

**European Commission**  
**DG Employment, Social Affairs and Equal Opportunities**

Study on the use of age, disability, sex, religion or belief,  
racial or ethnic origin and sexual orientation in financial  
services, in particular in the insurance and banking sectors

**Final Report**

***Part I: Main Report***

*prepared by Civic Consulting*

*Date: 16.07.2010*

*Contact for this assignment:*

Dr Frank Alleweldt  
Civic Consulting

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Final Report  
*Part I: Main Report*

c/o Civic Consulting  
Potsdamer Strasse 150  
D-10783 Berlin-Germany  
Telephone: +49-30-2196-2297  
Fax: +49-30-2196-2298  
E-mail: [alleweldt@civic-consulting.de](mailto:alleweldt@civic-consulting.de)

*This report was commissioned by and prepared for the use of the European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities. It does not necessarily represent the Commission's official position.*

*It was financed under the framework programme PROGRESS (Decision 1672/2006/EC of the European Parliament and the Council, OJ L 315/1 of 15.11.2006). For more information on PROGRESS see: <http://ec.europa.eu/progress>*

### Document Control

<i>Document</i>	<i>Final report - Study on the use of age, disability, sex, religion or belief, racial or ethnic origin and sexual orientation in financial services, in particular in the insurance and banking sectors – Part I: Main Report</i>
<i>Tender No.</i>	<i>Invitation to tender n° VT/2009/013</i>
<i>Main report prepared by</i>	<i>Dr. Frank Alleweldt (project director), Prof. Christopher Parsons (lead author current practices), Anna Fielder (lead author existing measures), Kate Scribbins (lead author problems of discrimination), Dr. Senda Kara, Dr. Sara Buccino, Rémi Béteille</i>
<i>Country studies prepared by</i>	<i>Yves Thiery, Prof. Caroline Van Schoubroeck (Belgium) Alexander Klose, Johanna Künne, Sandrina Zillmann (Germany) Dr. Per Norberg, Eberhard Stüber, Prof. Susanne Fransson (Sweden) Prof. Chris Parsons, Kate Scribbins, Prof. Erika Szyszczak (UK) Prof. Craig Brown (Canada) Prof. Paul Rishworth (New Zealand)</i>
<i>Checked by</i>	<i>Dr. Senda Kara, Dr. Frank Alleweldt, Dr. Sara Buccino, Rémi Béteille, Anna Altman, Paul Hockenos</i>
<i>Report finalised on</i>	<i>16 July 2010</i>

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## Key conclusions

This study identifies current practices of financial service providers with regard to the use of age, disability, sex, racial/ethnic origin, religion/belief, and sexual orientation in the supply and design of financial products, as well as problems of discrimination and existing measures to prevent discriminatory practices. Conclusions include:

- ⇒ *The factors age, sex and disability (or rather the underlying health condition) are widely used in the design and supply of financial products.* Pricing of consumer insurance and credit products is generally based on segmenting the population of covered risks and placing them into groups or classes having similar characteristics (and hence similar levels of risk). The criteria used to sub-divide the population of risks are those which are believed to reflect the probability of loss, including age, sex or disability. Many of the underwriting factors used by providers are not so much causes of loss as proxies for other things that may cause loss. The use of proxies is commonly justified by reference to the costs that would be incurred if a detailed examination had to be carried out for each consumer.
- ⇒ *There is very little direct use of racial/ethnic origin, religion, belief or sexual orientation as factors in the supply of financial products.* Some providers have affiliations with religious bodies and some products have been developed specifically for certain religious groups (e.g. Islamic banking products), but the study found no strong evidence of the use of these factors by suppliers on any of these grounds. However, the factor racial/ethnic origin may be used indirectly, e.g. through requirements concerning nationality and residence.
- ⇒ *In a highly competitive market, private insurers have a natural incentive to distinguish between risks as precisely as possible and charge premiums which are as accurate as they can be in actuarial terms.* An insurer that is able to assess the risk of loss more accurately than its competitors will be able to identify and attract lower-risk customers who are being overcharged by the rest of the market, while avoiding higher-risk customers who are being undercharged. However, the incentive to do so will be reduced if the market is not competitive, especially if the product in question is mandatory by law (e.g. third party motor insurance) or is one which is essential in practice. Fine-tuned differential pricing of insurance can also lead to very high-risk consumers being priced out of the market or even refused insurance altogether.
- ⇒ *The overall number of complaints about alleged discrimination in financial services appears to be low compared to other types of consumer complaints.* The total number of complaints was (taking into account estimates provided by some organisations) roughly equal to 0.6% to 1.0% of cases reported by major alternative dispute resolution schemes in the Member States specialised in financial services. However, because of likely underreporting of complaints, it is not possible to come to a firm conclusion about the scale of the problems of perceived discrimination in financial services without conducting quantitative consumer research. Reasons for underreporting of complaints include the lack of civil society organisations which work on issues of discrimination in financial

services in many Member States and the relatively recent setting up or restructuring of several national equality bodies. Furthermore, it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations.

- ⇒ *Insurance products are more likely to be subject to complaints concerning alleged discrimination than credit and banking products.* Within the insurance area, product categories most often subject to complaints are private health insurance, life insurance, motor insurance and travel insurance. Within the banking area, consumer credit and mortgage loans are the two product categories most often subject to complaints. Denial of access to financial services is the main reason for complaints. Age and disability were most frequently mentioned as discrimination grounds. Racial/ethnic origin ranked as third most important factor according to survey results, before the factors sex and sexual orientation. The use of exclusions and restrictions related to pregnancy and maternity by insurers indicates a need to clarify whether these are in line with the general rule of non-discrimination for reasons of pregnancy and maternity in Directive 2004/113/EC (the Gender Directive).
- ⇒ *A majority of documented decisions of courts, ombudsmen and equality bodies concerning discrimination complaints in the area of insurance and banking focus on the issue of proportionality of provider behaviour.* Reasoning of the bodies deciding on the complaints appears to draw on a relatively common understanding of the concept of proportionality which is rooted in the justification test to deal with alleged discriminatory character of unequal treatment, developed in case law of the European Court of Justice, the European Court of Human Rights and national constitutional courts.
- ⇒ *More than half of the documented decisions of courts, ombudsmen and equality bodies concern the refusal to provide a service (including because of age limits).* Decisions that came to the conclusion that under national non-discrimination law a refusal to provide a requested insurance or banking service is *not proportionate* in the particular case, are reported from Austria, Belgium, Cyprus, France, Greece, Hungary, Ireland, the Netherlands and Sweden. Decisions that found refusals to provide services to be *proportionate* in the cases investigated are reported from Germany, Poland and Portugal. Denial of access to a service not based on a proper risk assessment was often considered to be not proportionate by the investigating body, or led to settlements to avoid a decision. However, criteria for what can be considered to be a proper risk assessment vary.
- ⇒ *Article 5 of the Gender Directive has now been implemented in all the EU Member States except one.* All countries that implemented the provision have made use of the opt-out clause in order to differentiate insurance premiums and benefits between men and women for at least one type of insurance, most often related to life insurance contracts.

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- ⇒ *There is a patchwork of legislative and regulatory measures across the Member States that deal with discrimination caused by the use of other factors than sex.* The majority of countries prohibit any form of discrimination, with no exceptions, on the grounds of racial/ethnic origin, religion/belief and sexual orientation, including through the Constitutions of several of the countries. Thirteen Member States restrict by law the use of both age and disability in the design, supply or pricing of financial products. Seven additional Member States restrict use of disability only.
  - ⇒ *Voluntary initiatives of industry associations can play an important role to provide better access to financial products and to guide insurers and banks when applying non-discrimination legislation in practice.* Examples reported include codes of good practice prepared by insurance associations and guidance notes from actuarial associations. Voluntary initiatives in some countries directly address issues of accessibility that are subject to legislation in other countries.
  - ⇒ *Study results confirm the existence of problems of discrimination in the provision of financial services that need to be addressed through adequate measures.* Nearly half of the Member States already have various legislative provisions in place that prohibit the use of racial/ethnic origin, religion/belief and sexual orientation, and permit the use of sex, age and disability in the provision of financial services under certain circumstances, and thereby broadly anticipate the legal framework proposed by the European Commission.<sup>1</sup> In addition to legislative measures the study recommends to take immediate action in the following areas: Conducting a representative consumer survey in all EU Member States (a special Eurobarometer) to establish the scale of the problem, coordinated reporting of market impacts for the review process according to Article 5(2) of the Gender Directive, preparation of guidance for interpretation of key terms, development of the consumer complaints infrastructure as well as introduction of industry codes of good practice, sectoral agreements and signposting systems. These options for action at EU, national and industry level are not listed in order of priority, but rather follow a logical order of action.

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<sup>1</sup> The Commission has presented a Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation, COM(2008) 426 final, which will complement existing directives in the area of gender and race. Once the Draft Directive is adopted, the EU legislative framework would prohibit the use of racial/ethnic origin, religion/belief and sexual orientation, and permit the use of sex, age and disability in the provision of financial services under certain circumstances.

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## Executive summary

Access to financial services such as insurance or banking services plays an important role in the economy and society as a whole, as it not only allows individuals to make use of economic opportunities but also to improve their health, education, and overall well-being. Civil society organizations report cases of alleged discrimination based on e.g. sex, age, and disability in the provision of financial services. They say that discrimination often occurs through restricted access to some types of insurance and credit, and claim that premiums and rates do not always reflect risks. Financial services providers deny evidence of widespread discrimination. According to the financial services industry, differential treatment is an intrinsic feature of the business and does not constitute discrimination.

The European Commission has therefore commissioned Civic Consulting to conduct a study identifying current practices of financial service providers with regard to the use of age, disability, sex, racial/ethnic origin, religion/belief, and sexual orientation in the supply and design of financial products, as well as actual and potential problems of discrimination and existing measures to prevent discriminatory practices. The study is based on a review of relevant literature, surveys of key stakeholders in all 27 EU Member States and EFTA/EEA countries, results of in depth research in seven Member States (Belgium, Cyprus, France, Germany, the Netherlands, Sweden, and the UK) and two other OECD countries (Canada and New Zealand), and the analysis of documented complaints concerning discrimination in the provision of financial services collected from 18 Member States. The study consists of three parts: Part I presents the main report of the study. Part II contains reports concerning selected countries. Part III presents the annexes to the report.

### **I. Current practices of financial service providers**

For private insurers, the ultimate aim is to choose to cover, from all the risks that are offered to them, those which collectively will be profitable. Pricing of consumer insurance and credit products is generally based on segmenting the population of covered risks and placing them into groups or classes having similar characteristics (and hence similar levels of risk). Premiums for each group are arrived at by the statistical analysis of loss data and actuarial modelling.<sup>2</sup> The criteria used to sub-divide the population of risks are those which are believed to reflect or influence the probability of loss, including age, sex or disability. Many of the underwriting factors used by providers are not so much causes of loss as proxies for other things that may cause loss. The use of proxies is commonly justified by reference to the costs that would be incurred if a detailed examination (e.g. a medical examination or test of driving skills) had to be carried out for each consumer applying for products such as travel or motor insurance.

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<sup>2</sup> Of course, many other factors are taken into account in arriving at the final price to be charged, including the effect of a deductible (excess), loadings for contingences (that is, possible shifts in the underlying probabilities of loss, which cannot be identified in advance), adjustments for inflation, adjustments for investment income, expense loadings, etc.

In a highly competitive market, private insurers have a natural incentive to distinguish between risks as precisely as possible and charge premiums which are as accurate as they can be in actuarial terms. An insurer that is able to assess the risk of loss more accurately than its competitors will be able to identify and attract lower-risk customers who are being overcharged by the rest of the market, while avoiding higher-risk customers who are being undercharged. However, the incentive to do so will be reduced if the market is not competitive, especially if the product in question is mandatory by law (e.g. third party motor insurance) or is one which is essential in practice. Fine-tuned differential pricing of insurance can also lead to very high-risk consumers being priced out of the market or even refused insurance altogether.

### ***Use of age as a factor***

Age is an important factor in a number of key financial products. These include motor insurance, where age can make a very significant difference in terms of price and which can be more difficult to obtain for the very young and the very old. Much the same is true for travel insurance, although there is little evidence that the young are penalised to any degree. There is also some evidence that the pricing of travel insurance can be rather crude, with some insurers at least using relatively wide age bands which result in steep rises in premium as clients move from one age bracket to another. The cost of term life insurance rises remorselessly with age at entry. However, because premiums are flat throughout the duration of the contract this is likely to be less of a problem, at least for those who buy the product at an early stage in life. Age plays an equally important role in the provision of other forms of life insurance. As morbidity increases with age, premiums can also rise significantly for older people who buy private health insurance. This type of cover can also become increasingly difficult to obtain with age. However, this is not the case with schemes that use 'community rating' principles, i.e. charge the same premiums for all insured, regardless of their individual characteristics (as is the case in countries such as the Netherlands and Ireland). The potential problem of rising premiums is also alleviated in countries, like Germany, where suppliers charge clients level premiums through the use of age reserves. Again, potential problems for older people associated with the rising cost and reducing availability of cover diminish to the extent that health care is available through a public system. Nevertheless, demographic factors point to an increasing role for private health insurance in future and, perhaps, lower levels of publicly funded health care, in which case problems of availability and affordability for older buyers of health insurance may become more acute. Much the same considerations apply to other forms of insurance which respond in the case of accidents or illness. These include critical illness insurance, income protection insurance, loan insurance, long-term care insurance and accident insurance. In each case age is a significant factor in pricing and availability, but, once more, the impact of this on individual purchasers depends on the pricing method used (i.e. flat or rising premiums) and on the availability of publicly funded support to mitigate the effects of illness, accidents or infirmity. The age of the borrower is clearly a relevant factor in the availability of mortgage credit. However, other factors (especially income status) are much more significant. Much the same is true for other banking products, including

credit cards and deposit accounts, although it appears that the age of the borrower is less significant in (secured) mortgage credit than in unsecured lending. Finally, we can note the existence of a few financial products where the age of the consumer plays, at most, a small role. These include home insurance and private liability insurance.

