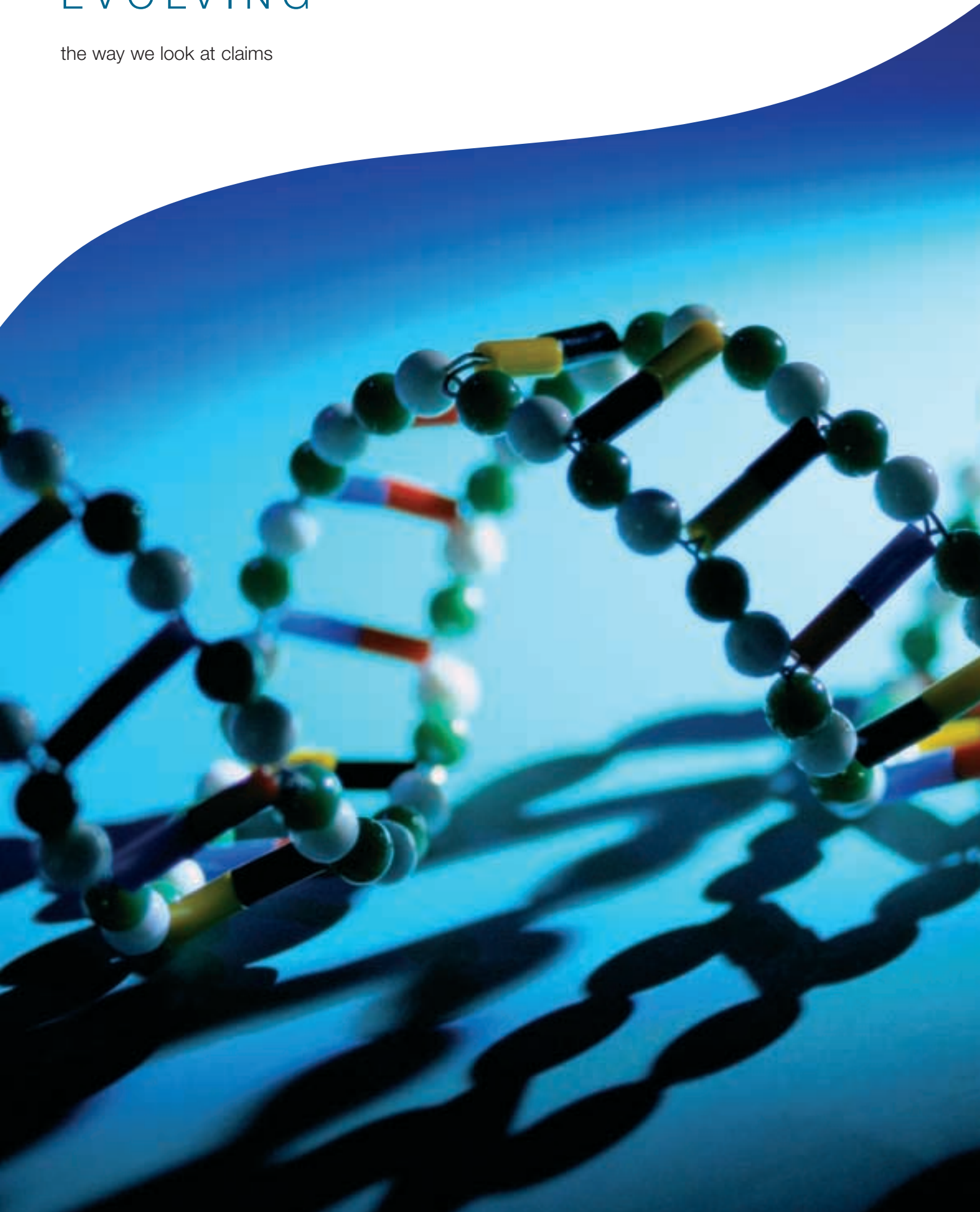


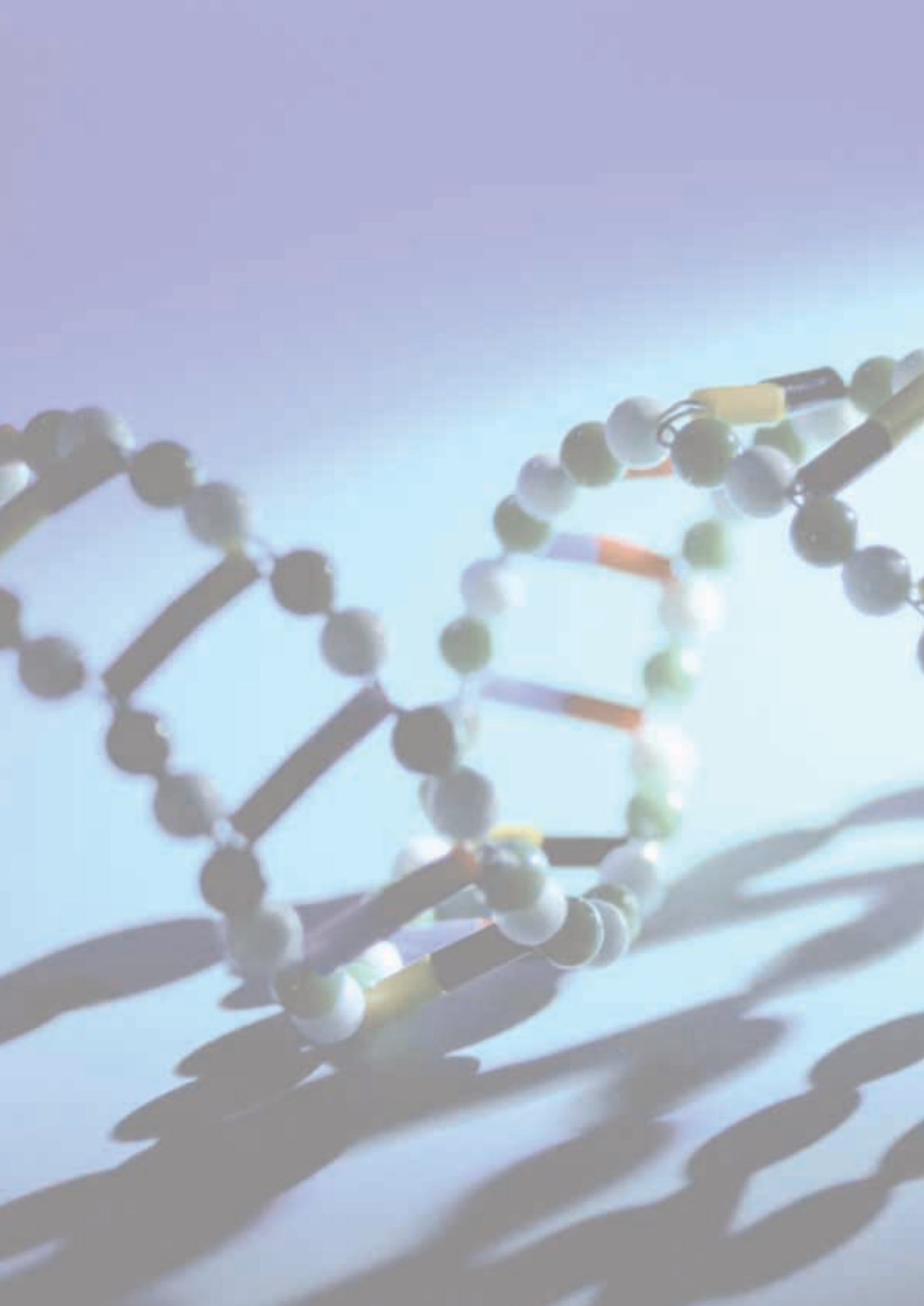
Group Income Protection



EVOLVING

the way we look at claims





Introduction

In everyday life, all of us experience symptoms of one sort or another. Most of us also know people who are affected by some form of disability or serious illness. What determines how a person reacts to a symptom or a serious illness? With some of these problems it is easy to understand how they can affect someone's abilities, but with others it can be much more difficult to understand how they can have this effect.

Think about a person in a coma. Clearly such a person is totally incapacitated. The other extreme would be complete health, which is defined by the World Health Organisation as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". There must be a spectrum ranging between these two states. Towards one end of the spectrum lie serious diseases and illnesses and near the other, minor problems such as an occasional headache or a slightly bruised finger.

