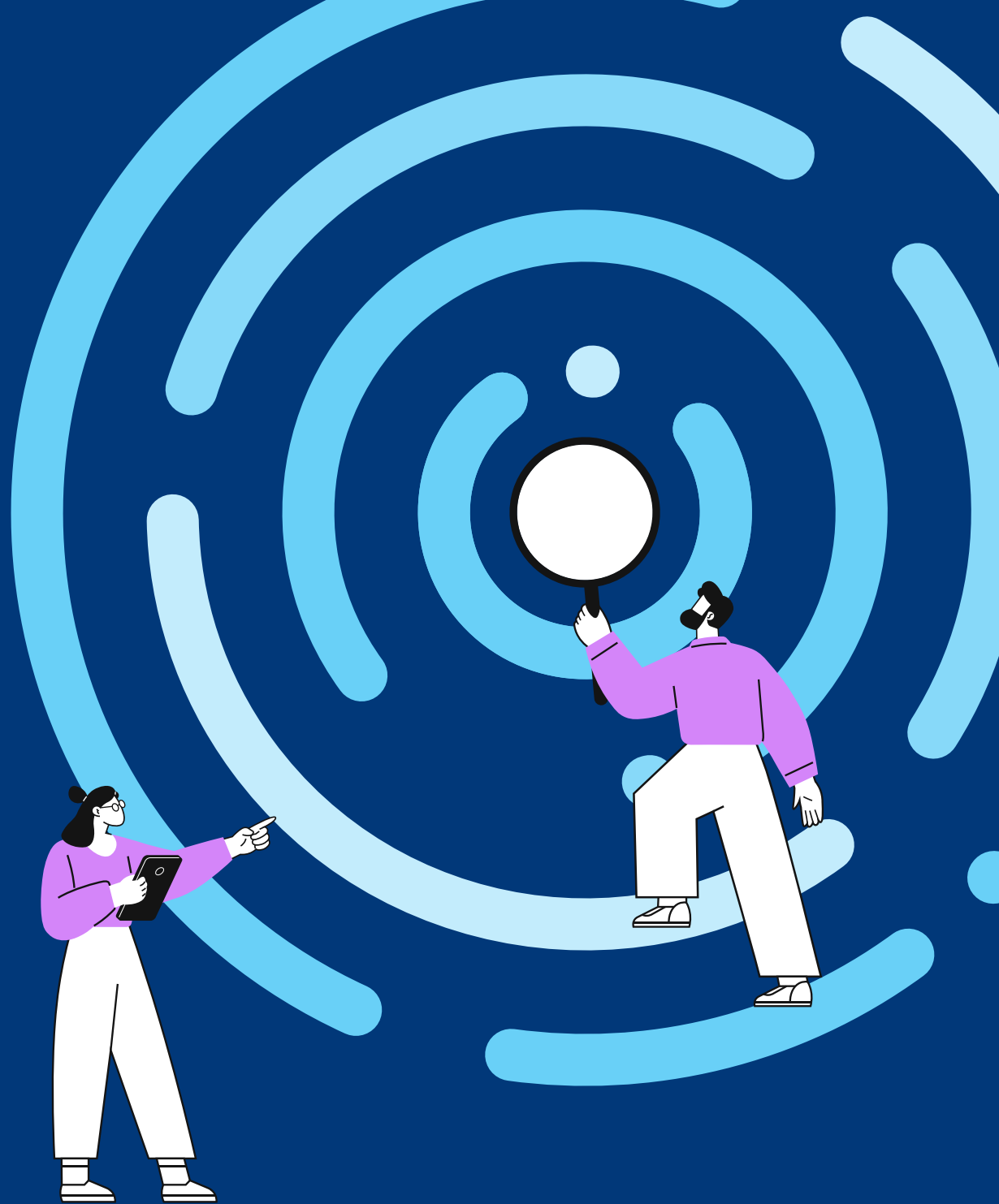


The Complexity Premium

The cross-scheme pressures
impacting claims in super



For trustees and insurers in superannuation, the mental health claims challenge is intensifying on multiple fronts: rising frequency, longer durations, increasing complexity, and growing regulatory expectations around fairness and service quality.

But the source of that pressure is not confined to the fund itself. Australia's personal injury schemes are not standalone mechanisms—they are part of a broader income support ecosystem shaped by eligibility rules, time limits, processing delays, and differences in who funds medical care and rehabilitation.

Evidence indicates that changes to mental health eligibility or benefit duration—particularly in workers' compensation—can drive increased demand into life insurance and social security, while creating periods of financial vulnerability that worsen recovery and return to work outcomes. A credible reform agenda therefore requires cross-scheme measurement, earlier intervention, and deliberate handover design, rather than isolated scheme optimisation.

The sections that follow set out the scale of the challenge, the cross-scheme dynamics driving it, and a practical roadmap for action.



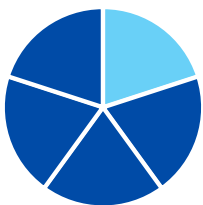
“Superannuation trustees are now managing claims portfolios reshaped by forces largely outside their control. Members move between workers' compensation, life insurance in superannuation, and social security—and the handover between systems is often where deterioration occurs.

When other schemes tighten eligibility, delay decisions, or end support, it is often life insurance in superannuation that absorbs the consequences. If we want to keep members connected to work and contributing to superannuation, and keep pooled cover affordable and trusted, we need to design transitions that reduce harm, support members earlier, and measure success by recovery and return to work, not just claim closure.”

Cameron McCullagh,
Executive Chairman, EML

The Growing Mental Health Burden

For insurers and superannuation, mental health conditions have moved from an emerging risk to a defining one. They are now a leading cause of disability among Australians of prime working age, with direct implications for claim volumes, durations, premiums, and the sustainability of default cover. ⁽¹³⁾ In any given year, about 20% of Australians experience a mental illness, ⁽⁴⁾ and the Productivity Commission estimates that mental ill-health costs the nation up to \$220 billion a year in healthcare, lost productivity, and reduced wellbeing. ⁽²⁰⁾ Health system expenditure on mental health and substance use was estimated at approximately \$11.9 billion in 2022–23 (around 7% of disease spending). ⁽⁴⁾



One in five Australians experience a mental illness each year—this is now an insurance affordability issue, not just a health issue. ⁽⁴⁾

These human and economic costs are turning a public health challenge into a core claims and affordability issue. Mental illness is now the single largest cause of Total and Permanent Disability (TPD) claims, accounting for about one in three TPD payouts, and it represents about 20% of all income protection (IP) claims. ⁽¹³⁾ Insurers paid out more than \$2.2 billion for mental health-related life insurance claims in 2024—almost double the amount five years earlier. ⁽¹³⁾ Industry leaders warn that Australia is approaching a tipping point. ⁽¹³⁾ For trustees, this trajectory means rising premiums, increasing pressure on default cover, and harder conversations with members about affordability and value.

Drawing on EML's experience across personal injury, disability, life insurance and superannuation claims, this paper sets out a practical agenda for change. Funds that act on these priorities will be better placed to improve member outcomes, support workforce participation, and protect affordability and long-term viability for all members.



Mental health has shifted from an emerging issue to a **defining risk**. ⁽¹³⁾



Mental ill-health is now the **single largest cause of TPD claims**—about one in three paid claims. ⁽¹³⁾



TPD claims for mental health among Australians in their 30s **have surged** over the past a decade. ⁽¹³⁾



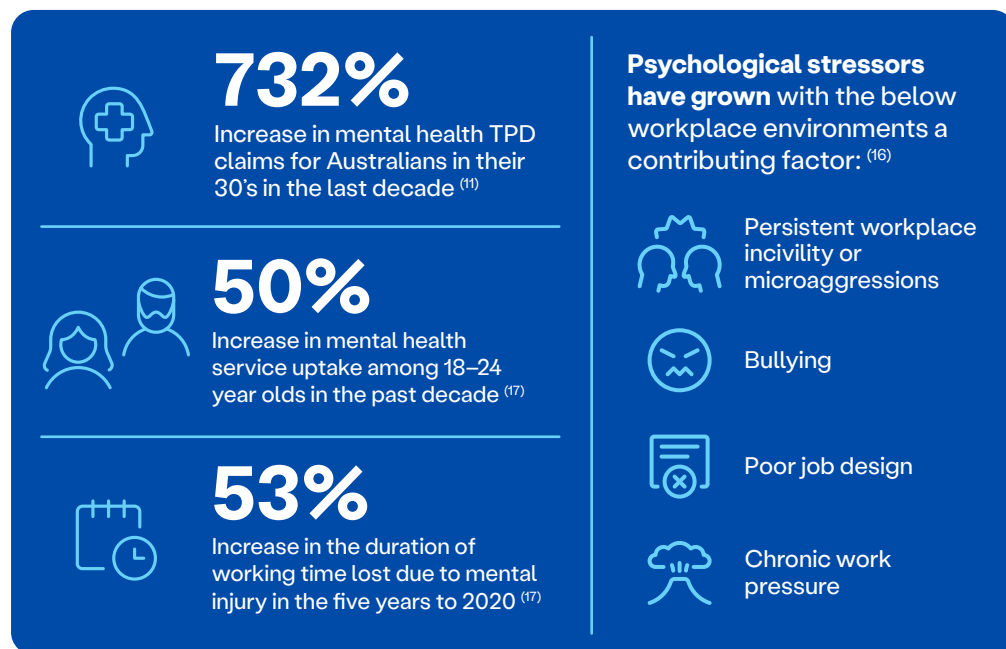
Insurers paid more than **\$2.2 billion** for mental health life insurance claims in 2024—nearly **double the amount** of five years earlier. ⁽¹³⁾

Key Factors Driving Mental Health Trends

Several factors are driving this rise. Nationwide, use of mental health services has increased markedly. For example, the past decade saw a 50% jump in service uptake among 18–24-year-olds, ⁽¹³⁾ and TPD claims due to mental health by Australians in their 30s climbed 732% over the same period, ⁽¹³⁾ indicating greater mental health needs and awareness among younger people.