***Use of sex as a factor***

Sex is a relatively significant factor in motor insurance though less significant than age, with greater variation in the practice of insurers. Those insurers that do price according to sex typically allow female policyholders lower premiums with the greatest differences being observed between young male and young female drivers. Sex is unlikely to affect contractual terms of motor insurance other than price. Most (but not absolutely all) insurers disregard the sex of the insured in the pricing and provision of travel insurance but cover for medical expenses may be restricted in the case of pregnant women. Sex is a significant factor in the pricing of term life insurance, since women tend to live longer, and the same is true for other forms of life insurance. Conversely, and for the same reason, women will pay more than men for annuity products providing similar benefits or receive lower benefits for the same purchase price. There is evidence that levels of morbidity vary between men and women of the same age, but whether private health insurers take this into account in pricing their products depends on a number of factors, including the funding basis of the scheme (i.e. whether there are flat premiums as a consequence of ‘community rating’ or whether premiums are individualised), the applicable law on gender discrimination, and the practice of individual insurers. Sex may occasionally influence the contractual conditions of private health insurance, childbirth and pregnancy being the most common areas where this may be the case. Much the same considerations as to sex apply to other forms of insurance which respond in the case of illness. These include critical illness insurance, income protection insurance, loan insurance, and long term care insurance. In each case sex may be a factor in pricing and availability, with premiums reflecting the greater longevity and (for some ages at least) higher morbidity of women. However, once more, the impact of this on individual purchasers depends on the availability of publicly funded support to mitigate the effects of illness or infirmity. Sex plays only a relatively minor part in the provision of mortgage (and other) credit. Other factors (especially income status) are much more important and most (but not all) providers say that the sex of the borrower is irrelevant. The same is true for other banking products, including credit cards and deposit accounts. However, sex (and age) are sometimes used in credit scoring and this may affect the provision of banking/loan products. Sex plays a minimal role in the provision of home insurance and private liability insurance.

***Use of disability as a factor***

Financial firms are not concerned with disability as such, but rather with any underlying health condition which may affect the risk assumed by the provider – e.g. the risk of accidents, illness, premature death or inability to repay a loan. In some cases a person may be ‘disabled’ for one or more legal purposes (e.g. entitlement to state benefits) but present no extra risk to a provider. Disability/health condition is often regarded as an

'underwriting' rather than a 'rating' issue, meaning that it is something which has to be assessed individually rather than something accommodated automatically within a pricing model, like age or sex. Motor insurers do not 'price' disability in a systematic way, rather they consider the (relatively rare) cases where a health condition might affect a person's driving on an individual basis and load premiums if they think it necessary. The screening process which most countries employ when issuing driving licences reduces the need for motor insurers themselves to carry out such health screening. When cover for medical expenses is provided within a travel insurance policy, the client's health status or disability can become significant. Travel insurance is a line of business where insurers commonly avoid the cost of individual medical screening by excluding pre-existing medical conditions generally, or at least certain defined pre-existing conditions, except, perhaps, in cases where the condition has 'stabilised'. The health condition of the applicant is a key factor for term life insurance and, indeed, for any form of life insurance. If the answers given to questions asked by life insurers suggest that applicant may be in poor health, additional health reports and/or medical examinations are likely to be requested and premiums may well be raised. These measures are more likely to be taken if the amount to be insured is large. Disability (or health condition) can affect either the price of private health insurance, or its contractual conditions, or both. Our survey suggests that it is rather more likely to affect the latter than the former. This is because, as suggested earlier, a number of insurers prefer to deal with clients presenting adverse health conditions by excluding the condition concerned rather than by raising the price of the cover. This form of contractual variation – the exclusion of pre-existing conditions – is widespread in markets where individual underwriting of health insurance is allowed. The considerations which apply to private health insurance as regards disability apply also to related forms of insurance such as critical illness insurance, income protection insurance, loan insurance and (to a lesser extent) long-term care insurance and accident insurance. In each case, disability may result in higher premiums, or the exclusion of one or more conditions or, in some cases, the denial of cover altogether. Disability/health condition in itself plays little or no part in the provision of mortgage loans or consumer credit and is likely to be relevant only in cases where it may restrict the earning capacity of the borrower (and hence their ability to repay the loan) or in cases where the borrower is required to arrange insurance in connection with a loan.

The following table presents an overview of the use of the factors age, sex and disability by financial product (based on frequency of reported use by stakeholders).

**Table: Reported use of factors for risk assessment by product**

Product category	Factors		
	Sex	Age	Disability
<i>Insurance products</i>			
Private health insurance	++	++	++
Critical illness insurance	++	++	++
Disability/income protection insurance	++	++	++
Life insurance	++	++	++
Annuity products	++	++	+
Motor insurance	++	++	+
Travel insurance	+	++	+
Accident insurance	+	+	+
Long term care insurance	+	+	+
Loan insurance/Payment protection insurance	+	+	+
Home insurance	0	+	0
Private liability insurance	0	+	0
<i>Banking/Loan products*</i>			
Mortgage loans	0	+	0
Consumer credit**	0	+	0
Credit cards	0	+	0
Deposit account	0	0	0

Notes: ++ = Frequently reported to be used.  
+ = Occasionally reported to be used.  
0 = Rarely reported to be used.

Product categories may include a variety of different types of products offered on the market. Bundled products are not covered. For definitions of products and categories see extended table in section 3.7.

\* Age and sex are sometimes used in credit scoring and this may affect the provision of banking/loan products.

\*\* Consumer credit includes motor finance and personal loans.

### ***Use of racial/ethnic origin, religion/belief and sexual orientation***

There is very little direct use of the factors racial/ethnic origin, religion, belief or sexual orientation as factors in the supply of financial products. Some providers have affiliations with religious bodies and some products have been developed specifically for certain religious groups (e.g. Islamic insurance and banking products), but the study found no strong evidence of the use of these factors by suppliers on any of these grounds.

However, the factor racial/ethnic origin may be used indirectly, e.g. through requirements concerning nationality and residence or by employing a 'zone rating' system, where premiums vary according to postcode, so that insurance may be more expensive (or cheaper) in areas dominated by certain ethnic groups.

## **II. Potential and actual problems of discrimination**

### ***Potential problems arising from practices of financial services providers***

The problems that can arise for consumers from the described practices of financial services providers are various in their nature and origins. First, the (economic) arguments which are advanced to support the current practices of insurers in relation

to the factors sex, age and disability presuppose that markets for financial products are competitive and efficient, whereas some EU markets are more competitive than others, with only a handful of providers in some smaller Member States. Lack of competition can weaken the natural incentive of market players to align premiums accurately to risk. Furthermore, even in a market where there is plenty of choice, information problems might make it difficult for consumers to find easily the best providers for their needs. Second, fine-tuned differential pricing can weaken the risk-spreading function of insurance and lead to 'red-lining', with very high risk individuals (e.g. very old or very ill people) being priced out of the market or denied cover altogether. An economist might argue that this phenomenon is quite consistent with overall market efficiency, in the sense that such individuals cannot be efficiently insured. However, at this point the argument shifts from the language of economics to the language of rights, with critics of current insurer practices arguing that it is wrong to deny services to a person as a consequence of something which they are powerless to change. Weighing these opposing views against each other is impossible, because they are simply incommensurable. Whether individual human rights should trump market efficiency is a policy matter, not an economic question. However, once it is decided that high risk individuals should have the right to secure cover, it is then possible to compare different ways of achieving this aim and weigh the benefits of each. A third problem for consumers arises not from fine-tuned segmentation of risk, but from an (almost) opposite situation where high risk assessment costs discourage such segmentation and lead to relatively crude classifications of risk. We find examples in (medical) travel insurance and in health insurance where insurers commonly issue standardised contracts and deal with people in poor health by excluding pre-existing conditions. This avoids (or at least reduces) the need for individual underwriting and enables insurers to speedily deliver relatively inexpensive cover to those in good health. However, this practice can create quite severe difficulties for those whose health is impaired.

### ***Complaints concerning discriminatory treatment of consumers***

Data about the number and type of complaints regarding discrimination in the provision of financial services and complementary consumer research are rare. This is true in many countries. The only country where meaningful quantitative consumer research regarding access to specific financial products could be found is the UK, and that focuses on age only. In other countries, all that exists is anecdotal evidence, and in some cases a frequency count of numbers of complaints recorded by relevant bodies.

The overall number of complaints about alleged discrimination in financial services appears to be low compared to other types of consumer complaints. Civil society organisations, national authorities, equality bodies and ombudsmen from 17 Member States reported detailed statistics concerning relevant complaints. In total 375 complaints were received on average per year for the period 2007-2009. This figure does not include data from a small number of organisations that could only provide an estimate regarding the total figure of relevant complaints. Taking these estimates into account, the average figure of complaints concerning alleged discrimination in financial services reported by participating organisations is approximately 1,075 to 1,675 per year. This is roughly equal to 0.6% to 1.0% of cases reported by major alternative

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dispute resolution schemes in the Member States specialised in financial services.<sup>3</sup> However, because of likely underreporting of complaints, it is not possible to come to a firm conclusion about the scale of the problems of perceived discrimination in financial services. Reasons for underreporting of complaints include the lack of civil society organisations which work on issues of discrimination in financial services in many Member States and the relatively recent setting up or restructuring of several national equality bodies. Furthermore, it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations.

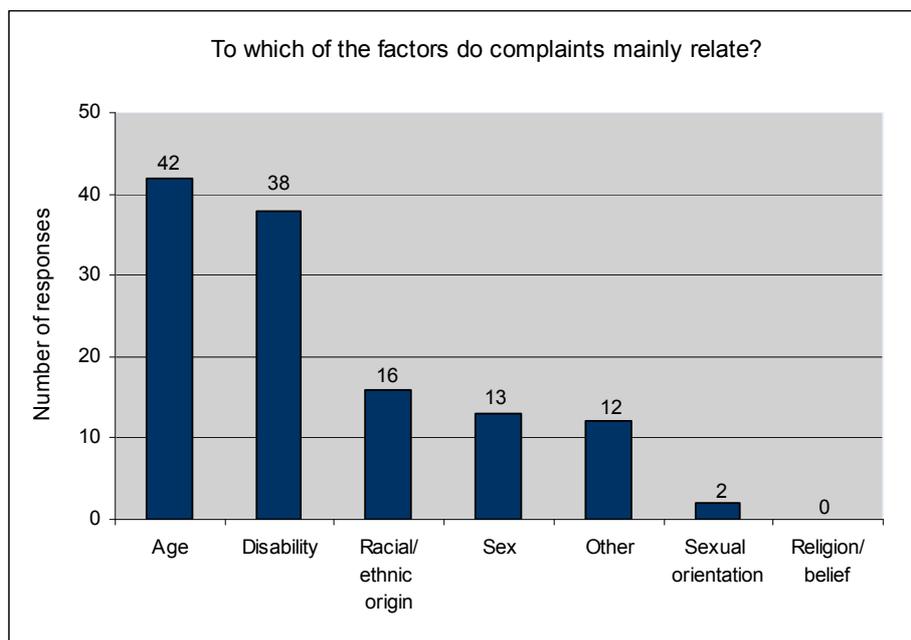
Insurance products are more likely to be subject to complaints concerning alleged discrimination than credit and banking products. Within the insurance area, product categories most often subject to complaints are private health insurance, life insurance, motor insurance and travel insurance. Within the banking area, consumer credit and mortgage loans are the two product categories most often subject to complaints (with complaints concerning deposit accounts also being relatively frequent). Denial of access to financial services is the main reason for complaints. Organisations responding to our survey most frequently indicated that complaints related to a refusal to provide requested services. Exclusions or restrictions and expensive premiums were also common areas of complaint.

According to stakeholders, age and disability are most relevant as discrimination grounds or factors to which complaints mainly relate (see following figure).

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<sup>3</sup> Experience of two specialised bodies in EU Member States that address consumer complaints in the area of financial services supports the higher estimate: The German regulator BaFin (*Bundesanstalt für Finanzdienstleistungsaufsicht*) estimates that complaints of alleged discrimination represented roughly 1% of the total complaints that BaFin received in 2008, and according to data provided by the Belgian Insurance Ombudsman 0.9% of all complaints received in the same year concerned alleged discrimination.

