensive treatment plan and objectivity through diagnoses, a senior psychologist stated,

> “Once a professional has defined that this person has this diagnosis, it’s not subjective anymore. It’s just subjective in terms of the patient report or the family report but once you have decided that yes, the person does need pharmacotherapy, psychotherapy, may be speech therapy... then it does not remain subjective anymore.”

When asked whether and how psychopharma can be covered under MHI, one psychologist answered “Again, why should it be a problem? I mean like any medicine or any intervention, you know psychopharmac just happens to be for a part of the body which is the brain so I don’t think there is any difference at all.” The Sodexo Corporate representative supported this assertion stating that counseling is an expensive affair, even more so for those with lower income, particularly when therapy and medication are sought over many years; both aspects should therefore be covered. This equivalence between mental and physical health is crucial to be

communicated to insurers and underwriters in order to develop holistic MHI products. This would also contribute to solving the paucity of data, which most insurance representatives stated as a

huge hindrance in determining policies. Dr. Chavda recommended having a lump sum basic X amount a year cover all treatment modalities, to begin with, in mental healthcare, emphasizing that all diagnoses need to be based on clinical evidence.

A significant finding from the interviews was the focus on including outpatient psychotherapy within MHI. All mental health professionals agreed that short-term, evidence-based psychotherapies (such as CBT) must be included within treatment options that are covered by MHI. One of the reasons cited was,

> "It (psychotherapy) should be in the basic package itself because you really cannot predict when and at what stage it should be an add-on… so for the very chronic conditions like psychosis or bipolar, the primacy should be for pharmac, but the add-on psychotherapy, even data shows, is a huge help so... I think it should be a part of the basic package."

An insurance company representative mentioned concerns regarding the possibility of abuse in the context of insurance for therapy, stating,

> "So we can price for the actual incidence and the actual cost of treatment but a health insurance company can never price for fraud. The way to really deal with fraud in such situations is very very difficult because you will have to have a physical brick and mortar model to really go and investigate and to really annul these kinds of frauds so I guess those are the issues, I would say the cons that we will have to watch out for."

However, unless we start somewhere, we would not be able to establish its efficacy. Coming back to the sparse mental health professionals in India as well as suboptimal methods for licensing and recognition, Pooja Nair suggested,

> "Let's say where you have like registered therapists who are vetted by a system. And, they are recognized by the insurance company and then when people come in and say that we have insurance for this, then you charge them a flat rate or something like that which you know is covered by the insurance company... Maybe that's one way of looking at it."

When asked about whether comorbidities should be covered under one plan, most mental health professionals agreed that they should, stating that individuals presenting with problems would likely have intertwined issues, and not just a singular distressing event. In this vein, Dr. Pragya Lodha said,

> "I think yes, because… generally in practice, there is nobody who's going to come and present only with depression. Somebody who comes with panic attacks will also have

elements of low moods, somebody who has psychosis may also show depression so premium covers have to be sensitive… ”

Conversely, some experts were also of the opinion that despite this being a necessity, it would be up to the insurance companies to calculate the risk and take a call accordingly. For instance, Mr. Bakhshy stated that even though mental illness does not discriminate among different class of people, there could be some environmental or social factors because of which certain communities may not get proper mental care. If insurance companies deem that such factors contribute to the higher prevalence of the mental illness, they could design products accordingly as they would do for designing a product for physical illness.

Another associated area of concern is how anti-selection for insurance might come into play for individuals with personal or family history of mental illness. Insurance officials unanimously agree that individuals with such history should be upfront about their conditions, so that they may be offered a suitable plan, thereby facilitating a smoother process for claims. A representative from the IRDAI stated, “Insurance is a contract based on “good faith.” A prospect should declare exact medical history to avoid any inconvenience at the time of claim settlement.” This was also supported by one of the insurance company representatives, who said that just a simple declaration without any additional form filling would be sufficient. However, another interviewee stated that the current declaration rates are minimal, owing to unavailability of proper and streamlined data on consumers. Further, with regards to pricing, it was suggested that if there are claims for which coverage and promises are upheld, this will build high trust in insurance products and awareness. This would also create competitive and dependable pricing principles avoiding a sudden surge in premiums.