Psychological stressors have also grown. Emerging research points to workplace environments as a contributing factor: persistent workplace incivility or microaggressions, chronic work pressure, bullying, and poor job design are now recognised as psychosocial hazards. ⁽¹⁶⁾ These stressors can compromise employees' mental wellbeing and, if left unaddressed, may lead to psychological injury claims.

Indeed, psychological injuries in the workplace are rising sharply—across Australia's workers' compensation systems, there was a 53% increase in the duration of working time lost to mental injury in the five years to 2020, ⁽²³⁾ and median time lost per claim was over four times longer than for physical injuries. ⁽²⁴⁾ If psychological risks are not addressed early, they often manifest as longer work absences, more complex claims, and rising costs across the system. For funds and insurers managing the downstream consequences, this reinforces an urgent priority: prevention and early workplace action are essential to sustaining recovery outcomes and the pooled cover that members depend on.



Impact on Insurance and Superannuation Systems

If you manage claims for a life insurer or superannuation fund, mental health is likely your most complex and fastest-growing challenge. Mental health claims often involve longer recovery times and complex support needs. They are also more prone to disputes or denials under strict policy definitions, indicating potential misalignment between product design, evidence requirements, and member needs.

The consequences for members are significant. The Australian Securities and Investments Commission (ASIC) data indicates that 77% of mental health TPD claims are rejected under Activities of Daily Living (ADL) tests, compared with only 15% of claims assessed under the standard TPD definition ⁽⁵⁾—a disparity that points to structural misalignment between product design and the nature of mental illness.

EML's experience supporting injured workers within and across schemes reinforces this picture: where early intervention, coordinated case management, and cross-scheme transition support are in place, outcomes improve materially. An independent evaluation of an EML program undertaken by Taylor Fry examined selected Comcare claimants, including newer claims involving primary or secondary psychological injury and older, long-duration claims. It found that participants were 247% more likely to return to work within six months than non-participants. ⁽²⁷⁾

Pressure to cut administration costs risks hollowing out claims management, resulting in delays, poorer decisions and more disputes.

This pattern raises a broader question. Across the superannuation sector, sustained pressure to reduce administration costs has been driven by competition for members and the broader push for value in superannuation. While cost discipline benefits members in many respects, there is a risk that claims management—which requires specialist mental health capability, time-sensitive assessment, and coordinated support—is being treated as a cost to minimise rather than a service to invest in. When claims teams are under-resourced, processing slows, decision quality declines, disputes increase, and members experience the system as adversarial rather than supportive. For mental health claims in particular, where timely and empathetic handling directly influences recovery outcomes, the link between cost compression and poor claims experience warrants close scrutiny from trustees and regulators alike.

Critically, insurers and super funds are beginning to respond. Many have introduced specialist mental health capability and training, so claims are handled with greater consistency, empathy and expertise. Insurers are also collaborating to improve data through a joint Financial Services Council (FSC) / KPMG initiative that provides granular, up-to-date industry data on mental health claims to inform underwriting and product design.⁽¹⁵⁾ However, material gaps persist—particularly in linking claims experience to outcome measures, including recovery and return to work. Better metrics, more consistent handovers, earlier intervention pathways, and clearer service standards are essential if the sector is to manage mental health risk more proactively.

Regulator and Policymaker Focus

Regulators and policymakers are also sharpening their focus. The Australian Prudential Regulation Authority (APRA) is signalling concern about group insurance sustainability, cautioning that rising mental health claims could undermine the viability of group insurance in superannuation.⁽¹⁾ Premium volatility has already been observed, with some funds experiencing large rate increases to offset a deteriorating claims experience.⁽¹⁾

ASIC has also intervened after finding high TPD claim denial rates for mental illness in its 2019 review, pushing insurers to overhaul definitions and practices to treat mental health conditions more fairly.⁽⁵⁾ Disability discrimination law now also compels insurers to justify any differential treatment of mental health conditions with robust data.⁽³⁾

In response, the industry's new Life Insurance Code of Practice includes specific commitments to mental health fairness,⁽¹²⁾ and Financial Services Council (FSC) Standard 21 is expanding mental health training for claims staff.⁽¹⁵⁾ These developments signal a strengthening alignment between regulatory expectations and industry efforts to adapt products and practices.

Cross-System Transitions: What the Evidence Says

What the system looks like—and why it matters

Trustees and insurers operating within this landscape need to understand the ecosystem their members are navigating. The Cross Sector Project mapped Australia's 11 major income-support systems for people with work disability – including employer entitlements, workers' compensation, life insurance in and out of superannuation (including retail TPD/IP policies), social security, Department of Veterans' Affairs (DVA) schemes, Compulsory Third Party (CTP) compensation, and superannuation withdrawals – and the services, rules and pathways attached to them. These systems were designed independently, each with its own legislation, administrators, eligibility tests, benefit durations, evidence requirements and service models. The ecosystem is growing rapidly in both recipient numbers

and expenditure. The 2025 Cross Sector Project update estimates that total expenditure across the 11 personal injury systems increased by around 73% from 2015/16 to 2023/24, driven primarily by more people being supported.⁽¹¹⁾



73% increase

The Cross Sector Project estimates a significant increase in total expenditure across the 11 schemes.⁽¹¹⁾

Vulnerability concentrates demand

For group insurance, this flow-on pressure is not theoretical. Scenario modelling commissioned by EML and conducted by the University of Melbourne indicates that tightening eligibility for mental injury in workers' compensation can materially increase demand on other systems—particularly life insurance IP. In an illustrative scenario where workers' compensation settings across Australian jurisdictions move in the same direction as recent Victorian scheme changes, the model estimates around a 19% increase in IP claim lodgements over a 10-year horizon, with approximately 10 fewer people per week reaching the 130-week workers' compensation claim wage replacement cap by year 10. These results reinforce that scheme-level reforms must be assessed as whole-of-ecosystem changes, not isolated adjustments.⁽¹⁸⁾ This dynamic is not unique: lessons from earlier tort and scheme reforms show that policy changes can expand insurance and increase TPD and IP claim frequency and cost.



Modelling suggests that aligning national workers' compensation settings with recent Victorian changes could drive a roughly **19% increase** in IP claim lodgements over 10 years.⁽¹⁸⁾

This evidence also shows that redirected demand is not evenly distributed. It concentrates among cohorts already facing higher vulnerability, including single parents, people living in socio-economic disadvantage, those outside major cities, and people with prior Centrelink history.⁽²⁵⁾ For trustees and insurers, the implication is clear: reforms earlier in the system can reshape both the volume and complexity of members entering life insurance and superannuation claim pathways.

Why “handover gaps” matter

Monash University research also highlights why boundaries create avoidable harm: systems have been designed separately, service models vary markedly, and there is limited support for people leaving one system and entering another.⁽²⁵⁾ This means the experience of “starting again” is not just administrative—it can disrupt recovery momentum and extend time away from work.



Implications for Trustees and Insurers

If you are a trustee or insurer, the priority is clear: reduce handover harm. But the message is broader and more urgent—your fund may already be under strain from rising mental health claims, and other schemes are tightening eligibility and benefit settings that will reshape the volume and complexity of members entering your portfolio. Trustees and insurers therefore need a forward-looking view of how those decisions will reshape both the volume and complexity of members entering life insurance and superannuation schemes over the next decade.

“People don’t suddenly improve the moment they leave a system - whether that departure is due to time limits, changes in eligibility, or policy reforms. They still need support, and they will often rely on some other system to provide it.”

- Dr Michael Di Donato

Monash University Healthy Working Lives Research Group

Practically, this means:



Designing a “one member journey”, with one accountable case lead (where feasible) so members do not have to “start again” when crossing a scheme boundary.



Standardising warm administrative handovers: transfer core records, decisions and referrals, plus a short plain-English transition plan whenever a member exits or enters a scheme.



Investing earlier in support: providing members with psychological support and vocational advice at first contact rather than after prolonged investigations.



Measuring transitions rather than inferring them: a shared, privacy protected dashboard tracking de-identified movement between schemes, alongside health and return to work outcomes.



Lifting specialist mental health claims capability and service standards: smaller portfolios, trauma-informed communication, and published contact cadence and decision timelines.



Aligning evidence requirements where feasible: use more consistent, evidence-based approaches to capacity assessment.



Standardising warm administration handovers: a practical starting point

- 1 At the start of a claim, funds can ask members whether they have a current or recent claim with another scheme.
- 2 Funds can then seek the member's consent to access relevant information directly.
- 3 With consent in place, funds can act immediately, rather than waiting for members to navigate the information gap themselves.
- 4 This can materially reduce delays and improve the quality of early decision-making.



Investing earlier in support

Evidence supports this shift. EML's early intervention programs—which provide structured psychological and vocational support from the point of claim—have **delivered return to work rates of 38% within six months, compared with 12% for those without equivalent support.** ⁽²⁷⁾

For trustees and insurers considering where to direct resources, this result signals that front-loaded, coordinated intervention can materially improve outcomes while reducing long-tail claim costs.