**Figure 1: Factors to which complaints mainly relate**



Source: Civic Consulting surveys of national industry associations, insurance companies, banks, national authorities, equality bodies, ombudsmen and civil society organisations.

Alleged age discrimination is the most frequent cause for complaints. Being turned down for motor and travel insurance, mortgages and credit, and high premiums for private health insurance and travel insurance were key areas of complaint. On the grounds of disability, denial of access or high premiums were the more common causes for complaints reported. Many of the complaints about denial of access due to disability or health condition related to whether the refusal was a reasonable response to the individual's circumstances. Complainants felt that insurers or lenders were too quick to deny access without fully understanding their case or ensuring their refusal was based on sound data. Perceived discrimination on the grounds of racial/ethnic origin was reported less frequently to be a main cause of complaints than perceived discrimination concerning age and disability, but still causing a significant number of documented complaints. Most of the documented complaints related to banking products, and involved problems caused by questions over citizenship, lack of passport or length of time in residence, implying indirect discrimination. Sex is also a relevant factor in terms of complaints, whereas sexual orientation was marked by few organisations as a factor to which complaints mainly relate. Some complaints in the insurance field concern the issue of pregnancy and maternity, mainly relating to denial of access and exclusions.

***Problems of discrimination identified***

To diagnose a discrimination problem, issues to be scrutinised revolve around the questions of evidence used by the financial services provider to justify differentiation on basis of protected grounds such as sex, and the proportionality of the behaviour that

gave rise to the complaint. Any assessment of a particular complaint regarding discrimination can therefore only be a case-by-case decision taken by a body with inquisitorial powers, be it a court, an equality body, an ombudsman, or any other consumer complaints body. This approach has therefore been used in this study by analysing a total of 43 complaints that were subject to a court case or inquiry.<sup>4</sup>

An inquiry of courts, ombudsmen and equality bodies concerning a specific complaint often involves an assessment of the evidence provided by the financial services provider to justify the behaviour that caused the complaint. Investigations conducted by these bodies have led to different conclusions depending on the circumstances of the case, reaching from the conclusion that evidence for the risk assessment was insufficient or, in other cases, was found to be sound. Key obstacles to investigate evidence provided by insurers and banks to justify differential treatment are the required level of actuarial expertise and limitations of the data that is provided by the defendant or available from other sources.

A majority of documented decisions of courts, ombudsmen and equality bodies concerning discrimination complaints in the area of insurance and banking focus on the issue of proportionality of provider behaviour. Reasoning of the bodies deciding on the complaints appears to draw on a relatively common understanding of the concept of proportionality which is rooted in the justification test to deal with alleged discriminatory character of unequal treatment, developed in case law of the European Court of Justice, the European Court of Human Rights and national constitutional courts.

More than half of the documented decisions of courts, ombudsmen and equality bodies concern the refusal to provide a service (including because of age limits). Decisions that came to the conclusion that under national non-discrimination law a refusal to provide a requested insurance or banking service is not proportionate are reported from Austria, Belgium, Cyprus, France, Greece, Hungary, Ireland, the Netherlands and Sweden. Decisions that found refusals to provide services to be proportionate in the cases investigated are reported from Germany, Poland and Portugal. Denial of access to a service not based on a proper risk assessment was often considered to be not proportionate by the investigating body, or led to settlements to avoid a decision. However, criteria for what can be considered to be a proper risk assessment vary.

### **III. Existing measures to prevent discriminatory practices**

#### ***Implementation of the Gender Directive***

Article 5(1) of Directive 2004/113/EC, the Gender Directive, states that Member States “shall ensure that in all new contracts concluded after 21 December 2007 at the latest, the use of sex as a factor in the calculation of premiums and benefits for the purposes of insurance and related financial services shall not result in differences in individuals’ premiums and benefits”. However, Article 5(2) of the Directive also allows Member

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<sup>4</sup> In total, the study documented 72 detailed examples of complaints of alleged discrimination from 18 Member States, of which 13 led to court cases, while 30 complaints were subject to an inquiry by an ombudsman or equality body but did not lead to a court case.

States to opt out of this rule and treat men and women differently in terms of premiums and benefits, if 'sex is a determining factor in the assessment of risk', providing this assessment is based on 'relevant and accurate actuarial and statistical data'. The Article also requires that any differences (in premiums and benefits) must be 'proportionate'.

Article 5 of the Gender Directive has now been implemented in all the EU Member States except one. At the time of finalising this report, only Poland had not yet fully transposed the requirements of this Article into its national laws. All countries that implemented the provision have made use of the opt-out clause in order to differentiate insurance premiums and benefits between men and women for at least one type of insurance, most often related to life insurance contracts.

A key issue remains that there is no consistent interpretation of any of the key terms of Article 5(2) of the Gender Directive across the Member States. The majority of Member States have followed closely the wording of Article 5(2) of the Directive in their national legislation. Terms such as 'determining factor', 'relevant and accurate actuarial and statistical data' and 'proportionate differences in ... premiums', however, are generally not defined in the legislation or through accompanying procedures or guidelines, leaving it either to the regulatory authorities, the industry itself or equality bodies and courts to apply these terms in practice. Surprisingly few Member States mention the need for further evaluation and research, particularly in the light of the potential impact on Internal Market cross-border trade. Some of the Member States mention the important challenges faced by smaller countries with smaller markets where sufficient historical and commercial data may not be available.

Member States have implemented the publication requirement in a variety of ways and by a variety of bodies, the most common being aggregated statistics for relevant insurance products published on the internet. Opinions (as there is little evidence) on whether these statistics are helpful to consumers and enhance their protection and awareness vary, but on the whole industry, civil society organisations and some of the governments agree that they are not that helpful for individuals, though can be important as a transparency and general evidence measure. Sweden provides a useful example of how the publication requirement can be combined with consumer advice functions. Industry's greatest concern regarding the publication requirement is its possible impact on pricing freedom, particularly in countries which require that the pricing be supported by the published data in some form or another.

Partly as a consequence of the Gender Directive, unisex non-life insurance products are available in many Member States. Availability varies between countries and can range from motor insurance to private health, accident to long term care insurances. Many of them were available before the EU legislation was implemented at national levels. The biggest changes in policy have taken place in Belgium and Cyprus, which had no restrictions prior to implementation of the Gender Directive. Both have now chosen to limit the opt-out from equal treatment only to contracts that involve life insurance. Little national research has been done on the impact of the legislation and evidence is generally anecdotal, from which no firm conclusions can be drawn. Most

insurers and insurance associations surveyed did not provide an assessment of impacts. Those who did indicated on average insignificant impacts.

***Implementation of other legislative measures at national level to prevent discriminatory practices***

There is a patchwork of legislative and regulatory measures across the Member States that deal with discrimination, including in financial services. The majority of countries prohibit any form of discrimination, with no exceptions, on the grounds of racial/ethnic origin, religion/belief and sexual orientation, including through the Constitutions of several of the countries. With a few exceptions, age and/or disability are the two most relevant grounds alongside gender, which Member States may allow to be used in the provision of financial services, either because they have no regulation in this respect or, in a number of countries, by means of an opt-out clause (or exception) in the relevant anti-discrimination legislation related to goods and services. Some of the countries have included such exceptions for age and disability alongside sex, during the transposition of the Gender Directive, in legislation dealing with insurance contracts, using similar wording. The exceptions in national legislations that allow for the use of age and disability in the provision of financial services in specific circumstances tend to be ‘horizontal’, i.e. applicable to all products.

A country-by-country overview table of restrictions on use of sex, age and disability is provided below.

**Table 1: Restrictions concerning the use of sex, age and disability in the design, supply or pricing of financial products by Member State**

Country	Sex	Age	Disability
Austria	Restrictions	No Restrictions	Restrictions
Belgium	Restrictions	Restrictions	Restrictions
Bulgaria	Restrictions	Restrictions	Restrictions
Cyprus	Restrictions	No Restrictions	Restrictions
Czech Republic	Restrictions	Restrictions	Restrictions
Denmark	Restrictions	No Restrictions	No Restrictions
Estonia	Restrictions	No Restrictions	No Restrictions
Finland	Restrictions	Restrictions	Restrictions
France	Restrictions	Restrictions	Restrictions
Germany	Restrictions	Restrictions	Restrictions
Greece	Restrictions	No Restrictions	No Restrictions
Hungary	Restrictions	Restrictions	Restrictions
Iceland	Restrictions	Restrictions	Restrictions
Ireland	Restrictions	Restrictions	Restrictions
Italy	Restrictions	Restrictions <sup>(a)</sup>	No Restrictions
Latvia	Restrictions	No Restrictions	No Restrictions
Lithuania	Restrictions	No Restrictions	No Restrictions
Luxembourg	Restrictions	Restrictions	Restrictions
Malta	Restrictions	No Restrictions	Restrictions
Netherlands	Restrictions	No Restrictions	Restrictions
Poland	Restrictions <sup>(b)</sup>	No Restrictions	No Restrictions
Portugal	Restrictions	No Restrictions	Restrictions

Romania	Restrictions	No Restrictions	No Restrictions
Slovakia	Restrictions	Restrictions	Restrictions
Slovenia	Restrictions	Restrictions	Restrictions
Spain	Restrictions	Restrictions	Restrictions
Sweden	Restrictions	No Restrictions	Restrictions
United Kingdom	Restrictions	No Restrictions <sup>(c)</sup>	Restrictions

Source: Civic Consulting survey and follow-up communication with national authorities and equality bodies. Notes: (a) In Italy, the use of age in motor insurance is partially restricted by the possibility of young drivers to enter an insurance contract with the same bonus class of a cohabitant parent. (b) Poland has not yet fully implemented the Gender Directive. However, the Act on Insurance Activities of 22 May 2003 (as amended) allows for the use of gender to determine premiums and benefits when gender constitutes a decisive factor in risk assessment based on relevant and detailed actuarial and statistical data. (c) Restrictions will apply starting from October 2010.

Several Member States have national legislation in place to ensure that specific financial products considered to be essential are available. Insurance products that are covered by this legislation are often reported to be motor third party liability insurance and private health insurance. On the banking side, a number of countries have introduced obligatory basic bank accounts to make it easier for those with impaired or restricted credit histories to open an account. Access to financial products is an area of debate and change in some Member States. The Belgian case of a new law to facilitate access to home loan insurance for people with health risks indicates that some Member States address problems related to access to financial services by direct legislative measures. In contrast, the UK approach in the context of age legislation is to improve access via the non-statutory solution of improved signposting (or referrals to available insurers) for consumers particularly in motor and travel insurance.

Voluntary initiatives of industry associations can play an important role to provide better access to financial products and to guide insurers and banks when applying non-discrimination legislation in practice. Examples reported from Member States and third countries include codes of good practice, statements and commitments regarding HIV, and insurance or predictive genetic testing and guidance notes from actuarial associations. Voluntary initiatives in some countries directly address issues of accessibility that are subject to legislation in other countries. Examples are a voluntary scheme in Germany to ensure universal access to basic banking, and a formal agreement in France between stakeholders that aims at ensuring access to loan insurance for consumers with aggravated health conditions.

#### **IV. Recommendations**

Study results confirm the existence of problems of discrimination in the provision of financial services that need to be addressed through adequate measures. Nearly half of the Member States already have various legislative provisions in place that prohibit the use of racial/ethnic origin, religion/belief and sexual orientation, and permit the use of sex, age and disability in the provision of financial services under certain

circumstances, and thereby broadly anticipate the legal framework proposed by the European Commission.<sup>5</sup> In addition to legislative measures the study recommends to take immediate action in seven areas. The following options for action at EU, national and industry level are not listed in order of priority, but rather follow a logical order of action.

### ***Conducting a representative consumer survey in all EU Member States***

Although this study has confirmed the existence of problems of discrimination in the provision of financial services, it is not possible to establish the scale of the problems because of likely underreporting of complaints. It would therefore be useful if the European Commission would conduct a representative consumer survey in all EU Member States to provide evidence regarding the extent to which consumers have experienced denial of access to specified financial products (the main cause of complaints) and regarding the extent to which consumers perceive they have experienced discrimination in the provision of financial services. More detailed questions could be included in a special Eurobarometer survey. To safeguard acceptance of results across all stakeholder groups, survey questions could be discussed in the framework of the Dialogue on the use of age and disability in financial services.

### ***Review process according Article 5(2) of the Gender Directive***

The review process for Member States that have used the opt-out provision according to Article 5(2) of the Gender Directive could be used to provide additional evidence concerning the impacts of the introduction of unisex premiums. In the review process, the relevant authorities of the Member States could invite service providers and their organisations to evaluate their data on operating costs, product prices, volume of sales and number of providers after the introduction of unisex rates (in those countries that have require them for certain products). To safeguard a coordinated review process, the European Commission could elaborate a template which would outline key criteria to be addressed in the review process.