Stressing upon the potential misuse due to which high anti-selection may occur, Raunak Jha stated, “Anti-selection is one of the biggest challenges which the whole industry is facing. It is not only I would say relating to mental health, it’s related to general behaviour of the public when it comes to health insurance. Especially, I would feel that given the individualistic nature of this product or the illness, it is going to be more prone to anti-fraud.” She further went on to stress that there is a higher probability of anti-selection when it comes to individuals seeking insurance, as opposed to families.

C. **Dissemination**

Dr. Kishore Kumar mentions, that there are several studies indicating that a large number of urban, rural, and tribal populations uniformly suffer of mental health concerns, which is why it is imperative to establish awareness regarding these issues. While the move by the IRDAI is a very welcome step in the right direction, it is important to remember that the dialogue surrounding mental health remains contentious and stigmatized in the Indian context. Therefore, the marketability of MHI products is closely related to awareness regarding mental illnesses as well as basic knowledge policyholders (current or future) have regarding treatment options.

a. Marketability

Interviewees unanimously agreed that much is yet to be done to destigmatize mental illness and raise awareness in India. Initial steps in a corporate organisation were narrated,

> "We are continuing to do awareness programs, but the cultural mindset is what we need to address. Are we well placed? Yes. Do we talk about it? Absolutely! Our leadership talks about it and everyone; it's a completely democratic program, available to everyone. We were the first in the industry to take up factory workers. 11,000 people, 9 regional languages and we started all this 3 years ago… We did everything we could to enable it and we send people to spread awareness. So we did *Nukkad Nataks*, we did orientations and that continues. It never stops."

Campaigning strategies equating physical and mental health; sharing of personal stories for destigmatisation and creating awareness; creating awareness at the primary school level by discussing mental illnesses along with physical illnesses; setting up awareness camps within communities, particularly for those from the lower socio-economic strata visiting government hospitals; using stand-up comedy effectively and sensitively; highlighting the efficacy of evidence-based treatments; and using digital and print media were some of the suggestions made. Emphasising the need to involve insurers in this awareness endeavour, Dr. Chavda stated,

> "I mean how many of the general public would know what psychiatric disorders are and technically insurance companies are general public. So they need to be informed first as to what they are insuring. Everybody knows about diabetes, and blood pressure and cancer and so on; very few people would know what's schizophrenia and bipolar disorders are all about. What withdrawal entails, how difficult it is to deal with the case of autism, how incredibly horrible it is when somebody attempts suicide, and somebody is stuck on a ventilator because of his suicide. So unless they get the information related to these things its not going to be easy for them to understand what the situation is and how important insurance is."

When discussing how underwriters might be educated regarding varied treatment options for mental healthcare, one psychologist said that they should have a good understanding of what getting better entails, so that they can make good policy. Another psychologist stated,

"I think they (underwriters) should be well informed; I think even written material can be created and given to them as part of a guideline and I think they should be given parallels from existing insurance packages which are there. Like for example, surgery plus physiotherapy can be an insurance package, then why not pharmacotherapy and psychotherapy? It's an exact equivalent; there is no difference."

From the perspective of insurers, one of the interviewees said, "The answer is that as an industry, the industry is first and foremost making provision to really create the products which are at par, both from a mental illness and a physical illness standpoint and in creating, provisioning the internal machinery to really support that."

To raise awareness, Sodexo Corporate initiated a mental health dialogue within the organization by showing employees a video (available in English and 7 local languages) about understanding mental health, how it affects them personally, and consequently their teams and organization. Furthermore, they also invited a counselor to speak to employees about the topic, and have introduced an intra-organizational counseling helpline, thereby creating awareness about mental health.

Organising regular meetings between mental health professionals and insurers would help reduce information asymmetry, especially by incorporating such interactions as part of an insurance agency's internal training protocol. According to Amrit Bakhshy, creating awareness, does not strictly fall under the prerogative of insurance companies, and therefore the onus should largely lie upon the Government to reach out to people, in a similar way as is awareness campaigns on HIV, TB, malaria, etc. A senior psychologist mentioned an innovative means to raise awareness and applaud those who have combatted mental illness: the Dwij Puraskar is a recovery award given to recovering (or recovered) patients and their caregivers, enabling them to become ambassadors of mental health.