Lifting specialist mental health claims capability

ASIC Report 806 and AFCA complaints data consistently highlight delays between notification and commencement of support as a key driver of poor claims experience—particularly following a member death or critical incident. ⁽⁶⁾

Trustees should set and publish clear timeframes for acknowledgement, first contact, and commencement of assessment, with accountability measures to ensure they are met.

With reforms ongoing, the question is no longer whether these pressures will intensify, but whether the system will manage them deliberately, fairly, and with recovery in view. Acting earlier and designing for transitions can reduce avoidable harm, improve claim efficiency, and keep more members connected to work and contributing to superannuation and protecting the pooled risk that underpins default cover.



Recovery should be the measure of success: earlier care, clearer navigation, and vocational support can reduce harm and improve outcomes.

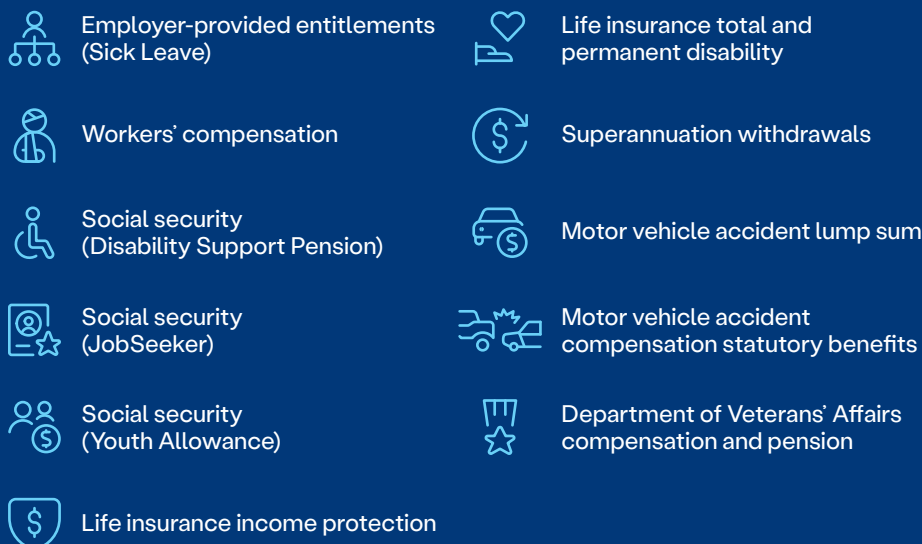
Connection Between Injury and Illness Schemes

Scheme boundaries are where people get stuck. If we want to achieve better outcomes and sustainable premiums, we must redesign the handover—including shared records, clear accountability, and early support—so the experience is seamless from the member’s perspective.

The Injury and Illness Schemes ‘Ecosystem’

The members arriving in your claims portfolio may have already navigated a patchwork of 11 major income support systems. Monash University’s Healthy Working Lives research confirms a practical reality that underlies this design: these systems were designed separately, each with its own legislation, administrators, eligibility tests, benefit durations, evidence requirements, and service models.⁽²⁴⁾ The Productivity Commission has noted that these systems interact in ways that can create spillovers and perverse incentives.⁽²⁰⁾ The result is that the same person with the same need can experience markedly different treatment depending on which scheme they enter—and the boundaries between schemes become a predictable pressure point for delay, duplication, and deterioration.

Australia’s 11 Major Income and Benefit Support Systems⁽⁹⁾

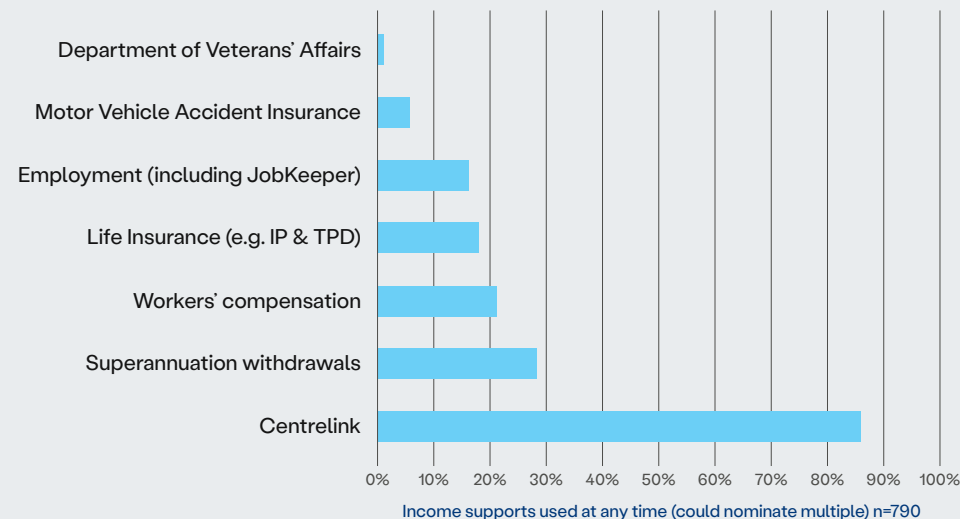


For mental health claims, the biggest risk is often what happens when support changes, narrows, or ends. The underlying need persists—but support and recovery momentum may not.

Personal injury schemes—workers’ compensation, CTP and parts of DVA—are often among the few pathways that can combine income replacement with funded treatment and rehabilitation. But they are also typically time-bound and decision-dependent. For mental health claims, where functional capacity is harder to assess and disputes are more common, the point of exit becomes especially high-risk.

Information is rarely portable, processes are seldom aligned, and people are often forced to repeat forms and retell their story as they move between systems—particularly harmful when recovery is sensitive to stress, delay, and uncertainty. In short, what happens in one system affects what happens next, and for mental health claims, that interaction frequently occurs before recovery has stabilised.

Proportion of Respondents Reporting Accessing Different Income Support Systems at Any Time⁽¹⁷⁾



How the System Connects: Five Mechanisms that Drive Movement

For anyone managing claims within this ecosystem, five recurring mechanisms explain most of the movement between schemes—and most of the avoidable harm that results when transitions go unmanaged.



Eligibility boundaries and dispute/denial pathways

When eligibility is contested, claimants may be pushed into a new system with new application processes and different evidentiary standards. These transitions commonly involve administrative load, inadequate guidance and stressful interactions—raising the burden on people least equipped to manage it.

A disputed decision can become a forced migration—new rules, new forms, new proof.

Time limits and benefit endpoints

Time limits are a direct structural connector: once benefits end, people must go somewhere else. Many workers' compensation schemes cap wage replacement at 104–130 weeks for most workers. In Monash's analysis of workers whose benefits ceased due to the NSW 2012 legislative reform (termed the "Section 39 Group" in the study), around 60% had moved to a social security payment within the following year—approximately two-thirds to JobSeeker and one-third to the Disability Support Pension (DSP).⁽²⁵⁾ Time limits can also change behaviour before benefits end. As an endpoint approaches, claimants and providers often pivot from rehabilitation momentum toward eligibility strategy and evidence gathering, especially if the next scheme uses a different test. That strategic pivot can slow return to work even before benefits end.

Workers Whose Benefits Ceased Under the 2012 NSW Workers' Compensation Legislative Reforms⁽²⁵⁾



Within 12 months of their workers' compensation claim ending, 60% of people with long-duration claims moved to social security payments.

Waiting periods, processing delays and “handover gaps”

Different systems have different processing times and time-to-support pathways. The result is a predictable handover gap: one form of support ends, or is denied, and the next takes time to begin—creating a period of uncertainty at precisely the point support is most needed. Repeated assessments, duplicated evidence requests, and clinicians unfamiliar with scheme-specific paperwork can compound delays, drive avoidable errors, worsen health, and reduce the likelihood of return to work.

Payment adequacy gaps and differing system purpose

Transitions often shift a person from wage replacement toward lower payments, alongside a new administration process. Even where total system expenditure is high, the lived experience at the boundary can be an abrupt step down in income, care access and certainty—factors that can directly undermine recovery. If a person transitions from a treatment-funding system into one that does not fund treatment, the risk of deterioration rises, reducing return to work likelihood and increasing longer-term support need elsewhere.

Differences in who funds treatment and rehabilitation

A final distinction concerns whether schemes fund treatment and rehabilitation or primarily provide income support. That distinction helps explain why some transitions are especially destabilising: the person is not just moving between payment systems, but between different models of recovery support.

This risk is amplified for mental health claims because assessing functional capacity is often iterative and contested. Touchpoints between claimants and decision makers increase, uncertainty persists, and symptoms may worsen as recovery-oriented action stalls. In practice, the boundary can become more than an administrative barrier—it can become a clinical stressor.