### ***Guidance for interpretation of key terms***

After consultation with stakeholders, the European Commission could issue a binding or non-binding guidance document, which would provide general principles and harmonised definitions of key terms. It could also clarify if exclusions, restrictions and waiting periods for pregnant women that wish to conclude an insurance contract e.g. for health insurance, are in line with the provisions of the Gender Directive which prohibits “less favourable treatment of women for reasons of pregnancy and maternity”.

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<sup>5</sup> The Commission has presented a Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation, COM(2008) 426 final, which will complement existing directives in the area of gender and race. Once the Draft Directive is adopted, the EU legislative framework would prohibit the use of racial/ethnic origin, religion/belief and sexual orientation, and permit the use of sex, age and disability in the provision of financial services under certain circumstances.

This guidance could be accompanied by a ‘gray list’ or ‘blacklist’ of specific practices of financial services providers related to evidence and proportionality could be developed. The grey list would describe practices which are prima facie considered to be not proportionate, although they can be acceptable under certain circumstances. The blacklist would describe practices that are not considered to be proportionate in all circumstances. This would create clarity for insurers and courts.

### ***Consumer complaints infrastructure and reporting***

The European Commission and Member States could work together with relevant stakeholders to ensure that consumers have adequate access to redress mechanisms for discrimination claims in the area of financial services. Greater sharing of experience and cooperation between equality bodies and specialised alternative dispute resolution schemes in the area of financial services (especially insurance and banking ombudsman schemes), could help to assist these bodies in settling disputes. Good coordination and signposting of consumers to relevant redress mechanisms for discrimination complaints is especially relevant, because it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract, as they generally focus on problems resulting from the performance of contractual obligations.

### ***Codes of good practice***

EU industry associations could, in cooperation with relevant stakeholders, develop voluntary codes that would cover issues such as transparency, complementary guidance regarding proportionality, complaint management, signposting, education/training of staff, best practices for sectoral agreements concerning declined risks etc. Because of differences in national insurance markets, EU level codes would need to be complemented by national codes of good practice.

### ***Sectoral agreements***

EU industry associations could exchange best practices concerning sectoral agreements on declined risks and encourage national associations to conclude such agreements. Sectoral agreements are a flexible and effective approach for declined high-risk consumers that can substitute legislative initiatives. An example for a sectoral agreement which addresses a country-specific problem of how to provide cover for declined risks is the AREAS Convention in France that aims at ensuring access to loan insurance for consumers with aggravated health conditions. Such agreements are particularly important where the financial product concerned is essential for the consumer.

### ***Signposting systems***

Member States could develop signposting systems tailored to the characteristics of each national market. These ensure that consumers who are declined by one insurer are given advice on finding an alternative, which could be a specialist provider. The feasibility and method of practical implementation of this depends on each national

market, the key requirement being maintenance of an up to date list of providers who specialise in or offer products to groups who may be rejected by insurers, and providing appropriate contact details to consumers. Market overviews and tests prepared by independent consumer organisations or other independent agencies and funded by government or industry levies could contribute to more transparency for consumers, including for vulnerable subgroups such as elderly and disabled persons, concerning financial products and help them select the most appropriate provider.

# 1 Introduction

Access to financial services such as insurance or banking services plays an important role in the economy and society as a whole, as it not only allows individuals to make use of economic opportunities but also to improve their health, education, and other social indicators, thus significantly improving their socio-economic well-being.

Civil society organizations report cases of alleged discrimination based on e.g. sex, age, and disability in the provision of financial services. Consumer groups and organisations representing elderly people say that discrimination often occurs through restricted access to some types of insurance and certain credit facilities. They also claim that premiums and rates do not always reflect risks and that policy terms and conditions use “bands” that are excessively broad and sometimes appear arbitrary. Financial services providers deny evidence of widespread discrimination and fear the consequences of prohibiting differentiation subject to legislation. According to the financial services industry, differential treatment is an intrinsic feature of the business and does not constitute discrimination.

EU legislation does not forbid differentiation in the provision of financial services, but it establishes that differentiation should be proportionate and based on a reasoned assessment of the risk. Article 5 of the Directive 2004/113/EC<sup>6</sup> (the Gender Directive) establishes that “Member States shall ensure that the use of sex as a factor in the calculation of premiums and benefits for the purposes of insurance and related financial services shall not result in differences in individuals' premiums and benefits.” An exception can be made “to permit proportionate differences in individuals' premiums and benefits where the use of sex is a determining factor in the assessment of risk based on relevant and accurate actuarial and statistical data.” The Draft Directive implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation,<sup>7</sup> proposed by the European Commission in July 2008, includes a special provision for insurance and banking services, and recognises that “actuarial and risk factors related to disability and to age are used in the provision of insurance, banking and other financial services. These should not be regarded as constituting discrimination where the factors are shown to be key factors for the assessment of risk.”

## Objectives and scope of the study

The study identifies current practices of financial service providers with regard to the use of age, disability, sex, racial/ethnic origin, religion/belief, and sexual orientation<sup>8</sup> in

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<sup>6</sup> Council Directive 2004/113/EC implementing the principle of equal treatment between men and women in the access to and supply of goods and services, hereafter referred to as ‘Gender Directive’.

<sup>7</sup> Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation, COM(2008) 426 final, hereafter referred to as ‘Draft Directive’.

<sup>8</sup> Age, disability, sex, racial/ethnic origin, religion/belief, and sexual orientation are protected under Article 19 of the EU Treaty and are referred to in this report as ‘factors’ or ‘protected grounds’.

the supply and design of financial products, as well as problems of discrimination and existing measures to prevent discriminatory practices.

The assessment covers all 27 EU Member States and EFTA/EEA countries (Norway, Iceland, and Liechtenstein). In addition, the study also compares the situation with 2 other OECD countries (Canada and New Zealand).

### **Structure of the report**

Part I presents the main report of this study. Following the introduction, chapter 2 briefly explains the methodology used for the study (the full methodological approach is included in Part III as Annex 6). Chapter 3 analyses the current practices of financial service providers with regard to the use of age, disability, sex, racial/ethnic origin, religion/belief, and sexual orientation in the supply and design of their products. Chapter 4 analyses actual and potential problems of discrimination in the context of financial services. Chapter 5 examines the implementation of the Gender Directive and of the UN Convention on the Rights of Persons with Disabilities, describes existing measures to prevent discriminatory practices including regulation, self-regulation and other initiatives. Chapter 6 concludes with recommendations for action at EU, industry, and national level.

Part II presents country reports for six selected countries (Belgium, Germany, Sweden, UK, Canada and New Zealand).

Part III presents the Annexes to the report.

### **Acknowledgements**

Civic Consulting would like to express its gratitude to all the supporters without whom this study would not have been possible. We would like to thank industry associations, banks, insurance companies, actuarial associations, civil society organisations, equality bodies, ombudsmen, ministries, and financial supervisory authorities that participated in the survey, as well the representatives of the main stakeholders at EU level and in selected Member States who provided valuable input through in-depth interviews. Finally, we thank the Directorate-General for Employment, Social Affairs and Equal Opportunities of the European Commission for the support provided throughout the study.

## 2 Methodological approach

### 2.1 Overview of methodological approach

The main methodological tools employed in the study are:

- In-depth desk research;
- Exploratory interviews with key stakeholders;
- Interrelated and complementary surveys targeting key stakeholders in EU Member States and EEA countries;
- In-depth interviews in selected countries;
- Collection of documented examples of alleged discrimination from various sources.

### 2.2 Selection of products for analysis

#### 2.2.1 *Relevant products*

Based on a brainstorming exercise, desk research, and exploratory interviews, the following main product categories targeted at consumers have been identified:

**Table 2: Main product categories**

Insurance products	Banking products
<ul style="list-style-type: none"> <li>▪ Motor insurance</li> <li>▪ Travel insurance</li> <li>▪ Private health insurance</li> <li>▪ Life insurance</li> <li>▪ Annuity products</li> <li>▪ Critical illness insurance</li> <li>▪ Disability/income protection insurance</li> <li>▪ Accident insurance</li> <li>▪ Long-term care insurance</li> <li>▪ Home insurance</li> <li>▪ Loan/payment protection insurance</li> <li>▪ Private liability insurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mortgage loans</li> <li>▪ Consumer credit</li> <li>▪ Credit cards</li> <li>▪ Deposit accounts</li> </ul>

For the surveys to stakeholders Civic Consulting clarified that the questions referred to product categories, and not to individual products, and that mixed/bundled products were not to be considered when answering the questions. In addition, definitions of each product category were included in the first page of the questionnaires distributed to stakeholders.

#### 2.2.2 *Selection of products for in-depth scrutiny*

In a second stage, on the basis of the results of the exploratory interviews, desk research and discussion with the European Commission, five financial products have been selected for in-depth scrutiny:

- Motor insurance
- Travel insurance
- Term life insurance
- Private health insurance
- Mortgage loans

**Motor insurance** has been defined as insurance for private cars covering at least third party liability. The study focuses on the main product in the relevant category, i.e. motor third party liability insurance. Motor insurance was one of two most frequently suggested candidates for in-depth scrutiny and it was also relevant based on available information on use of the protected grounds of sex, age, and disability, and on documented complaints. In addition, motor insurance covering at least third party liability is available throughout the EU, as it is required by law.

**Travel insurance** has been defined as temporary insurance that covers, for the duration of the trip only, at least medical expenses, as well as potentially financial and other losses incurred while travelling. Travel insurance was among the most frequently mentioned products by stakeholders as being a product for which consumers experience problems of access, mainly related to age.

**Term life insurance** has been defined as insurance that provides the payment of a death benefit to the beneficiary if the insured dies during the relevant term. Term life insurance was one of the most frequently suggested candidate products and belongs to the products where the protected grounds were most frequently reported to be used. In addition, term life insurance is a relatively homogenous product that is frequently used and that can be expected to be available throughout the EU.

**Private health insurance** has been defined as insurance that covers health risks in addition to (or for those not covered by) the national health care system. Private health insurance was one of the products where the protected grounds were most frequently reported to be used and where complaints were reported. In addition, given the nature of the cover, the consumer detriment of discriminatory practices or lack of access is potentially significant.

**Mortgage loans** have been defined as loans secured against a property. Mortgages were the most frequently suggested banking product where age and disability reported to be relevant factors in product design and pricing. Also, the consumer detriment deriving from lack of access is potentially high in this product area.

## **2.3 Methodological tools**

### **2.3.1 Desk research**

In-depth desk research aimed to identify, collect, and review literature, published data, and other materials that provided essential information for the study. The initial desk research had covered selected technical literature regarding key issues of the study,

as well as the documentation provided by the European Commission. In the course of the stakeholder consultation, several stakeholders provided additional materials such as court cases, annual reports, position papers and in-house research together with their response to the surveys. The study team also conducted a review of academic literature and other relevant analyses, such as price comparisons of insurance and banking products conducted by consumer bodies, with a special emphasis on the Member States which have been subject to country studies (Belgium, Germany, Sweden, and the UK) and follow-up research (France, Cyprus, and the Netherlands).

A bibliography with key documents identified and/or reviewed to date is provided in Part III, Annex 9 of this report.

### **2.3.2 Survey of stakeholders**

Civic Consulting implemented interrelated and complementary online surveys targeting the following stakeholder groups in EU Member States and EEA countries:

#### **Competent authorities, equality bodies, and ombudsmen:**

- Supervisory authorities in the field of financial services
- Ministries of finance/treasuries
- Equality bodies
- Ombudsmen

#### **Industry:**

- National insurance and banking associations
- National associations of actuaries
- Banks
- Insurance companies

#### **Civil society organisations:**

- National civil society organisations representing the interests of potential victims of discrimination (such as organisations promoting gender equality, defending the rights of the elderly, or defending the interests of people with disabilities);
- National civil society organisations defending consumer interests (such as consumer organisations).

The survey questionnaires are presented in Part III, Annex 10.

A total of 241 stakeholder organisations and companies participated in the survey. The largest number of online responses were received from individual financial services providers, both insurance companies and banks (120 responses or 52% of total). In addition, 26 national authorities (11%), 20 equality bodies and ombudsmen (8%), 40 insurance, actuarial, and banking associations (18%), and 22 civil society organisations responded to the online survey (10%). In addition, 5 banking and insurance organisations, 3 insurance companies, 1 national authority, 2 equality bodies

and 2 ombudsmen did not participate in the online survey but submitted separate written comments or answered through a separate document.

### **2.3.3 Interviews**

A first round of exploratory interviews was conducted with key stakeholders, including relevant organisations at EU level during the inception phase of the study. Parallel to conducting the surveys, a second round of interviews was carried out with national representatives of all stakeholder groups (industry associations, financial providers, authorities, equality bodies, and civil society organisations focusing on consumer financial services and/or representing the interests of potential victims of discrimination) in four selected countries (Belgium, Germany, Sweden, and the United Kingdom). In addition, interviews were conducted in three additional Member States (Cyprus, France, and the Netherlands) focusing on specific aspects that appeared to be relevant for the study, identified through the survey results. A total of 65 interviews were conducted.