In order to understand how various stakeholders perceived the severity of mental illnesses, and how the general public could be informed thereof, their opinions were garnered. One anonymous corporate representative stated that they were promoting helplines and inhouse counseling for employees, thereby opening up the conversation regarding mental health. Other inputs, particularly from therapists and counselors, indicated that mental health should be conversed about in a way that it is equal to physical health conveying that the mind and the body are one. Furthermore, campaigns should be launched similar to ones for the polio vaccine, which can raise public awareness about mental health and its degrees of severity.

The importance of acknowledging environmental factors that can be associated with mental illness was also mentioned; for instance, at the workplace, stressors have markedly

increased owing to advances in communication that interrupts a healthy work-life balance. Psychoeducation regarding buffers against developing common mental disorders as well as the role of specific situations in one's life was deemed important. In terms of the perceived severity of mental illnesses as well as treatment options for the same, Pooja Nair stated,

> "We need to be considering different kinds of evidence-based treatments for different categories and types of mental health concerns… you may have depression or anxiety that is relatively less chronic that might really do well with a short treatment program, but ones that are more chronic, more long-term, more severe, are in an environment that has more triggers, and may require a more comprehensive treatment program in which case, we are still learning about more evidence-based treatment for those kinds of concerns."

Key Lessons and Recommendations

Interviews with several professionals in mental health, insurance, and policy provided a closer look at what is yet to be accomplished to achieve the successful implementation of MHI in India. A summary of the chief findings and learnings from this paper are summarized as under.

Objective	Summary
Readiness	• Have a decentralised approach to training community health workers in mental health first aid • Empanel all facilities with mental health infrastructure simultaneously • Establish a separate regulatory authority (apart from the RCI), consisting of mental health professionals, policymakers, and government officials to ensure optimal implementation of MHI. • Increase the numbers of post-graduate seats in psychiatry and psychology • Streamline licensing formalities for counselling psychologists, psychotherapists, and other mental health professionals not under the purview of the RCI currently • Draft standard operating procedures and best practices to develop protocols for pharmacological, therapeutic, and combined treatment options • Empanel other counselors and psychiatric nurses to share the burden of providing mental health services • Enable universities to provide licenses to students passing out from psychology degree programs, if they meet preset criteria • Focus on increasing and empaneling more outpatient facilities
Design Guidelines	• Cover all mental illnesses, with more research required for coverage of some illnesses like personality disorders • Do not exclude any pre-existing condition, although premiums may be higher • Implement appropriate premiums based on declarations of policy seekers about comorbid and pre-existing conditions • Cover suicide attempts • Regardless of the diagnostic system followed (DSM/ICD), a psychiatrist or clinical psychologist must provide a diagnosis prior to availing MHI • Determine co-insurance on the basis of the illness, its severity, and treatment • Use data from the National Mental Health Survey to establish morbidity probabilities • Use previous history, pre-morbid features, family history, gender,

	age, and current stress as demographic factors when developing MHI products ● Cover inpatient hospitalisation, psychopharmacology, and psychotherapy under MHI ● Cover short-term and evidence-based psychotherapy
Dissemination	● Raise awareness of not only mental illness, but also mental illness treatments ● Use novel means (e.g., sensitive stand-up comedy) to destigmatize mental illness ● Share personal stories to facilitate destigmatization ● Set up mobile clinics for places that may not have access to mental health facilities ● Involve insurance agencies in mental health awareness campaigns ● Hold regular, joint meetings between mental health professionals and insurers ● Acknowledge the role of environmental stressors ● Make eminent personalities mental health champions ● Use campaigns that emphasize parity between mental and physical health and illnesses, thereby raising awareness

Future Directions

This white paper is an initial step towards understanding the implementation of mental health insurance in India. By speaking with stakeholders representing diverse interest groups (from mental health professionals to insurers), we were able to collate opinions and ideas regarding the rollout of MHI products in India. The interviews enabled an informal assessment of the readiness of the infrastructure available to support MHI execution; design guidelines regarding the nature of products and pricing were also commented upon; and last, the importance of raising awareness and dissemination strategies for MHI were discussed.

Therefore, with respect to subsequent action plans, numerous recommendations have been put forth. One suggestion that merits serious consideration is the establishment of a separate regulatory authority, consisting of mental health professionals, policymakers, government officials, and representatives from the insurance industry to ensure optimal implementation of MHI. An overseeing body that is dedicated to the planning and execution of MHI will enable the identification of loopholes, design flaws, and avenues for improvement. Such a collective can also be the nodal authority on empanelment, dispute settlement, and subsequent research within MHI.