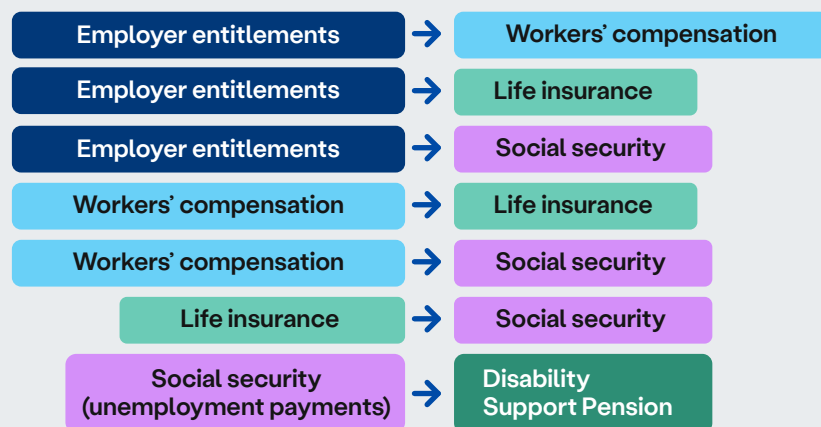
How People Actually Move: Common Pathways and Real-World Drivers

Evidence suggests movement is frequently driven more by health status – especially inability to work – than by formal eligibility thresholds alone. People may engage with multiple systems over time, sometimes concurrently, but structured support during transition is often limited—and it is at these points that harm concentrates.⁽²⁴⁾

Monash identifies the following common transition pathways and defines what “transitioning well” requires:

- Most people return to work, but some navigate multiple systems—especially those with long duration or complex conditions.
- Time away from work matters: the longer a person is out of work, the less likely they are to return—supporting a strong bias toward early, recovery-oriented action.
- Policy and product settings shape movement between systems, including eligibility rules, time limits, and benefit structures, and can unintentionally push people across scheme boundaries.
- Gaps in coverage are common because systems were designed in isolation; some people may be ineligible for support in multiple systems at once.
- People can access multiple systems simultaneously, yet support during transition is often limited—creating predictable pressure points for delay, duplication and worsening outcomes.

Common Transition Pathways⁽²⁵⁾



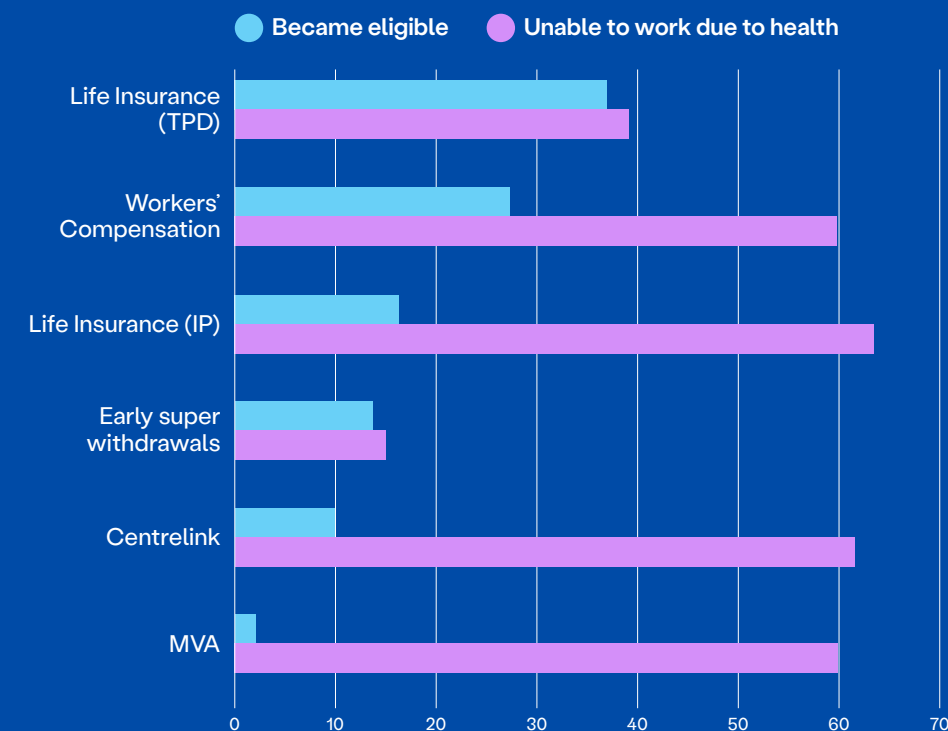
Mental Health is the Dominant Cross-Scheme Pressure Point

Of all the conditions driving movement between these systems, mental health stands out. It is the single largest cause of TPD claims, a growing share of income protection claims, and the condition most likely to involve prolonged transitions, disputed eligibility, and compounding harm.^(13, 25)

Flow-on effects: tightening one scheme can increase pressure on others

The interconnection between schemes means that policy and administrative changes in one scheme can shift volume and cost into others, even when the underlying health burden has not changed.

Main Reason for Moving to System (%)⁽¹⁷⁾



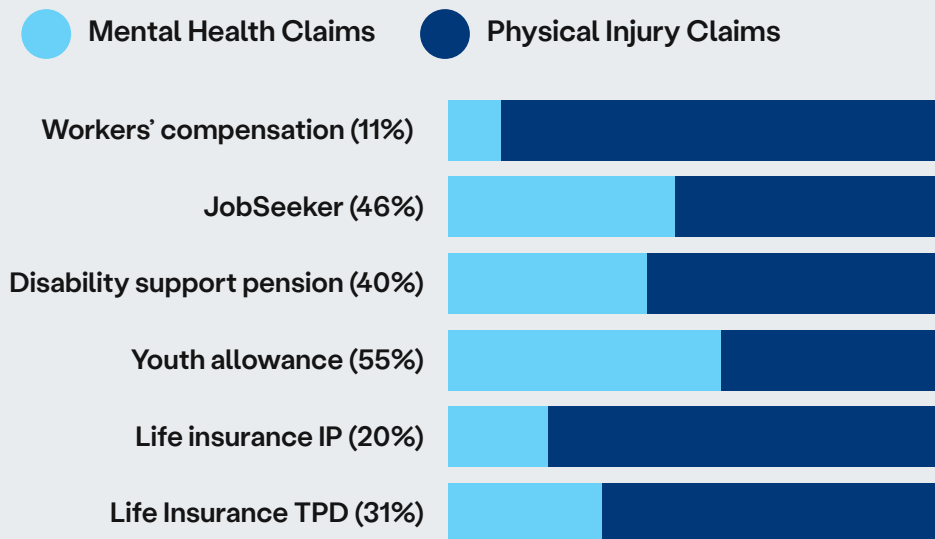
Main reason for moving to an income support system. Respondents had a greater focus on their health impacting their ability to work than meeting eligibility requirements across the income support systems.

“What matters is not only how people move between systems, but the condition they are in when they arrive - often after administrative hurdles, delays or time-limit exits, and in a state of heightened financial uncertainty or vulnerability.”

- Dr Michael Di Donato
Monash University Healthy Working Lives Research Group

Analysis by the Australian Institute of Health and Welfare (AIHW), drawing on the latest Australian Bureau of Statistics (ABS) *National Study of Mental Health and Wellbeing*, estimates that about 1 in 5 Australians experience a mental disorder in any year. It also estimates \$11.9 billion in health system expenditure on mental health and substance use in 2022-23 (around 7% of all disease spending).⁽⁴⁾

Mental Health “Share” in Systems ⁽¹¹⁾



Further analysis by the Council of Australian Life Insurers (CALI) reveals a consistently high mental health “share” across several systems.

Notably, inter-system comparisons require careful interpretation, as the reported mental health share varies by system given that entry requirements and coding practices differ. Even so, Monash notes mental health claim proportions in life insurance (IP/TPD) appear two to three times greater than in workers' compensation.⁽¹¹⁾

Life insurers are a major non-government funder. In 2018, they paid more than \$4.4 billion to 26,150 Australians not expected to return to work, including \$337 million for mental health-related TPD claims.⁽²¹⁾ By 2019, mental health comprised around 20% of income protection claims paid and had become the leading cause of TPD claims (around one in four TPD claims).⁽²¹⁾ In 2023/24, CALI estimates indicate that life insurance income protection supported 32,766 recipients at an estimated cost of \$4.3 billion, while life insurance TPD supported 22,089 recipients at an estimated cost of \$4 billion.⁽²⁵⁾

For funds and insurers, the signal is as much operational as financial: claimants increasingly arrive after difficult pathways through other schemes, bringing greater complexity from the outset.



Mental health is the standout condition driving system movement.^(13,25)



Mental health claims in life insurance are two to three times higher than in workers' compensation.⁽¹¹⁾

Growth, Churn and Cost Concentration Across the System

The ecosystem is large—and uneven

Total expenditure across the 11 systems has grown sharply over time. Monash's 2023/24 update highlights this trend: total ecosystem expenditure, expressed in 2023/24 dollars, increased by around 73% from 2015/16 to 2023/24. Per-person support remained relatively stable, but the total number of recipients unable to work due to illness, injury or disability increased by 7.2%. ⁽²⁵⁾