The problem is that the corresponding spectrum of functional impairment is not uniform or even measurable in a direct and obvious way. We all know that if you are unconscious you cannot care for yourself, but how do we measure what people are capable of if they have lesser problems?

What determines why one person with a painful back is completely incapacitated and why another with apparently more severe problems functions reasonably? Why has Stephen Hawking, who has the most severe disability, chosen and managed to continue working when others with much less serious problems give up work? Douglas Bader, a World War II flying ace lost both his legs in an accident and managed to become a fighter pilot again. Even after he was shot down and captured by the Germans, with both artificial legs badly damaged, he made several attempts to escape. How was he able to overcome his difficulties, when most of us would have given up? Stephen Redgrave, the Olympic rower suffers from insulin dependent diabetes, but still managed to win several Gold Medals. What drove him? The nature of these questions implies where some of the answers may lie.

The Medical Model

It has in the past been considered that medicine alone could supply the answer about how to measure incapacity. The accepted view was that the presence of disease led to impairment, which was measurable. This impairment would then have predictable consequences for function and could lead to predictions about capacity or incapacity.

Let's use the example of a heart attack. A blockage of a coronary artery leads to loss of blood flow to an area of heart muscle, which dies. Scar tissue forms and that area of heart muscle no longer functions. This leads to a loss of pumping capacity of the heart, which would then lead to a reduced ability of the body to cope with effort or exercise due to reduced blood flow around the body.

This seems logical and consistent until we realise that things are not quite so simple. Heart muscle surrounding the damaged area may make up some of the lost capacity. By training and exercise, an individual may be able to overcome the deficiency, and possibly end up with a heart that functions better than before the heart attack. In addition to this, some individuals may have other medical problems which prevent their effective rehabilitation. Clearly, in this case, a purely medical view of illness due to heart disease may set expectations for recovery far too low.

Using another example, this time of back pain, it used to be advised by most doctors that acute back pain was best treated by bed rest, followed only by a return to activity when recovery was complete. Doctors used to regularly ask for x-rays of the lumbar spine and then advise patients according to results. The presence of what are referred to as degenerative changes used to be described as spondylosis, and depending on the nature and severity of those changes, doctors would advise on varying degrees of activity or avoidance of activity. The problem with this approach is that we now know that more than 50% of the population aged over 40 have some degree of degenerative change, and many of those people have no symptoms, while many others who have no x-ray changes, have back problems. We cannot then, use objective measures like x-rays to predict incapacity with back pain.

There are many other examples of how the medical model of disability fails to fully explain incapacity or provide a way of measuring it. Does this mean that the model is completely wrong? Not exactly: diagnosis and impairment are still important and are vital in planning treatment and rehabilitation as well as in setting expectations for recovery. Clearly we need to explore what other factors add to illness and disease to make people become incapacitated.

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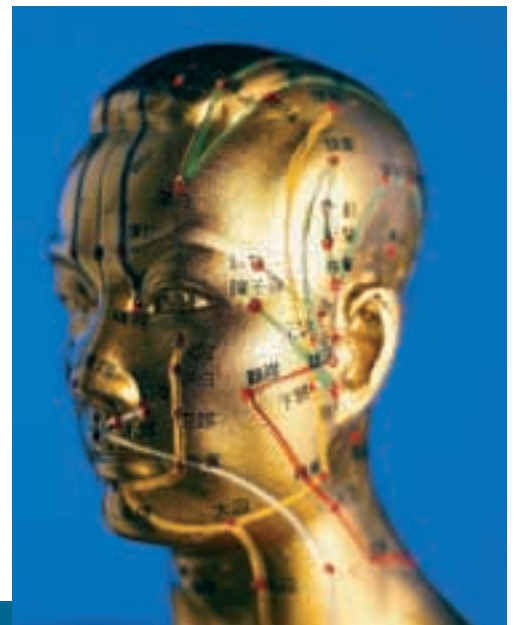
What is the Biopsychosocial (BPS) Model?

The BPS model attempts to take a holistic view of incapacity and disability. As mentioned, there is more to consider than just an illness or a disease. In fact we know that with back pain, for example, factors such as job dissatisfaction and beliefs about causation and meaning of pain are more important predictors of long-term absence than what exactly is wrong with the back.