From all interviews, the general sentiment concerning MHI was positive, lending hope and motivation for adequate and accurate implementation. To enable this vision of parity between physical and mental illnesses, a nuanced approach toward the treatment of mental illness must also be taken. Thus, another suggestion that worth heeding is the inclusion of psychotherapy as an outpatient expense within variously designed MHI products. Short-term and evidence-based psychotherapy can be included with the aim of assisting millions of Indians cope with common mental health disorders, such as anxiety and depression.

With a view to the future, the global burden of mental illness is only set to increase, with India being a large contributor. This burden translates into economic and productive losses as a proportion of the national population is unable to cope with the demands of daily life. Against this background, developing sustainable and useful mental health insurance products accessible to all Indians is the need of the hour.

References

Ahuja, S., & Kapoor, H. (2019). How Would Mental Health Insurance in India Work?. *The Wire.* Retrieved from https://thewire.in/health/how-would-mental-health-insurance-in-india-work.

Anil, R. A. N. E., & Nadkarni, A. (2014). Suicide in India: a systematic review. *Shanghai archives of psychiatry*, *26*(2), 69.

ASSOCHAM (2018). *White Paper on Women and Insurance in India*. Retrieved from https://www.assocham.org/upload/docs/Assocham-National-Council-for-Insurance-FY-2017-18.pdf

Bhat, M. A., & Rather, T. A. (2012). Socio- Economic Factors and Mental Health of Young People in India and China: An Elusive Link with Globalization. *Asian Social Work and Policy Review*, *6*(1), 1-22.

Duffy, R.M. and Kelly, B.D. (2019), "*India's mental healthcare act, 2017: content, context, controversy*", International Journal of Law and Psychiatry, Vol. 62, pp. 169-78, available at: https://doi.org/10.1016/j.ijlp.2018.08.002

Ganguli, H. C. (2000). Epidemiological findings on prevalence of mental disorders in India. *Indian journal of psychiatry*, *42*(1), 14.

Gururaj, G., Varghes, M., Benegal, V., Rao, G.N., Pathak, K., Singh, L.K.,. . . . . Misra, R. (2016). Prevalence, Pattern and Outcomes. *National Mental Health Survey of India, 2015-16*. Retrieved from http://www.nimhans.ac.in/sites/default/files/u197/NMHS%20Report%20%28Prevalence%20patterns%20and%20outcomes%29%201.pdf

India is the most depressed country in the world. (2018, October 10). *India Today*. Retrieved from https://www.indiatoday.in/education-today/gk-current-affairs/story/india-is-the-most-depressed-country-in-the-world-mental-health-day-2018-1360096-2018-10-10

Kapoor, H. (2017, April 23). A market for mental health insurance? Retrieved from https://www.livemint.com/Opinion/wtvnTJn38ZXv7deKCV2B0N/A-market-for-mental-health-insurance.html

Kapoor, H. (2018). Mental Health Insurance Cover in India is Welcome, but Unplanned Move. *The Wire.* Retrieved from https://thewire.in/health/mental-health-insurance-irdai-dsm5-clinical-psychology

Kapoor, H. & Ahuja, S. (2019). Mental health insurance: Products introduced; here's how they can be made better and widely accessible. *Financial Express.* Retrieved from

https://www.financialexpress.com/money/insurance/mental-health-insurance-products-introduced-heres-how-they-can-be-made-better-and-widely-accessible/1555765/

Math, S. B., & Srinivasaraju, R. (2010). Indian Psychiatric epidemiological studies: Learning from the past. *Indian Journal of Psychiatry,* 52(Suppl1): S95–S103. doi:10.4103/0019-5545.69220.

Mishra, A., & Galhotra, A. (2018). Mental Healthcare Act 2017: Need to wait and watch. *International Journal of Applied and Basic Medical Research*, *8*(2), 67.