Expenditure Comparison: 2015/16 vs 2023/24 ⁽¹¹⁾

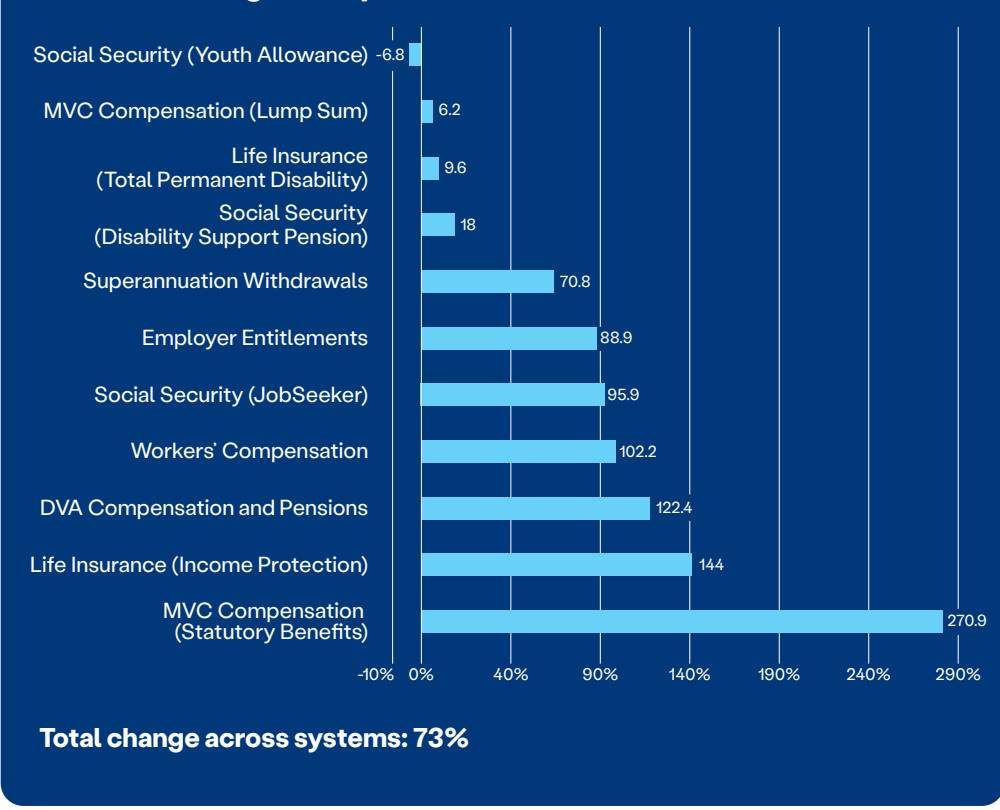
	Average Expenditure (\$)		Total Expenditure (\$M)	
	2015/16	2023/24	2015/16	2023/24
Employer Entitlements	\$3,490	\$5,757	\$22,844.8	\$43,160.8
Workers' Compensation	\$34,837	\$33,778	\$3,061.8	\$6,192.3
MVC Compensation (Statutory Benefits)	\$15,156	\$10,512	\$88.8	\$336.6
MVC Compensation (Lump Sum)	\$123,189	\$110,409	\$513	\$544.6
Life Insurance (IP)	\$27,105	\$110,409	\$1,762.2	\$4,300
Life Insurance (TPD)	\$122,774	\$395,375	\$3,649	\$4,000
Social Security (DSP)	\$26,390	\$26,709	\$7,452.1	\$8,796.9
Social Security (JobSeeker)	\$16,514	\$16,959	\$2,790.1	\$5,466.9
Social Security (Youth Allowance [Other])	\$12,933	\$11,250	\$124.8	\$116.3
DVA Compensation	\$33,079	\$35,415	\$585.8	\$1,302.8
Superannuation Withdrawals	\$100,582	\$90,733	\$2,715.7	\$4,639

Life insurance income protection now carries the highest per-person cost of any scheme—a direct consequence of receiving the most complex, long-duration cases that other schemes have been unable to resolve. For insurers and trustees pricing and managing these products, this is not a trend to monitor—it is a cost reality already embedded in their portfolios.

Where volume sits vs where the cost sits

One of the clearest signals is the mismatch between recipient rates and expenditure in some systems—particularly life insurance income protection. If recipient rates decline while expenditure rises, it typically implies rising cost intensity per claimant: longer duration, greater complexity, higher average paid amounts, or cost escalation in service and administration. Notably, life insurance income protection recipient rates fell from 4.1 to 1.91 per 1,000 workers between 2015/16 and 2023/24, while expenditure rose to \$4.3 billion—the highest average expenditure per person of any scheme. ⁽²⁵⁾

Percent Change in Expenditure from 2015/16 to 2023/24 ⁽¹¹⁾



This is the defining paradox of the system: as fewer people receive support, each case becomes more complex, more entrenched, and more expensive—because the people who reach life insurance are often those who have already exhausted every other option.

Movement is shaped by rules, timing, and claim decisions

Movement through the ecosystem is highly individualised, shaped by factors such as the nature of the condition, eligibility thresholds, employment status, access to treatment, and financial buffers. ⁽¹¹⁾ Understanding “time” in recovery and return to work is critically important. As a health condition becomes chronic and time away from work increases, the likelihood of returning to work declines, regardless of personal motivation. ⁽¹¹⁾

The University of Melbourne notes that the most likely points of movement out of workers’ compensation are not long-duration endpoints, but decision points—particularly claim denial—with reliance then shifting to social security schemes and life insurance IP and TPD. A core limitation remains: reported data often does not capture transition rates cleanly, making it difficult to quantify exactly what proportion moves from one scheme to another within a given timeframe. ⁽¹⁸⁾

When timing and process diverge, the handover itself becomes a risk point

There are also significant differences in claim handling and processing times, and these differences have stark human consequences. ⁽¹¹⁾ The result is predictable: weeks or months of uncertainty, duplicated evidence requests, financial stress, and weakened recovery momentum at exactly the point support is most needed.

Future Implications

To help trustees, insurers, and policymakers anticipate where pressure will build next, researchers from the University of Melbourne and Monash University developed a national systems dynamics model of Australia’s complex income support landscape, tracking how people move across scheme pathways. ⁽⁸⁾ The model enables ‘what if’ scenarios to be tested, and ripple effects to be traced across the wider income support ecosystem. ⁽¹⁸⁾

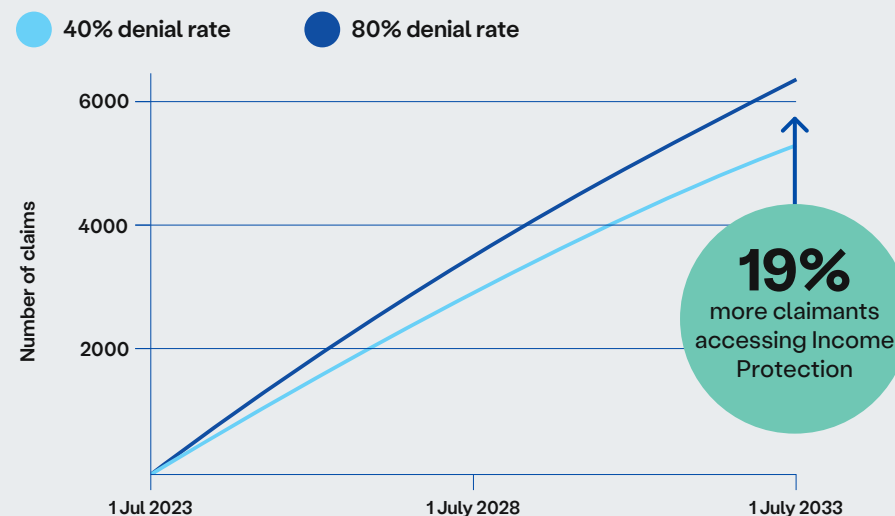
For this white paper, EML commissioned the University of Melbourne to model the impact of this kind of flow-on effect. The model’s Victorian scheme parameters were updated to reflect changes introduced through the Scheme Modernisation Act 2024, including revised eligibility criteria for mental injury claims and a new requirement for workers to demonstrate entitlement to weekly payments beyond 130 weeks.

Under a tightening scenario, reflecting changes to psychological injury denial rates (40% versus 80%) within the Victorian workers’ compensation scheme, the analysis indicates:

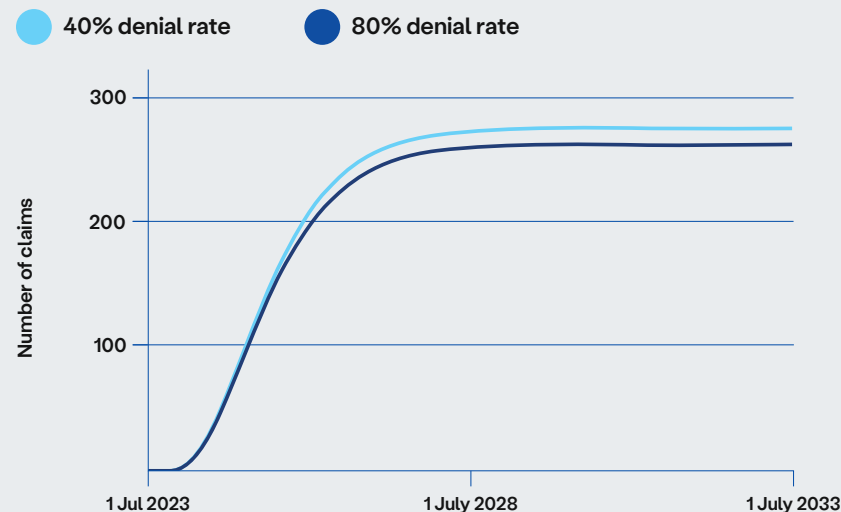
- **around a 19% increase in IP claim lodgements over a 10-year period;** and
- approximately 10 fewer people per week reaching the 130-week workers’ compensation duration cut-off by the end of the 10th year. ⁽¹⁸⁾

If similar changes were implemented across other Australian workers’ compensation schemes, comparable system-wide impacts could be expected over the next decade, subject to jurisdiction-specific scheme design and claimant behaviour.

Modelled Impact on Life Insurance Claims Rates ⁽¹⁸⁾



Number of Claims in Scheme at 130 Weeks ⁽¹⁸⁾



“If the support systems are connected in practice, they are best to be measured as connected systems: a cross-scheme view is essential to understanding where demand shifts, where delays occur, and where harm concentrates.”