The BPS model attempts to take these and other factors into account when predicting incapacity and devising treatments or rehabilitation programmes. We know that a belief that work has caused a back problem makes return to work much less likely for a sufferer. Where does that belief come from? In some cases, an injudicious remark from a doctor may be the trigger. In other cases, it may be that beliefs have been acquired throughout life, either through observation of others' behaviour, or through the way our parents treated us when we were ill. The social context can be important – if one is in a job such as nursing, where it is commonly held that work is a major cause of back pain, it is easy to see how an acute bad back may be seen as a catastrophe.

Going back to the example of heart disease, there are likely to be similar factors at play. One person may suffer an attack of angina and be advised by his doctor that he is at risk of heart attack if he does too much and that he should avoid exertion at all costs. It is easy to see how that could lead to a cycle of inactivity and

deconditioning, causing an increased susceptibility to angina, potentially worsening the underlying heart disease, leading to a downward spiral into serious ill health. Imagine the converse: the doctor advises that angina attacks are due to the heart's requirement for blood temporarily exceeding the supply as a result of exercise. He or she then goes on to say that the best way of helping this is not to avoid exertion, but to gradually increase one's fitness. In this way, alternative routes of circulation may open up, and the heart will become more conditioned to greater demands. It is easy to guess which person will be the most incapacitated, and also who will die sooner. Imagine the added effects that family advice, personal experience or knowledge of other angina sufferers will have on the behaviour and health of that individual.