Murthy, R. S. (2011). Mental health initiatives in India (1947-2010). *National Medical Journal of India,* 24(2):98-107. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21668056

Pattanayak, R. D., & Sagar, R. (2016). Health insurance for mental health in India: A welcome step toward parity and universal coverage. *Journal of Mental Health and Human Behaviour*., 21:1-3. doi: 10.4103/0971-8990.182089

Rejani, P. P., Sumesh, T. P.,& Shaji, K. S. (2015). Cost of Care: A Study of Patients Hospitalized for Treatment of Psychotic Illness. *Indian Journal of Psychological Medicine,* 37(1): 71–74. doi: 10.4103/0253-7176.150823

Sahithya B. R. & R. P. Reddy. (2018). Burden of mental illness: a review in an Indian context. *International Journal of Culture and Mental Health*. doi:10.1080/17542863.2018.1442869

Sarkar, S., Mathan, K., Sakey, S., Shaik, S., Subramanian, K., & Kattimani, S. (2017). Cost-of-treatment of clinically stable severe mental illnesses in India. *Indian Journal of Social Psychiatry*, 33:262-8. doi:10.4103/0971-9962.214600

Shahrawat, R. & Rao, K. D. (2012). Insured yet vulnerable: Out-of-pocket payments and India's poor. *Health Policy Plan*, 27: 213–21.

Sharma, P., Das, S. K., & Deshpande, S. N. (2006). An estimate of the monthly cost of two major mental disorders in an Indian metropolis. *Indian Journal of Social Psychiatry,* 48(3): 143–148. doi: 10.4103/0019-5545.31576

Shidhaye, R., & Kermode, M. (2013). Stigma and discrimination as a barrier to mental health service utilization in India. *International health*, *5*(1), 6-8.

Shidhaye, R., & Patel, V. (2010). Association of socio-economic, gender and health factors with common mental disorders in women: a population-based study of 5703 married rural women in India. *International Journal of Epidemiology*, *39*(6), 1510–1521. https://doi.org/10.1093/ije/dyq179

Srinath, S., Girimaji, S. C., Gururaj, G., Seshadri, S., Subbakrishna, D. K., Bhola, P., & Kumar, N. (2005). Epidemiological study of child & adolescent psychiatric disorders in urban & rural areas of Bangalore, India. *Indian Journal of Medical Research*, *122*(1), 67.

World Health Organization. (2017). *Depression and other common mental disorders: global health estimates* (No. WHO/MSD/MER/2017.2). World Health Organization.

Appendix A: Existing Public Healthcare Schemes in India

- **Ayushman Bharat Scheme**: Launched in September 2018, this is a flagship scheme of Government of India, offering cover for mental illness as well as physical illness. It has 17 packages for mental health disorders, which also includes psychoactive substance use. It covers ECT, rTMS as well as diagnostic services. Insurance facilities are applicable to public sector hospitals only and not private hospitals whereas, for other medical disorders, the scheme covers treatment in private hospitals as well. The scheme is cashless and paperless and there is no cap on the family size and age. It is targeted towards deprived rural and urban families. It functions on a twofold strategy: strengthening existing mental health facilities and introducing the Pradhan Mantri Jan Arogya Yojana, which provides cashless cover of up to Rs. 5 lakh per year. It aims to cover about 40% of the entire Indian population. The cost of premiums is shared between the central and state government (Singh, 2019).
- **Arogya Karnataka:** This is another version of the Ayushman Bharat Scheme only applicable to residents of Karnataka. It integrates all existing insurance schemes to form a universal health coverage package. It covers individuals below and above the poverty line. For the latter, a co-payment mode exists. Mental disorder packages include—organic and symptomatic mental disorders, mental and behavioral disorders due to psychoactive substance use, schizophrenia, schizotypal and delusional disorders, mood (affective) disorders, neurotic, stress-related, and somatoform disorders, behavioral syndromes associated with physiological disturbances and physical factors, mental retardation (Sangoi Bijal A, Naveen Kumar C, Manjunatha N, Mahesh Gowda, Vinay Basavaraju, 2019).
- **Rashtriya Arogya Nidhi:** The main aim of this scheme is to provide financial assistance up to Rs. 5 lakh to individuals below the poverty line, which is provided in terms of a 'one-time grant' ("*Rashtriya Arogya Nidhi*, "n.d.). Mental disorders and assessments covered include—

1. Organic psychosis
2. Functional psychosis including schizophrenia, bipolar disorder, delusional disorder and other acute polymorphic psychosis.
3. Severe OCD and somatoform disorders
4. Developmental disorders including autism spectrum disorders and behavioral disorders.
5. Psychodiagnostics, neuropsychological assessments, IQ assessments, etc.