### **2.3.4 Legal analysis**

In four selected Member States (Belgium, Germany, Sweden, and the United Kingdom) country studies were conducted that included an analysis of current practices of financial providers, an analysis of actual and potential problems of discrimination and a legal analysis of existing measures to prevent discriminatory practices in the provision of financial services. For comparative purposes, two non-EU OECD countries have also been scrutinised in depth for current legislative framework concerning discriminatory practices in the provision of financial services and existing measures to avoid discriminatory practices, namely Canada and New Zealand.

### **2.3.5 Documented examples of alleged discrimination**

In parallel to the survey, civil society organisations, ombudsmen, equality bodies, and national authorities were requested to document relevant examples of complaints regarding alleged discrimination through a separate complaint documentation form (presented in Part III, Annex 11) which was circulated to all relevant bodies across the EU.

### 3 Current practices of financial service providers

In this chapter we consider the current practices of financial services providers in Europe with regard to their use of age, sex, disability, racial/ethnic origin, religion, belief and sexual orientation as factors in the design and supply of products. The subject is considered at a general (EU) level but, where appropriate, we highlight key differences in practices among Member States and, occasionally, other countries. These differences will also become apparent from a study of the individual country reports (covering the Member States Belgium, Germany, Sweden, and the UK, as well as the third countries Canada and New Zealand) that form Part II of this report.

We begin in section 3.1 with a brief sketch of the European financial services market and note its general dimensions.

Section 3.2 analyses some key concepts for the analysis of the current practice of financial firms, including moral hazard and adverse selection, and the problems associated with these phenomena.

In section 3.3 we analyse the use of age, sex and disability in the provision of five particular types of products: motor insurance, travel insurance, term life insurance, private health insurance and mortgage loans. We then conclude with a broad analysis of the use of these factors in other banking and financial products.

Section 3.4 examines how financial service providers ensure that differences in treatment related to sex, age or disability are proportionate to differences in risk and also consider the problems associated with achieving 'mathematical proportionality'.

In section 3.5 we briefly consider the extent to which innovation in the market for financial products may change the use of sex, age, and disability as factors in the provision of financial services.

Section 3.6 considers the use by financial services firms of racial/ethnic origin, religion, belief and sexual orientation as factors in the design, supply or pricing of products. Because the direct use of these factors is not common or widespread in the financial services industry we consider the topic generally, rather than for each product in turn.

We conclude in section 3.7 with a general summary of the use by financial services firms of each of the factors mentioned (age, sex, disability, racial/ethnic origin, religion/belief and sexual orientation) and a brief discussion of how these practices can cause problems for consumers.

#### 3.1 Outline of the European financial services market

In 2008, European insurers generated a premium income of around 1,100 billion Euro, of which 61% was in respect of life insurance and 39% in respect of non-life insurance. These premiums, which account for 41% of the world market<sup>9</sup> were shared among approximately 5,170 insurance firms.<sup>10</sup> However, the individual insurance markets of

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<sup>9</sup> Swiss Re 2009.

<sup>10</sup> Figures taken from CEA 2009.

the EU Member States vary greatly in size, ranging from those of the UK, France and Germany which between them make up 22.6% of the world market, to those of Latvia and Estonia which together account for 0.03%.<sup>11</sup> The number of insurers serving each individual market varies considerably, too, from several hundred in the largest European countries to just a handful in the smaller ones. On a connected point, and as one would expect, the level of competition among insurers varies from one Member State to another. It also varies across different lines of insurance so that, for example, a Member State's motor insurance market might be very competitive while the market for other lines of insurance in the same country could be less so.<sup>12</sup> This point is made because a competitive insurance market is more likely to produce premiums which are accurately aligned to risk with proper and 'proportionate' weight being given to matters such as age, sex and the other factors which are the subject of this study. This point is examined more fully in the following section where we discuss the concepts of adverse selection and moral hazard.

According to the European Mortgage Federation, the total value of outstanding mortgage debt in the EU is currently around 6,087 billion Euro but, as in the case of insurance, there are quite significant differences among national markets. The three biggest markets - UK, Germany and France - make up about 54% of the total for Europe, while Bulgaria, Romania and Slovenia together account for only around 0.2%. Reliance on mortgage finance for the purchase of residential property also varies widely, per capita debt ranging from around 40,570 Euro in Denmark to less than 1,000 Euro in Bulgaria and Romania. Some European countries where insurance spending is high are quite lightly mortgaged by contrast. These include France and Italy, where per capita debt is around 11,000 Euro and 5,200 Euro respectively.<sup>13</sup>

It goes without saying that many European citizens depend heavily on financial products to maintain the quality of their lives. All of the five products that are analysed in detail in this report – motor insurance, travel insurance, term life insurance, private health insurance and mortgage loans – are very important, if not vital, for many people, because they affect significantly the ability of individuals to acquire homes, protect

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<sup>11</sup> Swiss Re 2009.

<sup>12</sup> Based on the Herfindahl-Hirschman Index (HHI) for motor insurance and home insurance, the German retail insurance market is the least concentrated in Europe, according to a recent study, which allocates Germany a score of 352 for motor third party liability (MTPL) and 272 for home insurance. According to the study, 13 EU Member States have an HHI score of 1,000 or less for MTPL and 10 for home insurance (1000 being a common benchmark for an unconcentrated market). Six Member States have a score between 1000 and 1800 for MTPL and six for home insurance (indicating a moderately concentrated market). There were seven Member States with a score of over 1800 for MTPL and 10 for home insurance (indicating a highly concentrated market for these lines). The most concentrated markets for MTPL were Slovenia, Slovakia, and Luxembourg (HHI 3406, 2686 and 2433 respectively) and the most concentrated for home insurance were Slovenia, Estonia and Lithuania (3406, 3,006 and 2973 respectively). However, the Slovenian HHI related to the non-life market as a whole and no figures were available for Malta. See Europe Economics 2009.

<sup>13</sup> European Mortgage Federation, Key Facts and Figures, available at <http://www.hypo.org/Content/default.asp?PageID=414>

their health and families and move about freely. If these products are not available to some, or not affordable by them, the consequences for these people can be dramatic.

Before we examine these products in detail, we examine in the next section some concepts which will help us to understand better the practices of their providers.

### **3.2 Key concepts for analysing current practices of providers**

In this section we examine some of the key concepts for understanding the practices of financial services providers and, in particular, the principles governing the pricing and underwriting of insurance and other financial products. For sake of simplicity and convenience, and because all but one of the products that we analyse in detail are insurance products, this initial discussion takes place mainly in the context of insurance and uses mainly the vocabulary of insurance. However, unless otherwise stated, these concepts are also relevant for other products covered by this study, including mortgage loans.

For private insurers, the ultimate aim is to choose to cover, from all the risks that are offered to them, those which collectively will be profitable. The overall process of doing this is often described as *underwriting*, which can be broken down into a number of distinct activities, including the following:

1. Accepting or rejecting risk offered;
2. Establishing standards of coverage to be offered to acceptable risks;
3. Fixing retentions (the insurer's retention being the *amount* of the risk that it is willing to cover);
4. Classifying risks and fixing premiums for them;
5. Achieving a safe and profitable distribution of risks and establishing rules and procedures to preserve those standards.

Our main concern are activities 1 and 4: the processes of acceptance or rejection of risks offered and risk classification and pricing. Before considering this, however, and with regard to activity 2 – establishing standards of coverage to be offered to acceptable risks – we should note that the products covered by this study are mainly offered to private consumers rather than businesses, and these 'personal lines' of insurance (as they are commonly known) are normally standardised or 'commoditised' products with relatively little individual underwriting or variation in their terms, other than price. By contrast, cover for a business insurance is often individually tailored, especially in the case of large complex risks. Nevertheless, for the products covered in our study we will find variations in the 'standard' cover for some *groups* of consumers (e.g. some restrictions in motor insurance policies for drivers under a certain age).

Concerning pricing, the usual practice for the types of products concerned is to segment the population of insured risks and place them into groups or classes having similar characteristics (and hence similar levels of risk). Appropriate premiums for each group can then be arrived at by the statistical analysis of loss data and actuarial

modelling.<sup>14</sup> This is sometimes called *class (or group) rating*. The criteria used to subdivide the population of risks are those which are believed to reflect or influence the probability of loss. These are known as *underwriting (or rating) factors* and may include age, sex or disability. Of course, the greater the number of such factors that can be identified and used, and the greater the number of sub-divisions within them (e.g. age bands in motor insurance), the more precisely can premiums be calibrated to risk. For some lines of insurance (motor insurance being an example) a large number of factors are used in most markets. However, precise calibration is only possible when data at a fine level of detail can be obtained and, as we shall see, the difficulty and cost of gathering such data has to be taken into account by providers and balanced against its usefulness.

Many of the underwriting factors used by providers are not so much causes of loss as proxies for other things that may cause loss. For example, the age of an insured person may be a proxy for ill-health or disease (which might cause an inability to work, expenditure on medical treatment or death), or for careless driving (which might cause a road accident) or for lack of financial means (which might result in default on a loan). The use of such proxies is commonly justified by reference to the costs that would be incurred (and ultimately born by all consumers) if a detailed examination or audit of each consumer had to be carried out (e.g. medical examinations, tests of driving skills or detailed financial audits). At this point we should note that proxies of the sort mentioned cannot hope to exactly measure some of the subtler aspects of the risks which are carried by providers (such as a person's temperament, spatial awareness and driving skill in the case of motor insurance). However, these can at least partly be captured by the provider taking into account the past loss record of the individual concerned and then, in the case of insurance at least, adjusting the premium on a continuous basis to reflect the level of losses that actually accumulate from year to year. This (pricing each customer on the merits of their own loss record) is sometimes known as *experience rating*. Motor insurance provides a good example of a type of insurance where class rating (initial pricing of risk based on a variety of rating factors) is used in combination with experience rating (adjustment of premium from year to year through the well-known 'bonus-malus' system, depending on the level of claims which are made).

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<sup>14</sup> Of course, many other factors are taken into account in arriving at the final price to be charged, including the effect of a deductible (excess), loadings for contingences (that is, possible shifts in the underlying probabilities of loss, which cannot be identified in advance), adjustments for inflation, adjustments for investment income, expense loadings, etc.

This leads to the following conclusion:

1. ***Pricing of consumer insurance and credit products is generally based on segmenting the population of covered risks and placing them into groups or classes having similar characteristics (and hence similar levels of risk).*** Premiums for each group are arrived at by the statistical analysis of loss data and actuarial modelling. The criteria used to sub-divide the population of risks are those which are believed to reflect or influence the probability of loss, including age, sex or disability. Many of the underwriting factors used by providers are not so much causes of loss as proxies for other things that may cause loss. The use of proxies is commonly justified by reference to the costs that would be incurred if a detailed examination (e.g. a medical examination or test of driving skills) had to be carried out for each consumer applying for products such as travel or motor insurance.

### **Adverse selection and moral hazard**

It is appropriate to introduce at this point two key concepts in insurance theory and practice: adverse selection and moral hazard. Adverse selection (or anti-selection – also sometimes referred to as ‘hidden knowledge’) can arise if the insured has better information about the risk he or she represents than the insurer, or the insurer has full knowledge of the risk but does not act on it (perhaps because the law does not permit the information to be used). If, for example, the insured knows that he is in much poorer health than most people (perhaps because of bad diet, smoking or alcohol abuse), a life or health insurer who does not know this will tend to under-price this person relative to other clients who are in good health. The latter will have to cross-subsidise the former through the premiums they pay, meaning that the risks they represent will be over-priced. The effect of this will be that people who represent the over-priced ‘good’ risks will be inclined to buy less insurance, or even to drop out of the insurance pool altogether. This could lead to a vicious circle whereby better risks leave the pool, requiring premiums to be raised (unless the insurer is prepared to risk insolvency), which reinforces that tendency further, ultimately causing the insurance pool to unravel. Perhaps more to the point, in a competitive insurance market, a person representing a ‘good’ risk which is over-priced will simply decamp to another insurer which offers an actuarially fair premium that is lower, the availability of a better price effectively signalling to the person concerned that he or she is currently being overcharged. The effect for the original insurer is the same in either case: that is, the retention of ‘bad’ risks which are under-priced, with the consequences discussed.

It follows from this that insurers have a natural incentive to distinguish between risks as precisely as possible and charge premiums which are as accurate as they can be in actuarial terms. In a highly competitive market, this becomes an imperative: accurate pricing will be a source of competitive advantage, because an insurer that is able to assess the risk of loss more accurately than its competitors will be able to identify and attract lower-risk customers who are being overcharged by the rest of the market, while avoiding higher-risk customers who are being undercharged.

In order to fine-tune premiums in the way described an insurer should therefore, at least in theory, identify and employ as many significant underwriting factors as possible and give each one an appropriate weight. It follows from this that there should be, again, a natural incentive on the part of insurers to ensure that the effect of each factor on the cost of insurance is proportionate to risk. However, in reality there are a number of factors that might limit an insurer's ability or willingness to finely segment the risk population and charge accurate differential premiums in the way described.