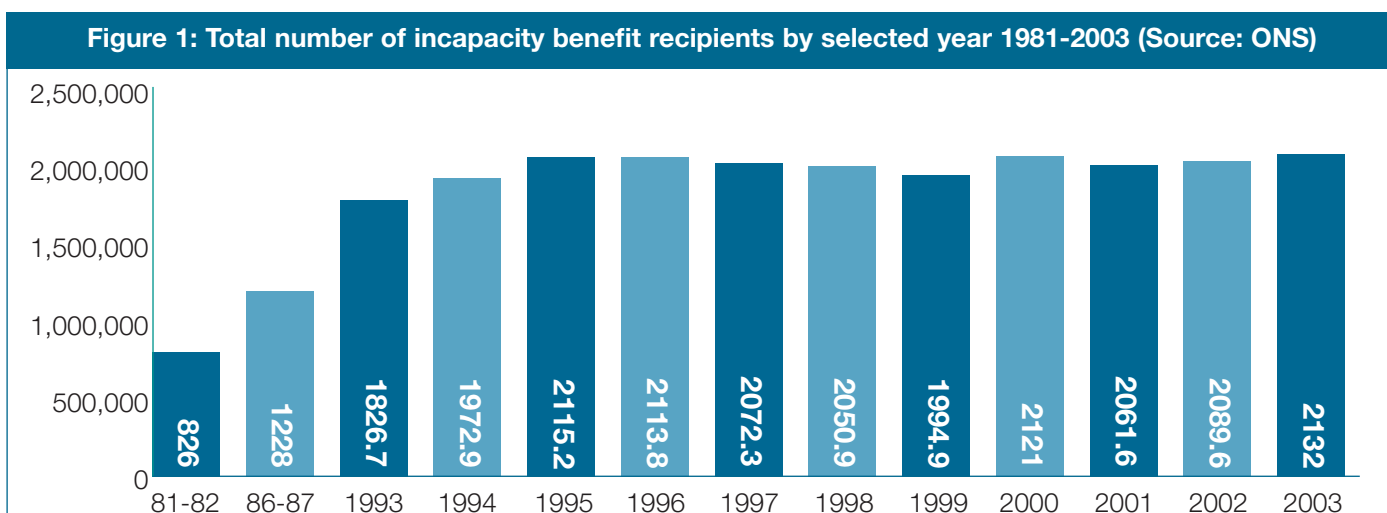


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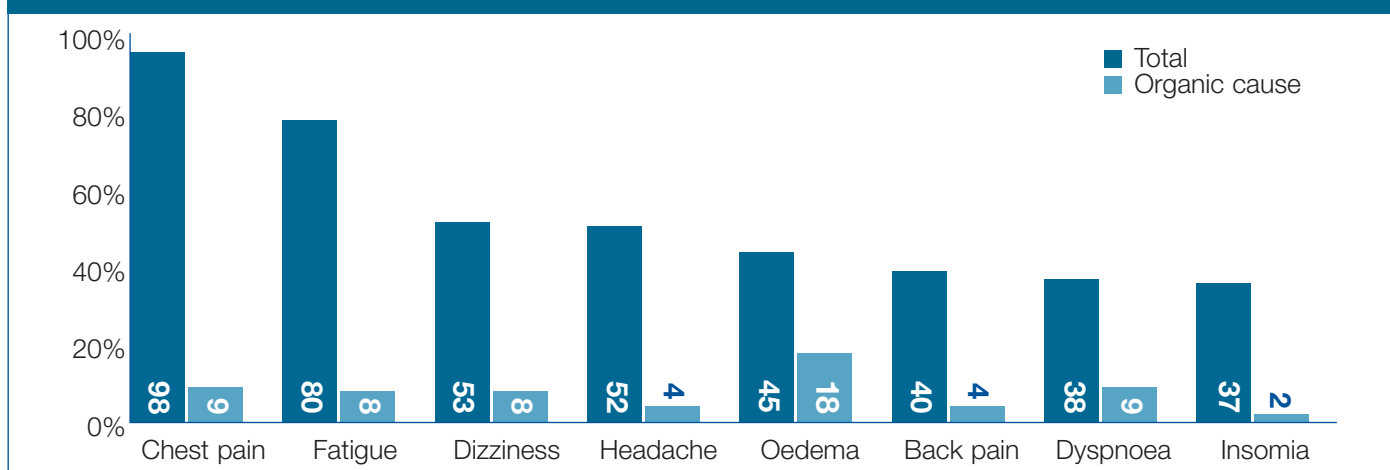
The BPS model seeks to remind us of all factors which come into play. Think about going to work every day for a boss who constantly belittles you or where you have no interest in your work or relationships with your colleagues. Think about what would happen if you developed a bad pain in your neck that made it difficult for you to get to work. It is easy to see how one or two days off could stretch into several, and then how when you do go back with your neck still sore you wonder why you did. Staying off sick can seem a sensible option. Unfortunately when you eventually go to your doctor, he is very busy and advises you to stay off until you have seen a physiotherapist. The appointment takes a few weeks to come through and you have been doing nothing to get your neck better. Fear avoidance leads you to restrict your movements and you develop protective muscle spasm. The physiotherapist may have no time for your fears and worries and do little to encourage activity. Is it any wonder that events conspire to lead to quite severe incapacity?

Such incapacity can be absolutely genuine, but at the same time completely dysfunctional and harmful. When illness behaviour of this sort becomes established it can be very resistant to conventional treatment. A belief that pain is harmful and indicates more damage, and an expectation that others are responsible for curing you, are two more pieces of what is now starting to look like a very complicated jigsaw.

How is this seen in the world at large? It is a known paradox that with all the medical advances of the second half of the 20th Century, there has been a huge increase in people who are considered too incapacitated to work. This rise in incapacity has taken place from the 1980's onwards and is seen in all developed countries. Figure 1 clearly shows this trend in the UK. It has to be remembered that this rise in incapacity did not take place as a result of any epidemic of disease or illness and therefore cannot be easily explained in medical terms.



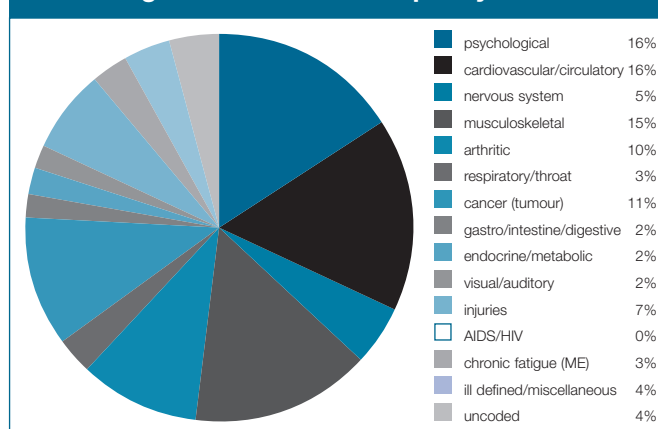
**Figure 2: Three year incidence (%) of symptoms in general practice
(Total and with organic cause: Kronenke & Mangelsdorff 1989)**