- **Swavalambhan Health Insurance Scheme:** This is a tailor-made Group Health Insurance Scheme by the Ministry of Social Justice and Empowerment with New India Assurance Company Limited for providing affordable health insurance to persons. It covers mental retardation and mental illness. Health insurance cover is up to Rs. 2 lakh per annum as family floater. However, for persons with mental illness and mental retardation, OPD cover is limited to Rs. 3000 per annum (Sangoi Bijal A, Naveen Kumar C, Manjunatha N, Mahesh Gowda, Vinay Basavaraju, 2019).

- **Rashtriya Swasthya Bima Yojana:** This covers day care treatments and procedures for psychiatric and psychosomatic illnesses. Insurance coverage includes screening and follow-up care including medical costs. The beneficiaries under the scheme are entitled to hospitalization cover of up to Rs 30,000 per annum on family floater basis, for most of the diseases that require hospitalization. The government has framed indicative package rates for hospitals for a large number of interventions. Pre-existing conditions are covered from Day 1 and there is no age limit. The coverage extends to maximum five members of the family, which includes the head of household, spouse, and up to three dependents. Additionally, transport expenses of Rs. 100 per hospitalization will also be paid to the beneficiary subject to a maximum of Rs. 1000 per year per family. Under RSBY, the beneficiaries need to pay only Rs. 30 as registration fee for a year while the central and state governments pay the premium as per their sharing ratio to the insurer selected by the state government on the basis of a competitive bidding (Saraswathy, 2017).

- **Biju Swasthya Kalyan Yojana (Odisha):** This scheme offers free treatment in all government and empanelled hospitals for a sum of Rs. 5 lakh for male members and Rs. 7 lakh for female members. Reimbursement is done by the state government and not by the insurance companies. It covers the cost of inpatient treatment of psychiatric disorders in government hospitals, including medication (Singh, 2019).

Appendix B: Interview Schedule

Theme	Sub-topic	Stakeholder				
		Mental Health Professionals/ Activists/ Policy makers	**IRDAI**	**Insurance Companies**	**Caregivers/ Individuals with lived experience**	**Corporates**
Infrastructure	Capacity of Existing Medical Facilities	What can be done to increase the capacity of inpatient mental health facilities - is this required? What about outpatient facilities?	How can the scant mental health facilities in the country be used to meet the demands of MHI?		What has been your experience with current infrastructure of mental health facilities? Do you meet your needs well?	
	Empanelment of Existing Medical Facilities	In what order should Government hospitals, private hospitals, and clinics be empanelled to provide mental health facilities as covered by MHI? Do you have any suggestions for the empanelment plan?			Where would you be most comfortable with receiving mental health care?	What kinds of medical facilities would you be the most comfortable with when tying up to provide MHI services to employees?
	State and National Mental Health Authorities	What do you think should be the role and responsibility of these authorities within MHI?	How can these authorities ensure the compliance of all empanelled bodies with respect to provisions of MHI?		-	-
Marketability	Awareness of mental diseases	What should be the involvement of various stakeholders (insurance companies, mental health professionals, etc.) in disseminating information about mental health issues and their treatment options? Do you have novel suggestions for the same?	How do insurance companies plan on ensuring internal capacity building/ training on mental health awareness? Do you have a plan to increase the awareness of mental health diseases and their treatment options as MHI products are rolled out?		How easy/difficult was it for you to seek mental health care? Were you ever diagnosed formally and what treatment options were provided to you? Have you ever approached an insurance company for MHI and if yes, what was their response?	How aware are employees in India regarding mental health concerns and what are the most common means to seek treatment for the same?