- First, the incentive to do so will be reduced if the market is not competitive, especially if the product in question is mandatory by law (as in the case of third party motor insurance) or is one which is essential in practice.<sup>15</sup> In extreme cases (e.g. where there is a monopoly provider or price-fixing cartel), the consumer may have little choice but to buy at whatever price is offered;
- A second problem concerns the availability of information and the costs of acquiring it. For some consumers (for example, very young people, very old people or those with rare medical conditions), the available loss data may be very thin, creating a high level of uncertainty as to the true level of risk. Furthermore, in all cases there are costs attached to the acquisition of more detailed risk information: for example, the costs incurred in carrying out a thorough medical examination of an individual who is to be insured or detailed physical inspection of property which is to be covered. As mentioned earlier, this cost has to be balanced against the benefits gained from getting more information. A further factor to be taken into account is the potential resistance of consumers to what they might regard as an unnecessary and intrusive probing into their personal lives. This might range from a simple unwillingness to complete very long application forms containing many searching questions to an unwillingness to undergo extensive medical tests.<sup>16</sup>

A further problem associated with fine-tuned differential pricing of insurance can arise in connection with those very high-risk customers which an exceptionally rigorous underwriting process may be able to pinpoint. The danger is that such consumers may be priced out of the market or even refused insurance altogether (the 'redlining' problem). This might lead to social exclusion and further impoverishment if, say, consumers in poor, crime-ridden (and hence very high risk) neighbourhoods are

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<sup>15</sup> As we have seen, some smaller EU insurance markets are highly concentrated. See footnote 12 and accompanying text.

<sup>16</sup> The use by motor insurers of GPS technology ('black box' or 'spy in the sky' systems) to continuously track the use of insured motor vehicles and the conduct of their drivers, which has obvious implications for privacy rights and civil liberties, provides a sharp illustration.

denied cover.<sup>17</sup> This highlights the fact that there is some tension between the risk-spreading characteristics of insurance and the need to price risk accurately.<sup>18</sup>

We now turn briefly to the connected problem of moral hazard (sometimes characterised as ‘hidden action’). In the context of insurance, it is the risk that the granting of insurance cover will bring about a change in the behaviour of the policyholder which makes the adverse and economically undesirable insured event more likely to happen. For example, persons who are immunised against loss by their insurance may become careless as a result or even cause losses deliberately to get the insurance money. Insurers employ a number of standard techniques to combat this problem. They invariably restrict cover to losses which are ‘fortuitous’ (accidental) only and, in non-life insurance, restrict payments to an indemnity only – i.e. exact compensation for the loss and no more. Indeed, insurers often provide *less* than full indemnity by requiring the insured to share any loss that does occur. This is done by including a deductible or co-insurance clause in the insurance policy, thus preserving an incentive on the part of the policyholder to take care. Another common device to reduce moral hazard is the use of restrictive policy terms which reduce coverage for high-risk policyholders, either in advance of losses occurring or as a consequence of claims experience, or require the insured to behave in a particular way if the cover is to remain operative.<sup>19</sup>

The levying of accurate variable premiums according to risk plays a part in combating moral hazard as well as adverse selection. This is so because the incentive to take care will be enhanced if a policyholder knows that the premium is likely to rise if he or she has an accident which results in a claim and may fall if there is no claim. The bonus-malus system commonly used in motor insurance, mentioned earlier, is partly founded on this principle. This technique is obviously less effective for lines of insurance where the insured has less influence over the risk, such as home insurance, where many losses arise from factors which are largely beyond the insured’s control, such as storms, lightning and floods.

Moral hazard can obviously have a social impact that goes beyond the profitability of insurers, because careless behaviour can affect others, such as road accident victims, and have wider impacts on society. Again, if incorrect pricing leads to high-risk individuals being subsidised by low-risk customers, the former may make choices

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<sup>17</sup> There are a number of solutions to this problem, including ‘declined cases’ agreements whereby risks that are unacceptable to individual insurers are pooled and spread across the market (see footnote 112). The issue of financial exclusion is not covered by this report and was subject of a separate study, see: European Commission, 2008a.

<sup>18</sup> The ultimate *reductio ad absurdum* is the theoretical and imaginary position whereby an insurer can exactly predict the losses which will be incurred by every individual policyholder. The premium charged in each case will be then amount of these losses (plus expenses!) with the result that insurance becomes ‘Euro swapping’ with no risk spreading at all.

<sup>19</sup> Common examples include general conditions requiring the insured to take ‘reasonable care’ in relation to the insured risk or specific conditions, such those which forbid the policyholder from driving when drunk or under the influence of drugs, or require him to maintain his vehicle in a roadworthy condition at all times, or fully secure his house when he is not at home.

which increase the risk for all: for example high-risk drivers who are charged low premiums may well be tempted to buy more powerful vehicles, further increasing the danger to society.

Ultimately then, insurance underwriting involves a number of compromises in which the risks of adverse selection and moral hazard have to be balanced against the costs involved in avoiding them, the preferences of consumers and the need to remain competitive in the market. In practice rigorous 'individual underwriting' is more likely to be employed in the case of risks which are large, complex or unusual and for which premiums are high enough to absorb the additional cost involved. In the case of simple risks where cover has to be provided at relatively low cost (travel insurance being an example) individual risk assessment will be rare. For these lines of insurance, providers are likely to adopt simplified underwriting processes in which they restrict both variations in cover and the number of questions they ask their customers to the minimum.

This leads to the following conclusion:

**2. In a highly competitive market, private insurers have a natural incentive to distinguish between risks as precisely as possible and charge premiums which are as accurate as they can be in actuarial terms.** An insurer that is able to assess the risk of loss more accurately than its competitors will be able to identify and attract lower-risk customers who are being overcharged by the rest of the market, while avoiding higher-risk customers who are being undercharged. However, the incentive to do so will be reduced if the market is not competitive, especially if the product in question is mandatory by law (as in the case of third party motor insurance) or is one which is essential in practice. Fine-tuned differential pricing of insurance can also lead to very high-risk consumers being priced out of the market or even refused insurance altogether.

### 3.3 The use of age, sex and disability in the design, supply and pricing of key products

In this section we discuss the use of the factors age, sex and disability in the provision of five types of products: motor insurance, travel insurance, health insurance, term life insurance and mortgage loans. These factors are considered in relation to each product in turn.<sup>20</sup> The employment by financial services providers of other factors covered in this study, i.e. racial/ethnic origin, religion/belief and sexual orientation is considered in section 3.6. The use of the factors is summarised (including in relation to other types of products) in section 3.7 below.

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<sup>20</sup> This analysis focuses on how these factors are used in design, supply and pricing of the selected products. Actuarial analysis of the relevance of the factors (e.g. to determine how exactly age/life expectancy of the insured population in a specific country or otherwise defined group influences claim costs) was outside the scope of this study. However, for illustrative purposes Annex 4 in Part III of this report presents exemplary statistical data showing how the factors sex and age can influence claim costs for selected products in some countries as reported by the insurance industry and selected literature.

### **3.3.1 Motor insurance**

Motor insurance can be regarded as a particularly important form of cover, from a variety of perspectives. First, motor insurance – or at least motor third party liability cover (MTPL) – is compulsory throughout the EU, which means that persons who find it unaffordable or unobtainable are likely to suffer serious disadvantage in terms of their personal life and employment opportunities if they are unable to drive as a result. Second, motor vehicles provide an important means of securing the free movement of goods and people around Europe – a key tenet of the EU. Third, motor insurance is a major line of insurance from the perspective of insurers also. The number of vehicles in Europe is enormous<sup>21</sup> with the result that motor insurance typically accounts for somewhere between 30% and 50% of total non-life premiums. Not surprisingly, there is a correspondingly large number of motor insurers in the EU.<sup>22</sup>

Motor insurance is sold through a variety of distribution channels in the EU, including independent insurance brokers, (tied) agents of various sorts, banks and financial institutions, major retailers, and motor dealers. Many insurers also market their products directly to the consumer and the use of the internet as a distribution channel is of increasing significance.<sup>23</sup>

The pricing of motor insurance in the EU generally follows the basic principles set out in section 3.2 above. In most EU markets, motor insurance pricing is sophisticated, with insurers using a large number of underwriting factors (perhaps 20 or more, including age, sex and disability) with many subdivisions for each factor (e.g. age bands or vehicle types).<sup>24</sup> Thus, while data for some lines of insurance is often rather limited in scope, in motor insurance there are often large quantities of data at a fine level of detail. These can be used to construct premium rates based wholly on previous data, which can be adjusted later on basis of the claims experience. The results have to be treated carefully, since they are likely to be based on one or only a few years' experience, but they can provide some useful signposts. For example, it may be possible to detect which areas of the business are profitable and which are not. Companies can also seek to exploit 'niche' markets where they are able to make profits and steer away from markets where they make losses.

Motor claim types (e.g. third party property damage, third party bodily injury, theft, windscreen breakage, own damage, etc) are often modelled separately. The reason for

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<sup>21</sup> The CEA suggests that there were over 315 million vehicles of all types on the roads in Europe in 2007 (CEA 2010).

<sup>22</sup> CEA estimates that there were around 1,100 motor insurers operating in Europe in 2007, although the number has declined at a fairly steady rate of about 4% per year over the last few years (from 1385 companies in 2002) as a consequence of market consolidation (CEA 2010).

<sup>23</sup> This is significant because certain groups of consumers (especially the elderly) are less likely to use the internet.

<sup>24</sup> Commonly used factors (in addition to age, sex and disabilities) include the vehicle type, its area of use, the occupation of the insured, the use of the vehicle, the insured's accident and claims record, record of motoring convictions, insurance history and bonus-malus entitlement, the type of cover required, where the vehicle is kept when not in use, distance driven in a typical year, type of driving licence held by the insured and date of his acquiring the licence, and details of other drivers.

this ‘component pricing’ is that different factors may affect each type of claim, and the factors may affect each in different ways. Thus, it is expected that more accurate modelling can be achieved in this way. For each claim type, separate models are usually formed for the claim frequency and severity, using past data, to determine the effect of various factors. The expected values for frequency and severity are multiplied together to get an expected claim cost for each claim type (per unit of exposure). These are then added over claim types and adjustments are made to allow for expenses, contingencies, etc.<sup>25</sup>

It is worth noting that while many motor insurers do not specialise, but offer to insure a wide range of potential customers and their vehicles, others choose to specialise in one or more particular market segments. These might include unusual or non-standard types of vehicle, vehicles used for a specialised purpose or policyholders working in particular trades or business. Insurers may do this because they have identified a particular sector as being especially profitable, as discussed above (which implies that other firms in the market are over-pricing the category in question) and/or because their strategy is to invest resources and build up expert knowledge in a field where other insurers have less expertise.<sup>26</sup> This practice is mentioned because a motor insurer could, for the reasons given, decide to specialise in groups characterised by age (e.g. very young or elderly drivers) or even those with certain disabilities.

We now turn to the use of age as a factor in the provision of motor insurance.

## **The use of age as a factor**

### ***Age as a factor in pricing***

There is convincing evidence illustrating the relationship between driver age and the incidence of motor accidents,<sup>27</sup> with young drivers (especially young men) presenting a significantly enhanced risk and elderly drivers a somewhat enhanced risk, though this is tempered by the tendency of elderly people to reduce their exposure to risk by driving lower distances than the young and avoiding places where traffic is dense and driving conditions are stressful. Age (normally, that of the main user of the vehicle) is therefore a significant factor in the pricing of motor insurance and is used by most, if not all, motor insurers, at least for the insurance of individually owned vehicles used for private purposes.<sup>28</sup>

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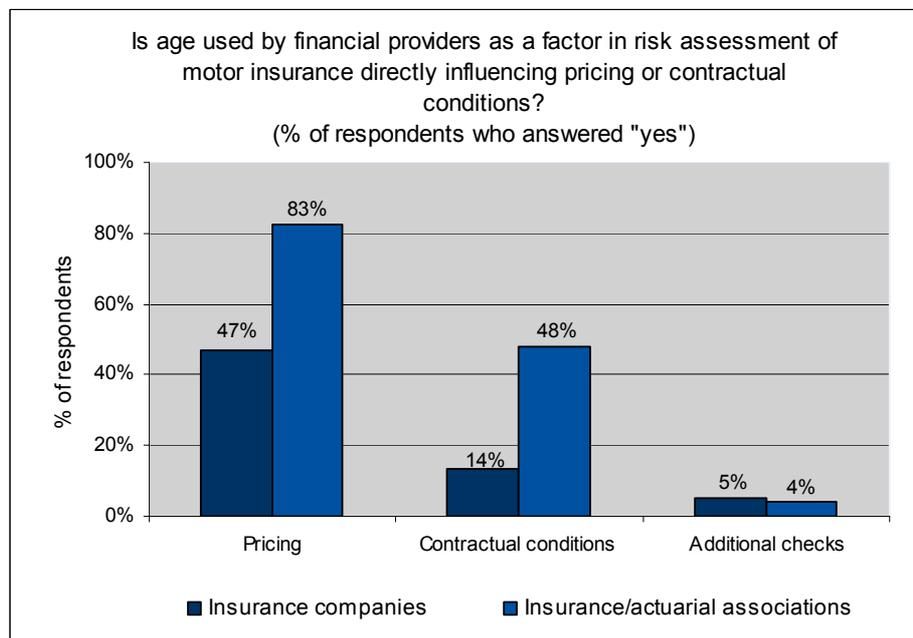
<sup>25</sup> See footnote 14.