- Jason Thompson

Professor of Mental Health System Reform, The University of Melbourne

Even where the precise magnitudes are uncertain, the direction of effect is the core point: systems are coupled. Tightening access in one place tends to redistribute demand, not eliminate it. The same research identifies risk factors associated with vulnerability and reduced resilience—for example, single parents, those experiencing socio-economic disadvantage, those living outside major cities, and those with prior Centrelink history.⁽²⁵⁾

Why This Matters for Insurance and Superannuation

Mental health conditions have moved to the forefront of Australia's current and emerging insurance and superannuation pressures. In any given year, about 20% of Australians experience a mental illness, and the national economic cost of mental ill-health is estimated to be up to \$220 billion annually.⁽²⁰⁾

Those human and economic costs are now translating directly into insurance claims. Mental illness is now the single largest cause of TPD claims and represents roughly one in three TPD payouts and about 20% of IP claims.⁽¹³⁾ The trajectory is steep: life insurers paid over \$2.2 billion in mental health-related claims in 2024, almost double the amount five years earlier, with \$887 million of that attributed to income protection alone.⁽¹³⁾

This rise is especially pronounced among younger adults. TPD mental health claims for people in their 30s have increased 732% over the past decade, pointing to more Australians leaving the workforce early because of psychological injury.

⁽¹³⁾ In some cases, people are being pushed toward products and pathways that recognise permanent incapacity more readily than recovery potential.⁽¹³⁾ This suggests traditional product design is poorly suited to the nature of many mental health conditions.⁽¹³⁾

For trustees and insurers, it is important to recognise that this is not contained within your fund. It sits within a broader income support ecosystem in which your members move between systems, but their support and information often do not move with them.

The pressure is visible across multiple cover types and pathways within superannuation:



TPD in super: Most super funds provide default TPD cover as a last resort for people who can no longer work. Mental health now dominates these claims, yet the claims process is often protracted. APRA-reported timeframes indicate **TPD claims in super** average nearly four months, and approximately 18% stretch beyond six months.⁽²⁾



IP: Mental illness accounts for about 20% of IP claims.⁽¹³⁾ These claims often involve longer work absence and more complex recovery needs. Without effective support, claimants may relapse or progress to permanent disability, compounding costs for both insurers and members.



Death cover: While death claims are less frequently attributed directly to mental ill-health, the indirect impact is real. **Mental health conditions, including severe depression or PTSD, can increase mortality risk**, and each case is a reminder of the ultimate cost of delayed or inadequate intervention.



Early release of superannuation benefits: Australian Taxation Office (ATO) data indicate **rising approvals for compassionate release of super for acute or chronic mental illness**. In some cases, people who do not meet the criteria for insurance payouts turn to retirement savings to cover treatment costs or make ends meet, undermining long-term retirement security.⁽⁷⁾

Taken together, these trends mean mental health is now a material strategic risk for Australia's insurance and superannuation systems. Beyond the human toll, APRA has warned that, if unaddressed, rising mental health claims could undermine the viability of group insurance in superannuation.⁽¹⁾ Some funds have already faced significant premium increases to offset worsening claims experience. The pooling principle of insurance is being tested as mental health claims skew higher among some groups, including younger members, and challenge traditional product definitions.

ASIC has also spotlighted fairness risks. It noted mental health claims are five times more likely to be declined under ADL tests compared with other claims.⁽⁵⁾ In a 2023 review, ASIC found three in four mental health TPD claims assessed under strict ADL criteria were denied.⁽⁵⁾ This has prompted regulators to urge insurers and trustees to review claims practices to ensure decisions are fair, consistent, and evidence based.



Consequences for Stakeholders—and the Urgency to Act

The confluence of these trends is already creating tangible consequences for your members, your fund, and the wider system:



For Individuals and Members

The personal consequences are often severe. Younger workers may exit employment early, ⁽¹³⁾ losing not only income but years of super contributions. People making claims often face drawn-out assessments, and burdensome proof requirements, and unsupported transitions at exactly the point they are most vulnerable. Consumer advocates warn that poor claims handling can worsen mental health and create a vicious cycle, ⁽²⁶⁾ while cross-system transitions can compound distress rather than support recovery. ⁽²⁵⁾



For Insurers and Super Funds

Rising mental health claims affect costs, pricing, and product design, member experience, and reputation. If this trajectory continues, insurers will need to raise premiums or tighten terms, which can make default group cover less affordable or less generous for members. At the same time, funds that improve mental health support can strengthen trust and engagement, turning insurance from a source of added stress into a service that actively supports recovery.



For the Wider System and Society

At a system level, the current trajectory is unsustainable, resulting in:

- **Premium erosion:** If rising claims are not matched by earlier intervention and better recovery pathways, premium increases ultimately impact all members. In a worst case scenario, some higher-risk occupation cohorts or younger members might find default cover priced out of reach, undermining the mutualism of group insurance.

- **Coverage gaps:** Many mental health-related claims are denied or abandoned due to process friction. Those people don't just disappear; they often end up on government supports or in public healthcare, shifting cost to taxpayers.
- **Workplace productivity:** The insurance system's struggles reflect broader workplace pressures. This signals a need for employers to engage more actively in prevention and to build capability in handling workplace tensions and disputes earlier.

The conclusion is inescapable: mental health is no longer a peripheral issue. It sits at the centre of fairness, affordability, and sustainability in insurance and superannuation.

Part of this challenge is structural. The sustained industry-wide drive to reduce administration fees—driven by competition for members, pressure on costs, and the broader push for value in superannuation—has compressed the resources available for claims management. Yet mental health claims demand the opposite: specialist capability, longer handling times, trauma-informed communication, and coordinated support across multiple providers. When these functions are under-resourced in the pursuit of cost efficiency, the predictable result is slower decisions, higher dispute rates, and a claims experience that compounds rather than alleviates member distress. For trustees, this is a tension that must be confronted directly. The cost of a well-resourced claims function is not an overhead to minimise—it is an investment in the member outcomes that underpin trust, retention, and the long-term sustainability of default cover.

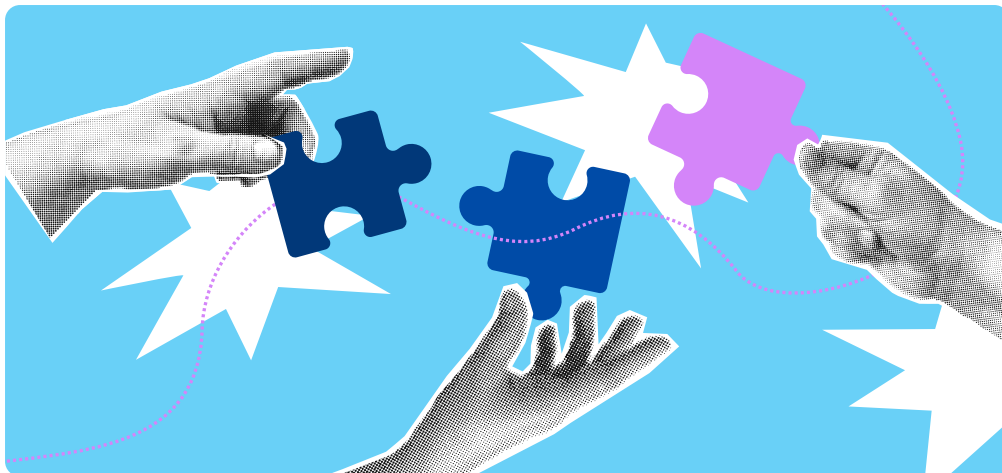
What This Means for Trustees and Insurers

The practical consequence for your fund is direct: reforms in one part of the system are already reshaping the claim mix arriving in yours. A growing share of your future life and super claimants may arrive after disputes, denials, ineligibility decisions, or time-limit exits in another scheme—bringing psychosocial, clinical, and administrative complexity from the outset.

For superannuation, the implication is twofold. First, more members may enter life insurance and superannuation after a difficult pathway through another scheme, increasing complexity at the point of claim. Second, if transitions are poorly managed, deterioration during handover gaps can increase time away from work, interrupt contributions, push people toward permanent exit-pathways, and worsen outcomes and costs for members and funds.

For superannuation funds, this is also a sustainability issue. When members are out of work for extended periods, superannuation contributions are interrupted, so helping manage claim outcomes and supporting return to work also supports long-term fund sustainability.

The next section responds to that problem: how to reduce fragmentation, shorten time to support, and improve recovery and return to work—without simply shifting cost and complexity elsewhere.



Industry Recommendations: A Phased Response

Mental health is now central to the fairness and sustainability of insurance in super. If we want to keep pooled cover affordable and trusted, we must lift claims practice, share evidence across schemes, and judge success by outcomes—health and return to work—not just payouts.

The following recommendations are designed to help you act—whether you are a trustee, insurer, employer, or policymaker. The short-term actions reduce handover harm now, the medium-term actions build the systems and products that make recovery the default, and the long-term actions create the data infrastructure and policy architecture that make improvement measurable and sustained. Together, they respond directly to the central finding of this paper: people move between systems, but support often does not move with them. The practical task is to reduce fragmentation, strengthen transitions, and improve health and work outcomes.



Short-Term Actions (Next 1–2 Years)



Enhance Claims Management and Member Support

This is the action most directly within your control: immediately make mental health claims handling more recovery-oriented, trauma-informed, and compassionate.