	Perceived role of "chance," environmental factors	How can we communicate to prospective insurance buyers that mental illness can be managed and/or treated through medication and psychotherapy? How can we indicate that environmental factors, such as job stress, also play a role on our mental health?	Do you believe that mental illnesses can be managed and/or controlled? How can we indicate that environmental factors, such as job stress, also play a role on our mental health when MHI products are rolled out?	Were you given an explanation of why you developed a mental illness? Were there any assessments or a formal diagnosis done?	What. according to you, are factors contributing to deteriorating mental health in the work context in India?
	Perceived severity of mental diseases	How can we communicate to the general public that common and severe mental disorders need to be assessed by a professional? How can we reduce the stigma associated with seeking such help?	Are insurers aware of the nature, severity, and variability in the presentation of mental illnesses? How will MHI products attempt to reconcile these variations?	According to you, what are common and severe mental disorders? What is the difference in treating them?	Does your organisation have a provision to seek mental health assistance when employees require the same? Are there information campaigns regarding mental health held in your organisation?
Pricing	Morbidity Probabilities	Where do you think we can get the latest data to establish morbidity probabilities for mental health illnesses in India?	Which dataset is going to be used to estimate morbidity probabilities for MHI products in India?	-	-
	Rating Factors (Identification and Impact; e.g., sex, age, etc.)	What according to you should be the most salient demographic factors to be included when computing premiums for MHI?			
	Co-Morbidities	What do you suggest in cases of clients who have comorbid conditions - either two mental illnesses or a mental and physical illness? Should pricing of premiums be differentiated according to this?			

	Duration of Various Treatments - Therapy	Should evidence-based therapies for specific mental disorders, like depression, be covered under MHI? How do you propose this can happen?	What are the pros and cons of including psychotherapy in MHI?	How many therapy sessions should be covered by insurance? Or what other mechanism should be used to cover psychotherapy?	
	Duration of Various Treatments - Medical	Should psychopharma be covered under MHI? How do you propose this can happen?	What are the pros and cons of including psychopharma in MHI?	How should psychopharma coverage work in MHI?	
	Duration of Various Treatments - Inpatient/Hospitalisation	Should inpatient/hospitalisation be covered under MHI? In conjunction with this, if the patient requires psychotherapy as recommended by the psychiatrist, should this also be covered under MHI?	What is delaying the coverage of inpatient/hospitalisation treatments under MHI? In conjunction with this, if the patient requires psychotherapy as recommended by the psychiatrist, should this also be covered under MHI?	Should inpatient/hospitalisation be covered under MHI? In conjunction with this, if the patient requires psychotherapy as recommended by the psychiatrist, should this also be covered under MHI?	-
	Expenses	To what extent should underwriters be informed about mental health and associated treatment options to be able to effectively organise MHI?	Please provide insights into the following: Claim Settlement, System Set-up, Training, Product development	How much would you be willing to pay for MHI and what kind of product would you like (in terms of coverage)?	
	Anti Selection	-	What measures can be taken to reduce anti-selection for MHI?	-	-

Design	Illnesses Covered	Should all mental illnesses (including substance abuse disorders) be covered? Is this a gray area?	Is the plan to cover all mental illnesses or only a subset of common and severe mental disorders (like Singapore, which covers five conditions - major depressive disorders, schizophrenia, bipolar disorder, obsessive-compulsive disorder and Tourette Syndrome)?	Should all mental illnesses (including substance abuse disorders) be covered? Is this a gray area?	What are the most common mental health concerns at the workplace that should be covered under MHI?
	Definitions of illnesses	Which system of diagnosis should be followed for MHI in India - DSM or ICD? Should a diagnosis by a psychiatrist be mandatory for filing an MHI claim?	Is the plan to follow the ICD system for MHI claims as is done in other countries? How will this be implemented?	Did a psychiatrist provide a formal diagnosis for your condition?	-
	Policy Exclusions	Which pre-existing conditions should be excluded from MHI?	Which policy exclusions under MHI would be prominent? Pre-Existing Conditions: Mental as well as Physical?; Substance Abuse?	Which policy exclusions should be recommended from the perspective of pre-existing conditions?	
	Indemnity basis vs. Cash	-	Which option should be preferred?	-	-
	Miscellaneous	How should self-admission and/or suicide attempts be dealt with within MHI?			-
	Add-on	-	Is it going to be an add-on or a part of the existing policy?	-	-
	Term	What should the latency period be in the case of pre-existing conditions?			-