<sup>26</sup> For example, building up a relatively large book of a particular type of non-standard risk may justify the expense of employing one or more underwriters who specialise in that field, which other insurers, with just a few such risks on their books, may not be able to afford.

<sup>27</sup> See, for example, Government Equalities Office 2009 (the Oxera-Report).

<sup>28</sup> Age is unlikely to be used for motor fleet insurers, for example.

**Figure 2: Use of age in risk assessment of motor insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

We can see from Figure 2 that 83% of respondents from the survey of national industry associations and national actuarial associations confirmed the use of age as a factor in pricing of motor insurance. Only 47% of individual insurers confirmed this fact, but the figures are distorted by the inclusion in the survey of a number of insurers who do not write motor insurance and which, as a consequence, did not answer the question concerned.

Attempting to exactly quantify the effect of age on insurance price is problematic because there are many variables to take into account. For example, the Belgian consumer organisation *Test-Achats* gives the example of ‘*omnium*’ (or ‘comprehensive’) motor insurance cover for persons aged 22, 26 and 46 years whereby a 26-year-old pays 50% more premium than a 46-year-old and a 22-year-old pays 200% more.<sup>29</sup> However, a similar ‘mystery shopping’ exercise on a UK-based comparison website produced much lower differentials, with an increase in premium of only around 26% in the first case and 68% in the second.<sup>30</sup> Some insurers employ pricing models that use individual age while others use age bands.<sup>31</sup>

<sup>29</sup> Test-Achats 2010.

<sup>30</sup> Quotations were obtained from Confused.com in March 2010 based on a woman policyholder based in West London driving an ordinary family car. The percentage figures given are based on the average of the five cheapest quotations for policyholders of the stated ages.

<sup>31</sup> Based on responses by insurers to the online questionnaire and interview with a representative of the actuarial profession in the UK.

### ***Age as a factor in the availability of cover***

It is clear from our survey that some insurers will insure clients of any age. However, others refuse to insure the youngest drivers (e.g. under 21 in the case of one insurer respondent), especially if there are other adverse risk factors present (e.g. possession of a high-powered vehicle, poor driving record, high-risk use or occupation). Many motor insurers will decline to quote for new customers above a certain age.<sup>32</sup> Upper age limits among our survey respondents ranged from 70 to 99 years<sup>33</sup> but at least some of these insurers do not impose any upper age limit on those renewing a policy.<sup>34</sup>

One insurer in the survey stated drivers over the age of 81 (as well as those with certain medical conditions) were required to provide medical evidence of their continued fitness to drive. Another (Belgian) company apparently makes would-be insured persons older than 70 prove their driving skills and the Belgian national insurance association, *Assuralia*, confirms that some insurers offer a test to their older customers when they have caused one or more accidents or when they are considered an increased risk in terms of health.<sup>35</sup>

### ***Age as a factor in contractual terms***

In some instances the age of the main driver of the insured vehicle is likely to affect the terms on which insurance is offered. Restrictions in the scope of cover for young drivers commonly mentioned in our surveys include the limiting of cover to named drivers with no availability of 'any driver' cover, refusal of a common facility which allows policyholders to drive vehicles owned by another on their own insurance and higher deductibles. Again, as noted earlier, a number of insurers stated that they would insure young persons who drove small, ordinary low-powered vehicles but not those driving expensive limousines, high-powered vehicles, sports cars and the like. Restrictions in the scope (as apart from availability) of cover for older policyholders are evidently less common, with no examples mentioned in our survey. However, motor policies which offer accident benefits (i.e. which pay out sums in respect of injury to the driver and/or passengers which do not depend on fault) may reduce such cover for older people. See, for example, the example quoted in our Belgian country report where the sum insured in case of death is reduced if the insured has reached the age of 75.<sup>36</sup> A Belgian consumer guide for motor insurance also cites examples where so-called 'gross negligence' (*faute grave*) is excluded after a certain age.<sup>37</sup>

<sup>32</sup> E.g. about 90% in the UK. See ABI/CRA International 2008.

<sup>33</sup> Ibid., the average upper age limit in the UK is 83.

<sup>34</sup> Government Equalities Office 2009 (the Oxera-Report).

<sup>35</sup> See Assuralia 2005.

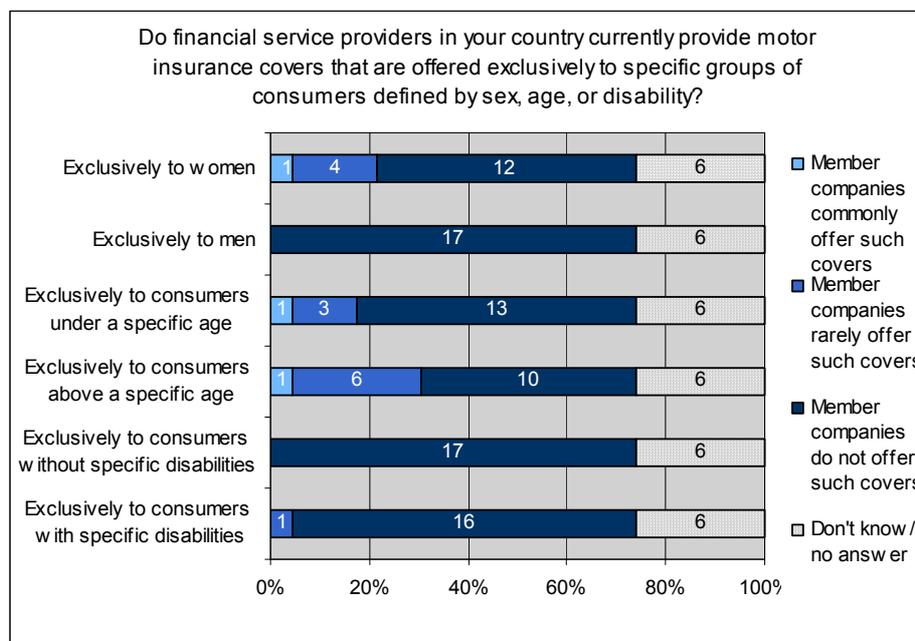
<sup>36</sup> See also J.-P. Coteur, P. Louyet and A. Moriau 2007. See for instance, <http://www.aginsurance.be/nl/canal/ag/particuliers/00792000500n.pdf>, p.4, where the sum is reduced by 50%.

<sup>37</sup> See <http://assurance-voiture.guides-123.be/fr/etape-1--bon-a-savoir/exclusions>. Gross negligence is for instance, driving under influence of alcohol, drugs or narcotics not prescribed by a physician.

**Age as a factor in marketing and business strategies**

It is apparent from our survey that few insurers target market segments defined, at least in part, by age: see Figure 3 (bars 3 and 4) below.

**Figure 3: Provision of motor insurance covers to specific groups of consumers**



Source: Civic Consulting surveys of insurance/actuarial associations (N=23).

Clearly, a few insurers offer insurance only to older people and (we believe) rather fewer to younger ones only. We infer that insurers do this as part of a business strategy or because of their links with organisations that support the elderly or young people, such as students. It is clear also that some insurers, while not absolutely excluding younger or older clients, positively seek to attract what might be called 'mature' (but not very elderly) clients through their marketing campaigns. Again, a few insurance companies (and a number of insurance brokers) specialise in adverse or hard-to-place risks, which may include young drivers as well as those with other adverse risk features.

**The use of sex as a factor**

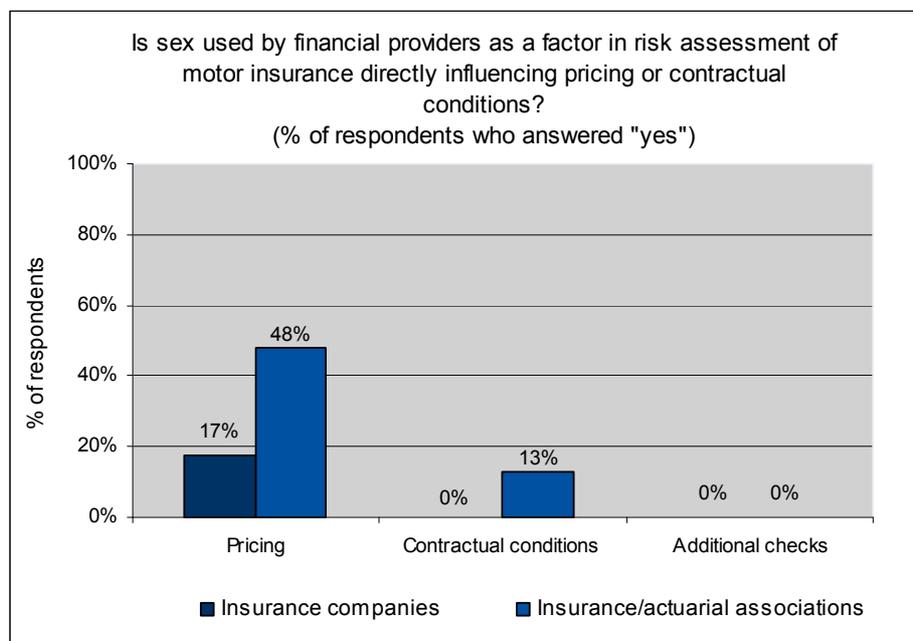
Generally, sex is a significant factor in motor insurance though less important than age, with greater variation in the practice of insurers. There appear to be three main categories. First, there are cases where the use of sex as an underwriting factor is forbidden by law, even though insurers might otherwise want to use it;<sup>38</sup> second, cases

<sup>38</sup> Groupe Consultatif Actuariel Européen 2009. The Member States which require unisex motor insurance prices are Belgium, Bulgaria, Cyprus, Estonia, Latvia, Lithuania, Netherlands and Slovenia.

where there is no such legal restriction but where sex is not used in practice; and third, cases where it is used.

The results of our survey on this subject are shown in Figure 4.

**Figure 4: Use of sex in risk assessment of motor insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

### ***Sex as a factor in pricing***

As Figure 4 shows, sex is a factor used in the pricing of motor insurance by some insurers, though it is of less significance than age, which is used by most insurers. Sex is regarded by some insurers as a proxy for driving behaviour, because female drivers have fewer accidents than men. They are also likely to drive for a smaller total distance in the course of a year, although this factor (distance driven in the course of a year) is sometimes the subject of a separate question on motor insurance application forms and hence taken into account and priced in its own right, without regard to sex. The difference between premiums for men and women is likely to be most marked in the case of young men and women, since evidence suggests that the former pose a much higher risk.<sup>39</sup> A number of respondents in our surveys suggested, however, that there is still an element of cross-subsidy involved, with young men paying premiums that are lower than their true actuarial premium and other groups paying rather more.<sup>40</sup>

<sup>39</sup> For example, UK data provided by the Association of British Insurers in compliance with the requirements of the Gender Directive suggest that, in the 21-25 age band, the claims cost for men is 60% greater than for women (see ABI 2009b).

<sup>40</sup> Including the UK Association of British Insurers, a representative of the UK Institute of Actuaries.

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### ***Sex as a factor in the availability of cover, business strategies and contractual terms***

We found no examples of motor insurers offering cover exclusively to men but a few respondents in our survey suggested that some companies provide insurance exclusively to women, including two insurance companies (from 43) which reported that they did so. However, it is not clear from the responses whether these insurers refuse to insure men altogether or merely market a special insurance product adapted for women alongside their normal form of policy.

A few respondents from the categories of national industry associations and national actuarial associations claimed that sex could influence contractual terms for motor insurance, though no individual insurer respondents did so (see Figure 4). Our belief is that contractual terms for motor insurance are unlikely to vary significantly, if at all, between men and women in the vast majority of cases.<sup>41</sup>

#### **The use of disability as a factor**

'Disability' is somewhat different from the two factors discussed above in that the word does not refer to a single, concrete, objective condition (like age or sex); rather, it is an umbrella term used to cover a very wide range of bodily and mental impairments which affect people's ability to carry out normal day-to-day activities. Motor insurers generally are not concerned about whether or not their clients are disabled (which depends, in any event, on precisely how disability is defined) but rather with any underlying health conditions which could affect the risk of motor accidents.<sup>42</sup> Quite frequently the insured may be disabled as far as discrimination law is concerned but does not present any enhanced risk to the motor insurer.