Insurers and super funds should train claims teams in mental health awareness and, where feasible, assign each claimant a dedicated case manager. Using plain language, setting clear expectations, and proactively communicating next steps can reduce confusion, delay and complaints. A simple minimum standard should be adopted across funds and insurers: covering response timeframes, the timing and clarity of evidence requests, proactive check-ins, and escalation pathways for vulnerable claimants, including financial hardship flags. These common definitions and minimum standards would also support more consistent data collection and transparency. They should be treated as a capability and cultural uplift, not merely a process change: teams need technical depth, trauma-informed communication, shared decision making, and clear next step discipline. Regular case conferencing, coaching, and access to specialist advice should be part of the operating model.

Make claims handling recovery-oriented and compassionate; measure success by health and work outcomes.



Improve Education and Navigation Across Systems

Government, regulators, and peak bodies should lead this action, with life insurers and super funds as active contributors: Make the system easier to understand before people reach crisis point.

In the short term, stakeholders can develop a one-stop online resource and helpline that clearly explains the main support pathways—from workers' compensation

Opportunities to Improve the Experience



Education and awareness

Public awareness on the different income supports available and better education on how to access them as soon as health impacts a person's ability to work.



Common use of language

Common language across all systems to better support individuals to understand their entitlements and complete the required documentation.



Administrative handover between systems

Individuals are provided their personal file of relevant information upon exiting the system.



System design

Systems to streamline application processes to reduce physical and psychological burden. More frequent touch points with individuals are required to communicate the progress of the application.



Future planning

Systems to provide better education and upfront planning to assist individuals to identify where their best outcome is likely to be.



Extend case management function

Individuals would benefit from case managers having a more holistic view of the various systems of income support and how they operate. Ensuring individuals are accessing the most appropriate service of income support available to them.

and disability insurance in superannuation to social security benefits—and how to access them. This could be accompanied by a public awareness campaign and a minimum initial claims standard across funds and insurers, including simplified standard forms and consistent digital authority pathways, including e-signature and electronic ID verification. Member-facing communications should map common pathways and decision points, use a shared plain-language glossary, and build “future planning” prompts into communications before benefit cessation or major decisions, so people know what happens next and what documents and support they may need.



Facilitate Smooth Transitions Between Schemes

Each scheme administrator and trustee should embed this into existing case management frameworks: establish warm handover protocols so people do not have to “start again” each time they cross a scheme boundary.

If a workers' compensation claim is ending or disputed, there should be a structured process to connect that person with their superannuation insurer or other relevant support. The same problem can arise within a super fund when a member moves from income protection to TPD. In operational terms, that means providing everyone with their personal file, a clear referral to the next safety net, and designated liaison officers who can assist with applications and continuity. Using existing structures, these handovers can be improved quickly through industry agreements or multi-agency working groups. Transition support should follow a consistent design standard drawn from the Monash evidence: flexible timing, participant-led planning, practical help with applications and appointments, tailored service intensity, and financial counselling where income changes are likely.



Initiate Early Intervention Pilot Programs

Life insurers and super funds should fund and evaluate these pilots, in partnership with health providers: do not wait for legislative reform before testing earlier support.

In this context, early intervention means providing structured psychological and vocational support from the point a claim is lodged—not after liability is determined or a member's condition has become entrenched. In practice, this includes timely access to counselling or clinical triage, a dedicated case manager with mental health expertise, coordinated communication across the fund, insurer, treating practitioners, and employer, and practical support such as vocational guidance or financial counselling. What distinguishes effective early intervention from standard claims processing is not speed alone, but the quality, coordination, and continuity of the support provided. Insurers and super funds should pilot programs that provide help before a claim becomes a crisis. This could include

offering pre-claim support through partnerships with low-intensity digital mental health services like Beyond Blue's NewAccess coaching program or extending Employee Assistance Program-style support to insurance members. Likewise, life insurers can emulate innovative practices from some workers' compensation schemes by funding up to six months of "provisional liability" psychological therapy for people reporting mental health issues while their claim is still being assessed. These short-term pilots can test whether earlier support reduces deterioration during the claims process and improves recovery outcomes, while building the evidence base for broader adoption and regulatory support. Evidence from EML's own portfolio supports this direction: participants in structured early intervention programs returned to work within six months at a rate 247% higher compared to non-participants—a difference that points to the scale of opportunity available when support begins before functional decline becomes entrenched.



Participants in structured early intervention programs returned to work within six months at a rate **247% higher** compared to non-participants.



Strengthen Data Collection and Transparency

Industry bodies (FSC, the Association of Superannuation Funds of Australia (ASFA)) and regulators (APRA, ASIC) should convene this effort, with insurers and funds committing data. The goal is to capture and share key data on mental health claims across the industry to inform decision makers.

In the short term, insurers and superannuation trustees should agree on core metrics—such as claim incidence, average claim duration, denial and dispute rates, time to first contact, time to support, time to treatment, and return to work outcomes—and publish them regularly. They should include transition metrics aligned to Monash's findings, including benefit cessation and exits due to time limits, source and destination scheme, handover gaps, and post-transition health, function, and work outcomes. Existing data sharing collaborations, such as the FSC/KPMG mental health claims data project already underway, should be expanded to include inter-scheme insights, helping illuminate how people move between systems and where interventions are most needed. Improved transparency in the short run will lay the groundwork for more sophisticated data initiatives later.



Case Study

A practical proof point is EML's re-engagement supports. EML's career transition programs target injured workers with psychological injuries and long duration claims who still have some assessed work capacity but have not yet returned to work. The programs pair participants with a facilitator who works on transferable skills, resumes, job applications and interview practice, while moving at a pace matched to readiness and health milestones. For a cohort of injured workers in the Comcare scheme, the evaluation reported improved self-efficacy and psychological distress outcomes,

and 38% of participants achieved a return to work outcome within six months, compared with 12% of non-participants.⁽²⁷⁾

EML's broader programs add two practical elements that are relevant to life insurance/superannuation. Its Care Coordination Program is a free, voluntary service generally delivered over 6 to 12 weeks, connecting people to supports such as financial counselling, mental health and wellbeing services, housing support, job seeking support and other community services through a tailored plan based on individual circumstances.

Its career transition support/career management services add more explicit work-focused assistance: career assessment and coaching, clarifying job goals and transferrable skills, planning, resume and application support, and interview preparation. Together, these EML programs suggest that the immediate opportunity for life insurance/superannuation is not only early treatment but coordinated navigation and tailored work-focused transition support that helps members re-engage before they deteriorate further or disengage from work altogether.



Medium-Term Actions (2–5 Years)



Standardise Processes and Definitions Across Schemes

Work toward harmonising the way different systems handle mental health-related claims.

Reduce avoidable complexity by standardising what can be standardised. Regulators and industry bodies should develop common standards for critical processes—such as core claim forms, standard authority pathways, and simplified certification requirements—so claimants, clinicians, employers, and claims teams are not forced to navigate entirely different administrative languages and formats in each scheme.



Align Evidence Requirements and Work Capacity Assessments Across Schemes

Where feasible, schemes should move toward shared, evidence-based approaches to work capacity and mental health assessment.

Monash's research shows that when one system tightens in isolation, demand shifts elsewhere and handover harm rises.⁽²⁵⁾ Aligning definitions, assessment logic, and evidence requirements across schemes is therefore a practical way to reduce duplication, contradictory requirements, avoidable disputes, and setbacks when members move across scheme boundaries. The goal is not to erase scheme differences, but to reduce unnecessary reassessment and inconsistent demands.



Expand Cross-Scheme Case Management and Transition Support

Building on short-term measures, transition support should be formalised rather than improvised.

By years two to five, there should be either a dedicated case management service spanning multiple schemes or a clearly defined “one accountable case lead” model with shared protocols. This could involve joint case manager roles or inter-agency teams that follow high risk cases across boundaries, partnered information sharing, and coordinated navigation, clinical, vocational, and financial support. Priority should be given to cohorts where Monash identifies that transitions concentrate risk.⁽²⁵⁾ These indicators can be used for proactive triage, so support is offered earlier, before people decline or disengage from work.



High-risk cases need **one accountable case lead across schemes**, with shared protocols and earlier, proactive support.



Reform Insurance Product Design to Encourage Recovery

Product settings should support recovery pathways, not simply confirm permanent exit.

Trustees and insurers, with APRA's guidance, should test more flexible mental health benefit structures, such as default short term income protection benefits or staged payments that support the person through treatment and gradual re-entry to work, rather than relying primarily on large lump-sum TPD outcomes. Industry analysis suggests that roughly one third of current default cover could be reallocated to more appropriate income support and rehabilitation benefits without increasing costs.⁽¹⁴⁾ Any such reforms should be evidence based and introduced carefully, with regulators and insurers collaborating to ensure pricing remains sustainable and members' interests are protected. Product features should also be tested for navigability and administrative burden, so supportive design does not create new barriers in practice. Monash's “time away from work” finding should be a design test: longer duration and longer handover gaps are strong predictors of non-return,⁽⁹⁾ so benefits should pull support forward and reward re-engagement and graduated return to work.



Enable Funding of Mental Health Treatments by Insurers

If your fund or insurer operates in a jurisdiction that permits it, this is an opportunity to fund evidence-based treatment and support earlier—before a member's condition deteriorates to the point of permanent exit.