We know that most people who see their doctor do not have conventional explanations for most of their symptoms. Figure 2 shows the results of a seminal study of people who, over a three-year period, attended a General Practice clinic in the USA in the 1980's. The study looked at whether a physical (organic) cause could be identified for apparently physical complaints. The results of the study show that, in most cases, even with apparently obvious physical symptoms such as dyspnoea (shortness of breath) and oedema (swelling due to fluid retention), no organic cause could be found.

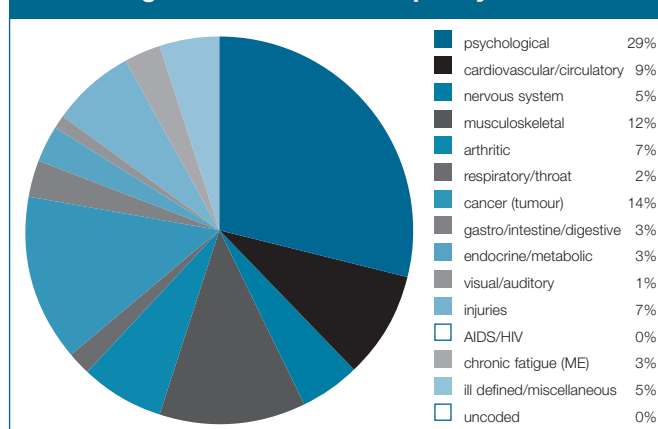
Over the last ten years, there has been no significant change in the proportion of insured lives who submit claims, in spite of better medical treatment for all sorts of illnesses and diseases. However, we are seeing a much greater proportion of claimants with psychological illness as the stated reason for incapacity. This is demonstrated in figures 3 & 4.

Figure 3: Cause of Incapacity 1995



(Source: UnumProvident claims portfolio)

Figure 4: Cause of Incapacity 2004



(Source: UnumProvident claims portfolio)

What does this mean for the assessment of incapacity?

Does this mean that every illness is in the mind? Or does it mean that people who choose not to work because of 'imagined' problems should not have their eligibility for benefit assessed? No it does not – nor does it mean that we should not have expectations for behaviour and capacity in illnesses.

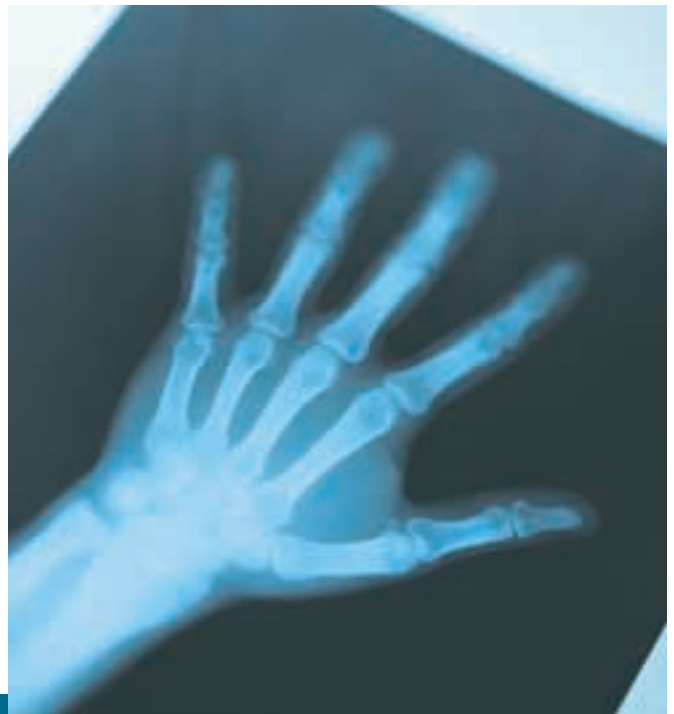
When assessing claims we look for “the three C’s” – credibility, consistency and consensus. We also have reasonable medical expectations based on diagnosis. The diagnosis is important, because it assists us in deciding expectations. We look for some form of reasonable relationship between the illness and the claimed incapacity – in other words ‘credibility’. We look for reasonable consistency between reports from doctors and what the claimant tells us, and whether the activities performed in his or her daily life are actually consistent with an inability to perform the insured occupation. Finally, we look for agreement between the various opinions that we seek, whether from treating or independent doctors ‘consensus’.