	Deductibles/ Co-Insurance	How would this system work, especially for outpatient daycare treatments like psychotherapy?		How much percentage would you be willing to pay for mental health treatments if this is to be shared with the insurance company through co-insurance?	How much percentage would you be willing to pay for mental health coverage for your employees if this is to be shared with the insurance company through co-insurance?
Practical Issues	Availability of Medical Professionals	Which paramedical professionals do you see assisting in dividing the workload that will inevitably be brought on by MHI?		-	-
	Waiting Times (for immediate issues/ treatments)	How many clients/patients do you have on your waitlist right now? What is the usual waiting time to be able to see a mental health professional?	By empanelling only public hospitals with MHI delivery, how would waiting times for treatments and hospitalisation be managed?	How long did you have to wait to meet a mental health professional by appointment?	-
	Professional Integrity of Practitioners	What suggestions do you have to make the licensing procedures for clinical and counselling psychologists more streamlined in India, especially those who are not affiliated with a government or private hospital?	Are private practitioners eventually going to be empaneled under MHI? How do you see that happening with current the current licensing system for only clinical psychologists in place?	-	-
	Standardisation of Diagnosis, Treatment	How can we support evidence-based practice when recommending treatment options, both inpatient and outpatient?	Because diagnosis and evidence-based treatment are standardized across patients, what is the reason (if any) that MHI will not cover all mental health treatments?	Did your treatment entail a standardized therapy plan/ psychopharma plan?	-
	Tendency to Over Hospitalise or over-diagnose?	If only inpatient admissions are covered under MHI, what do you think will be the chances of over hospitalisation and overdiagnosis? According to you, what proportion of individuals with a mental illness seek inpatient treatment versus outpatient treatment?			-

	Miscellaneous		What is the provision of the inclusion of a Medical Proxy? How is private MHI is going to be implemented vis-a-vis state health insurance (that is, Ayushman Bharat)? Some insurance agencies cover AYUSH treatments - how did this come to be (e.g., Max Bupa)?		

Appendix C: Informed Consent Form

Declaration of Consent

I, the undersigned, hereby give consent to Poddar Foundation, in collaboration with Monk Prayogshala (Research Partner for the white paper) to audio record the interview being conducted for the purpose of developing a white paper on inclusion of mental health treatment costs within insurance. I give permission to use the information in the recording or/and quote me from the same for the white paper only. I understand that I will not be entitled to receive any payment in consideration for the use of details related to my person as set forth above. The transcripts and audio recordings solely belong to Poddar Foundation without any obligation to seek any further authorization by the undersigned.

I wish to be quoted anonymously: ……

Signature: .....

Name: .....

Date: .....

Place: .....

About the Organisations

About Poddar Foundation

Poddar Foundation is a duly registered NGO, since 1983, which focused on education, arts and culture in India. In 2016, the Foundation shifted its focus on mental health awareness through preventive drives.
We believe that prevention is better than cure. Our mission is to create awareness about mental health, physical health and emotional health in order to identify, rectify, and manage mental and physical health disharmonies. The Foundation works through its flagship program 'SILENCE TODO' to sensitize people with understanding and knowledge about mental health and its various issues.

Through collective actions towards a common cause, Poddar Foundation is able to combat ignorance surrounding mental health to create a community of harmony. These training sessions are highly interactive through the use of audiovisual aids, role-plays and real-life situations to engage participants with enthusiasm. The discussion encompasses issues like Depression, Bullying and Peer Pressure, Anxiety, ADHD and learning disorders.

All the programs are focused on preventing mental health illnesses. through drives that aim at educating people on the unrecognized threats of mental health imbalances and encourage coping strategies to live healthy, happy lives.

Visit us at: www.poddar.foundation
Follow us on: **LinkedIn** Poddar Foundation| **Twitter** @poddarfoundation| **Facebook** @Poddar Foundation

About Monk Prayogshala

Monk Prayogshala is a not-for-profit academic research organisation that undertakes projects spanning the entire research life cycle, from conceptualizing research problems to data analysis through to publication and feedback integration. Prayogshala consists of a team of highly-trained researchers from the social sciences and aims to further the cause of academic research in and from India, and improve the quality and volume of the nation's research output into the global academic research community. Prayogshala has been working with reputed Non-Government Organisations and NPOs to measure research impact and publish their work in high impact research journals.

Visit us at: www.monkprayogshala.in
Follow us on: **LinkedIn** /मंक-प्रयोगशाला | **Twitter** @monkprayogshala | **Facebook** @mprayogshala