The Productivity Commission has recommended that life insurers be permitted, on a carefully managed basis, to pay for mental health treatments for claimants to improve outcomes.⁽²²⁾ In the next two to five years, governments should act on this recommendation by amending the Life Insurance Act and related laws or guidance so insurers can invest in evidence-based treatments without fear of breaching insurance regulations. With appropriate safeguards, this would allow earlier intervention, potentially reduce long-run claim costs, and help people access timely support rather than waiting until their condition deteriorates enough to meet a benefit threshold. Before scaling this approach, governments, funds and insurers should also ensure superannuation funds can practically manage rehabilitation and

Recommendations in the Development of Future Transition Support Programs ⁽⁸⁾



Be flexible with timing

Participants indicated the best timing for the service was in the final stages of workers' compensation wage replacement, as part of service delivery. It should be identified if the proposed timing of the service suits the individual's circumstances.



Listen to the participant's story

Transition Specialists should have the opportunity to listen to the participant's story. All participants reported that they appreciated having someone to talk to, who would listen and follow up to check in on progress.



Provide practical support

Participants described a desire for practical help, such as assistance with Centrelink applications and help to find suitable employment.



Support for the Transition Specialist

Transition Specialists should receive support and opportunities to debrief to ensure they can conduct the role without elevated risk to their own health. Transition specific communication training should be provided.



Financial counselling

Participants nominated financial counselling as a service that would be helpful in the lead-up to transition.



Local knowledge

Transition Specialists should be equipped with local knowledge where possible.



Tailor the service

Participants described a wide variety of challenges they were dealing with in the lead up to transition. Providing services tailored to participants' needs, rather than offering the same services to all participants, maximises benefits for all participants.



Data

Future programs should involve routine data collection to effectively monitor participant outcomes. For evaluation purposes, an appropriate comparison group should be recruited to maximise the confidence in the demonstrated effects of the service.

treatment supports, drawing on lessons from existing insurer rehabilitation support models. By legitimising and encouraging a more active role for insurers in recovery, policy can unlock innovative approaches to mental health care that benefit individuals and the system.

Design benefits to encourage recovery—not permanent exit.



Boost Employer Engagement and Workplace Mental Health Initiatives

Strengthen the connection between insurance, workplaces, and early recovery.

Insurers and superannuation funds should work more closely with employers to build mentally healthier workplaces, support earlier action on psychosocial risks, and design better return to work pathways before claims become long-duration or cross-scheme. This could include providing tools and guidance on managing psychosocial risks and workplace conflict, recognising that earlier employer action can prevent distress from escalating and help people stay connected to work. Employers and insurers can co-design graduated return to work plans that anticipate decision points and benefit cliffs, reducing deterioration during handover periods. Where return to the pre-injury role is not viable, warm referral to employment services should be treated as a standard pathway rather than an exception. Governments and industry can also explore incentive schemes that reward good practice: premium discounts or recognition for employers that implement effective mental health programs and demonstrate lower injury rates. Regular knowledge sharing forums should be in place where insurers, employers and healthcare professionals exchange best practices. These efforts will not only improve outcomes for individuals but also reduce claim incidence over time by addressing problems at their source.



If super funds fail to lead on recovery-focused claims and health collaboration, rising mental health claims risk eroding both affordability and member trust.



Long-Term Actions (5+ Years)

Drive Systemic Integration and Equity



The long-term objective should be a more integrated and equitable system in which support is shaped by need, not by administrative boundaries.

Policymakers, in collaboration with industry, should explore reforms to link or harmonise Australia's various schemes into a cohesive safety net, or at least a more consistent framework for assessing and supporting work incapacity due to mental health. This would mean that, regardless of whether a person's condition is work-related or not, they could access more comparable supports and rehabilitation pathways. While ambitious, this direction is consistent with the purpose of insurance and superannuation: to protect and support individuals over the long term and ensure fewer people fall through the gaps of an overly fragmented system.

Without greater alignment across Australia's income protection and work incapacity schemes, people's mental health needs don't disappear—they are too often left unsupported in a fragmented system.

Build a Shared Data Ecosystem to Underpin Continuous Improvement



Trustees, insurers, and regulators should collaborate to build a privacy-conscious claims data ecosystem that links your claims data with health and employment outcomes across schemes—giving you the evidence base to target interventions where they will have the greatest impact.

This should support both research and routine performance improvement. It would enable policymakers and industry to answer practical questions: which early interventions yield the best return to work results, what factors predict long-term disability, and where people are most likely to become stuck during transitions.

Advanced analytics can be used to proactively identify trends, such as physical injury claims that often lead to secondary mental health issues, so that preventative steps can be taken earlier. By around the five-year mark, the industry should be able to publish an annual Mental Health Insurance Outcomes Report tracking claim incidence, duration, time to contact, time to support, transitions between schemes, and post-claim health and work outcomes. Once linked data exists, a shared measurement framework and benchmarking discipline should become standard, so performance can be compared consistently across insurers, trustees and relevant agencies, and improvement efforts can be targeted where they matter most.



Embed Mental Health as a Core Business Priority

Culturally, insurers and superannuation funds must treat mental health as a permanent strategic focus rather than a temporary claims issue.

That means leadership from the top—boards and CEOs setting objectives, dedicating resources, and measuring success not only by financial metrics but by recovery, return to work, and member wellbeing. Over time, the sector should move toward a culture in which collaborating with healthcare providers and recovery supports is part of normal insurance practice. Conversely, if stakeholders neglect this issue, rising claims and eroding trust could threaten the system itself.



Forge Ongoing Preventive Partnerships

Over time, the sector should move further into prevention and population-level mental wellbeing.

Insurers and super funds should work with employers, healthcare providers, and community organisations to promote mental wellbeing and prevent illnesses from escalating. That could involve supporting public initiatives that improve access to mental health care and addressing social determinants such as financial stress. Super funds can also use their influence as major investors by encouraging stronger workplace mental health policies. Such partnerships may sit beyond the traditional claims function, but they are consistent with the long-term purpose of insurance and superannuation: protecting the wellbeing of members and helping create a healthier workforce and community—and, in doing so, building a more resilient system over time.

Taken together, these actions form a coordinated roadmap. The short-term actions improve claim experience and plug the most immediate gaps. The medium-term actions reshape operating models, product settings, and transition support. The long-term actions build the data, policy, and partnership architecture for a more integrated and preventative system.

If these recommendations are acted on, the sector can do more than process rising claims—it can reduce avoidable harm, support recovery earlier, keep more people connected to work, and better protect the affordability and purpose of default cover.



Conclusion

Australia's insurance in super is being reshaped by mental health. The challenge is no longer diagnosis alone, but whether the system can respond in ways that are fair, sustainable and recovery oriented.

Research by Monash University and the University of Melbourne warns against siloed reform: when one scheme tightens, need does not disappear—it shifts, often into life insurance in superannuation. The task now is execution: reduce handover harm, act earlier, and measure success through recovery and return to work outcomes.

A system at a crossroads—and mental health is now central to sustainability

The evidence in this paper points to a clear conclusion: mental health is no longer a peripheral claims issue. It is now central to sustainability, affordability and fairness in insurance and superannuation. It influences claim volumes and durations, member experience, premium pressure and the viability of default cover—and those pressures do not remain contained within a single scheme.

That means incremental improvement within individual silos will not be enough. A more sustainable response will require three foundational shifts:

- Acting earlier and more deliberately at the first sign of transition between schemes.
- Redesigning handovers, products and data systems to support continuity rather than reinforce fragmentation.
- Measuring success through recovery and return to work outcomes, not just claim closure rates.

When schemes tighten in isolation, the burden shifts—it doesn't disappear

Reforms pursued in isolation can redistribute cost and complexity rather than resolve them. When access is restricted or benefits are time-limited in workers' compensation, the common pattern is fewer people entering or remaining in that scheme and more people moving into other forms of support, including social security and life insurance through superannuation.

The flow-on effect is not theoretical. University of Melbourne scenario modelling demonstrates that tightening eligibility in workers' compensation can materially reshape demand elsewhere in the system, generating a significant increase in income protection claim lodgements. The point is not that every jurisdiction will replicate any one reform exactly, but that the effects are real, measurable, and concentrated in life insurance and social security pathways.

The roadmap is clear—the test is execution

A growing share of future life/super claimants may arrive after disputes, ineligibility decisions or time-limit exits in another scheme, bringing higher psychosocial, clinical and administrative complexity from the outset.

The recommendations in this paper are not for insurers to act on alone. Super fund trustees, insurers, regulators, healthcare professionals, and policymakers each have a role to play in building a more coordinated, recovery-oriented, person-centred system.

The prize—and the risk

The payoff for decisive action is significant: a more resilient community, better protection for members' retirement outcomes, and a sustainable insurance system that upholds its promise. The risk of inaction is equally clear: pressure continues to build, people deteriorate in transition, and costs are displaced rather than reduced.

If stakeholders act now to reduce handover harm, support recovery earlier, and measure what matters across scheme boundaries, the sector can deliver a fairer, more trustworthy, and more sustainable response to mental health. If it does not, fragmentation, delay, and cost-shifting will deepen. The choice is no longer whether to respond, but how deliberately and how quickly.

EML works with trustees, insurers and employers across Australia to support more coordinated, recovery-oriented responses to mental health claims. Our experience managing complex claims across multiple schemes—and our investment in early intervention, biopsychosocial profiling, and employer engagement—gives us practical insight into how you can move from acknowledgement to execution. If this paper has identified a gap worth closing in your fund, we would welcome the conversation.

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