Once the diagnosis has been established and expectations set, it is easy to see how the management and assessment of claims is actually very similar, whatever the initial cause of the incapacity. We need to understand those cases where there are positive restrictions (things people should not do) and where we may expect limitations (things people cannot do or find difficult to do). The onward management of such cases is then largely independent of diagnosis. Finally, we need to be aware of co-morbidity (the presence of two diagnoses – typically the primary physical problem and a secondary psychiatric one).

When assessing claims we look for “the three C’s” – credibility, consistency and consensus.

Our current ‘impairment based’ claims team structure

Our current claims team structure is based on impairments. This means that different teams are aligned around different causes of incapacity. This has proved useful in gaining understanding of medical issues for the Claims Department, but we are now finding that as we better understand the BPS model, the structure may be impeding our ability to manage claims in the best possible way. For instance, our Rehabilitation Services team is aligned around brokers for our Active Key Account Management (AKAM) clients, and their structure does not align well with an impairment-based team structure. We find that our Claims Management Specialists (CMS’s) are hampered in their ability to form relationships with employers and brokers – the people who can assist them in better understanding work-related issues. This means that one major part of the psychosocial component of disability is not being fully understood, and that we may not be finding the best solutions to meet everyone’s needs.



Our current team structure is based on impairments.

Our new claims team structure (with effect from 07.11.2005)

Customer feedback and our knowledge of the BPS model have led us to evolve our claims team structure. With effect from 7th November 2005, we are moving to a new structure, which will be aligned around brokers and employers. The new team structure will mean that we have expertise in all impairment areas spread throughout our two offices in Dorking and Basingstoke. Each team will continue to be supported by its own Insurance Nurse Specialist and Vocational

Rehabilitation Consultant, and support to the teams will still be provided by our two doctors. Our new structure will mean that we can continue to set reasonable expectations in light of the medical information and still have access to expert interpretation of medical reports. In particular, it will mean that we shall have psychiatric expertise much more readily available to all CMS's. This will enable us to identify much more readily those cases where depression or other psychiatric illness lies behind or complicates the medical presentation of incapacity. It must be remembered that the BPS model is still of relevance even in more serious medical conditions.

An added advantage will be that as CMS's get to know their customers, they will become much more aware of potential work issues behind claims, and also what steps individual employers may be able to take in assisting an employee's return to work. In addition, customers will have the advantage of having just a single point of contact within the claims organisation. As relationships develop between CMS's, brokers and employers, we hope that each will gain a greater understanding of the others' positions, problems and capabilities. The fact that our Rehabilitation Services team is already aligned with brokers will lead to streamlining and better working, all of which should in turn lead to much improved customer service and satisfaction.



Customer feedback and our knowledge of the BPS model have led us to evolve our claims team structure.

What will this mean for claims assessment?

- We believe that, with increased understanding of work issues, better relationships with employers, together with better alignment with our Rehabilitation Services team, the potential to identify solutions to claims will improve.
- We hope that co-morbidity (the presence of two diagnoses – typically the primary physical problem and a secondary psychiatric one) will be identified and addressed more readily.
- The essentials of claims management – the formulation of expectations, “the three C’s” and an understanding of what it would be reasonable for the claimant to actually try to do in his or her employment – will remain the same.

Conclusions

At UnumProvident, we believe that we have always been at the leading edge of disability assessment and management. From our experience and expertise – built up over the years – we are now moving to a new phase in our thinking. This will build on the knowledge we have gained to date, and will be accelerated by our links with the UnumProvident Centre for Psychosocial and Disability Research at Cardiff University.

We know that our views and understanding are not yet in the mainstream of doctors’ thinking, but Government Policy is moving in the same direction, to a large extent being driven by our thinking and that of our close associates, both in the UK and overseas. It will not be many years before the rest of medicine follows our lead.

Michael O’Donnell, Chief Medical Officer, UnumProvident.



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