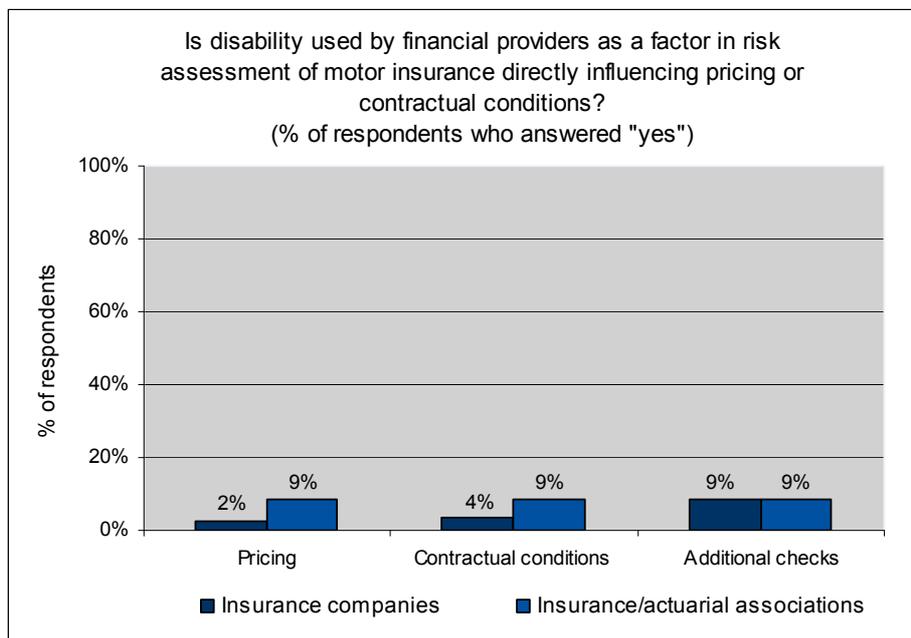
In any event, our survey responses indicate that disability is a relatively minor factor in risk assessment of motor insurance, which only a relatively small proportion of insurers take into account (see Figure 5 below).

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<sup>41</sup> Differences in cover which we have identified appear to be cosmetic rather than substantial. For example, one UK car insurer specialising in women drivers (while not refusing men) offers extra 'handbag' cover and 'female friendly repairers'.

<sup>42</sup> Though insurers may also want to know about disabilities if they are likely to affect the service that insurers need to provide in the event of a claim. For example, insurers may need information about the type of replacement car required by a disabled driver.

**Figure 5: Use of disability in risk assessment of motor insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

#### ***Disability as a factor in pricing and the availability of cover***

The majority of respondents in our survey stated that disability is not taken into account in the provision of motor insurance. With regard to the minority that do take this factor into account it is clear that disability is a broad ‘underwriting’ issue rather than a narrow ‘pricing’ issue. By this we mean that those insurers which take disability into account do not have a systematic pricing structure for disabled persons (as nearly all do in the case of age), but rather look at disabled persons on an individual basis, sometimes basing their decision on medical reports. This is reflected in our survey by the 9% of responding insurers and insurance associations who declared disability to be a factor which influenced the need for additional medical checks (see Figure 5). In some such cases premiums may be raised, but in others a policy will be issued on normal terms. An example given by the UK Association of British Insurers illustrates this well:

*“A 42-year-old woman with a diagnosis of manic depression applies for motor insurance. Based on actuarial data relating to the risks posed by a person driving when in a manic episode, she will have to pay double the normal premium because of her condition. However, she produces credible evidence to show that she has been stable on medication for some years and that she has an unblemished driving record. In these circumstances, charging a higher premium is unlikely to be justified. In the circumstances of the particular case, [a motor insurance policy is issued on standard terms with no extra premium]”<sup>43</sup>*

<sup>43</sup> ABI 2003.

Clearly the key issue for insurers is whether or not the disability affects the applicant's ability to drive. Individual responses to our insurer survey indicate that some insurance firms take the view that the possession by the insured of a valid driving licence is sufficient guarantee of that ability.<sup>44</sup>

No respondent in our survey stated that they offered insurance exclusively to persons without specific disabilities (see Figure 3 above). Two respondents stated their companies provided cover exclusively to persons with specified disabilities, but it does not follow that these insurers cover only disabled persons. For one respondent we know that this is not the case.<sup>45</sup>

### ***Disability as a factor in contractual terms***

It is clear from our survey that disability rarely influences the contractual terms or benefits of motor insurance policies. The very small number of respondents who stated that disability did influence motor insurance in this way evidently referred to cases where the insurance policy requires the insured vehicle to be adapted so as to comply with the restrictions imposed by a licensing authority, or where accident benefits have to be adapted in line with an existing disability.<sup>46</sup>

This analysis leads to the following conclusion:

3. ***Age is a significant factor in the pricing of motor insurance and is used by most, if not all motor insurers, at least for the insurance of individually owned vehicles used for private purposes.*** It is clear from our survey that some insurers will insure clients of any age. However, others refuse to insure the youngest drivers, especially if there are other adverse risk factors present (e.g. possession of a high-powered vehicle). Many motor insurers will decline to quote for new customers above a certain age, commonly in the range of 70 to 99 years, but at least some of these insurers do not impose any upper age limit on those renewing a policy. Sex is also a significant factor in motor insurance though less important than age, with greater variation in the practice of insurers. In contrast, disability is a relatively minor factor in risk assessment, which only a relatively small proportion of insurers take into account.

<sup>44</sup> For example, in the UK, the Driver and Vehicle Licensing Agency (DVLA) effectively screens drivers in order to determine whether they are fit to hold a driving licence. DVLA can refuse a licence or impose conditions on it to take account of disabilities. Licenced drivers have a duty to notify DVLA if they subsequently develop a disability which might impede their ability to drive, with the result that the licence may then be restricted or have to be surrendered. If certain restrictions are imposed by the licensing authority (e.g. concerning the type of vehicle a person is allowed to drive), insurers can provide cover only in line with these conditions.

<sup>45</sup> A large UK insurer refers to a 'Motability' scheme for individuals who qualify for a state disability allowance and can use this allowance to lease a vehicle. The company provides insurance for this scheme but also has a large book of 'ordinary' motor insurance business.

<sup>46</sup> For example, these benefits may provide compensation for loss of one or more eyes or limbs.

### **3.3.2 Travel insurance**

Travel insurance is available to cover a range of risks associated with trips that are taken for either business or pleasure purposes. These risks include loss or damage to luggage, personal possessions or money; liability incurred towards others in connection with accidents; costs associated with travel delays or unavoidable cancellation of journeys; and the expenses of medical treatment and repatriation. These risks can sometimes be insured selectively, but they are most frequently covered as a package. Policies can cover single trips or be issued on an annual basis for those who anticipate taking a number of journeys in the course of a year. In contrast to (third party) motor insurance, travel insurance cover is not mandatory in any EU Member State. Furthermore, some of the risks involved may either be covered by other forms of private insurance<sup>47</sup> or are alleviated by the availability of free or reduced-cost medical treatment through Member States' public health facilities.<sup>48</sup> Nevertheless, many people regard travel insurance as essential to ensure that there are no gaps in coverage and, in particular, to guarantee that medical treatment of a high standard can be secured promptly in the event of an emergency. Older people, and those whose health is frail, may be reluctant to travel at all if insurance is unobtainable or unaffordable.

Travel insurance policies (especially 'single trip' contracts) are generally low cost products, especially when compared with motor insurance.<sup>49</sup> Mainly to comply with consumers' expectations on price (and speed of issue in some cases), insurers generally issue standardised contracts and use simplified procedures in relation to documentation, business processing and underwriting. Relatively few rating factors are used: principally, these are destination or area of travel, purpose and duration of the trip and age.

#### **The use of age as a factor**

##### ***Age as a factor in pricing***

Travel claims divide between those which are medically-related (e.g. cost of medical treatment for accidents or illness) and those which are not (e.g. claims for lost

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<sup>47</sup> For example, home insurance policies sometimes include full travel cover for a certain number of days per year (e.g. 45) and these, together with separate 'all risks' contracts, often give cover, for personal possessions at least on a 'world-wide' basis.

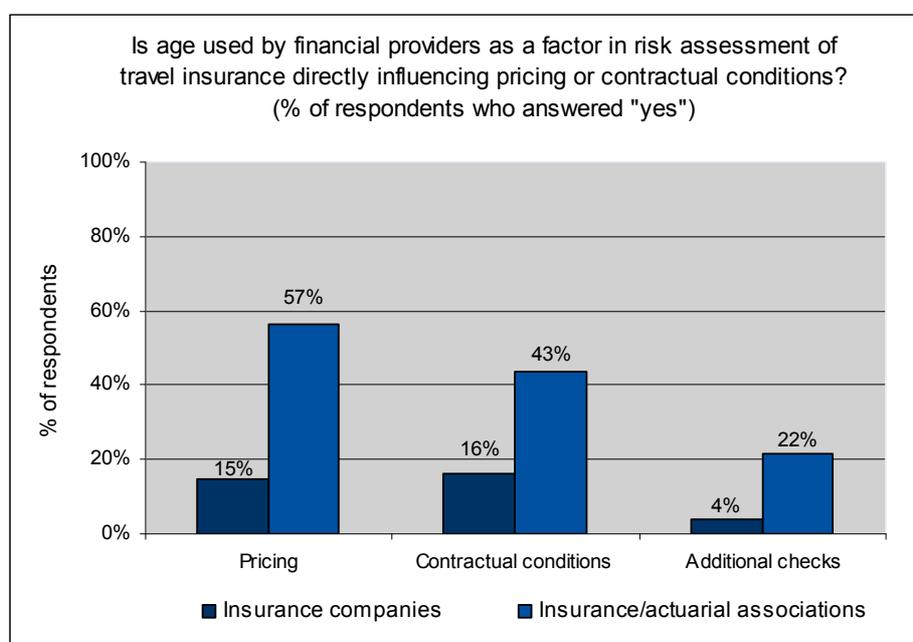
<sup>48</sup> E.g. for consumers carrying a European Health Insurance Card. The card makes it easier for people from the European Union's 27 Member States plus Iceland, Liechtenstein, Norway and Switzerland to access health care services during temporary visits abroad, by providing access to the public sector health care of the country visited, see <http://ec.europa.eu/social/main.jsp?catId=559>.

<sup>49</sup> For 2007, CEA quote average motor private car premiums per insured (MTPL and own damage) ranging from around 200 Euro (in Poland) to 775 Euro (in the UK), with an average of 439 Euro in Europe as a whole. The 2007 average in Europe for MTPL premiums only was around 242 Euro (CEA 2010). Data on average premiums for travel insurance in Europe are not available. However, single trip travel insurance (based on a person aged 40 travelling within Europe for 15 days and not engaging in winter sports) can be obtained in the UK for as little as 7.5 Euro, or 22 Euro for annual cover (prices obtained from Confused.com on 5 March 2010).

baggage, cancellation, transport delay, etc.). There is evidence suggesting that the expected average claims cost for each sort of claim tends to rise with the age of the insured person, and rises steeply in the case of medical claims.<sup>50</sup> For this reason, travel insurance can be markedly more expensive for older people, age being used by travel insurers as a proxy for health.

The results of our survey are somewhat ambiguous in that most responding national insurance associations and actuarial bodies (57%) assert that age influences the pricing of travel insurance while only a relatively small proportion of insurance companies (15%) state that they use age as a rating factor for this line of insurance. However, again this result is likely to be distorted by the inclusion in the survey of a number of insurers who do not write travel insurance. Furthermore, some respondents which do not use age as a rating factor may either issue 'non-medical' travel insurance only, or employ low upper age limits (see below), in which case the need to rate according to age would be much reduced.

**Figure 6: Use of age in risk assessment of travel insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

Apparently, most travel insurers which do price according to age, unlike motor insurers, do not use narrow age bands but rather use a relatively small number of such divisions, ranging from three only (e.g. age 18 or under, 18-59/64 and 64 or older) to seven or eight (e.g. with clients over the age of 64 dividing into a further five age bands).<sup>51</sup>

<sup>50</sup> Government Equalities Office 2009 (the Oxera-Report).

<sup>51</sup> Country report UK, Part II.

This results in premiums which usually move up step-wise with age. Inevitably, and especially where a small number of age bands is used, clients will suffer sharp increases in cost on moving from one band to another. Because different insurers use different age bands, there would be some smoothing effect for people who test the market regularly and switch from one insurer to another (which is probably quite common for buyers of single trip insurance) but the effect could be quite dramatic for clients who do not switch but regularly renew an annual policy with the same insurer. In any event, there seems to be no strong reason why travel insurers, like motor insurers, should not use narrow age bands since this would not require them to obtain any extra information beyond the date of birth which they invariably request.<sup>52</sup>

#### ***Age as a factor in the availability of cover***

It appears from our survey that the majority of insurers impose age limits for travel cover, typically in the range of 70 to 85 years.<sup>53</sup> Age limits are more common, and sometimes lower, for annual policies. This means that an elderly person who travels regularly may be obliged to take a number of 'single trip' policies because the (usually) cheaper alternative of an annual policy is not available. As in the case of motor insurance, some insurers have higher age limits for persons renewing a policy than for new customers. Several respondents mentioned the need for extra checks or medical screening in the case of older clients (see also Figure 6).

#### ***Contractual terms, marketing and business strategy***

In some cases the contractual terms of travel insurance policies may vary according to the age of the insured but this appears to be rather less common than variation in price (see also Figure 6). One respondent gave the example of reduced benefits for death or disability in the case of persons above a specific age.

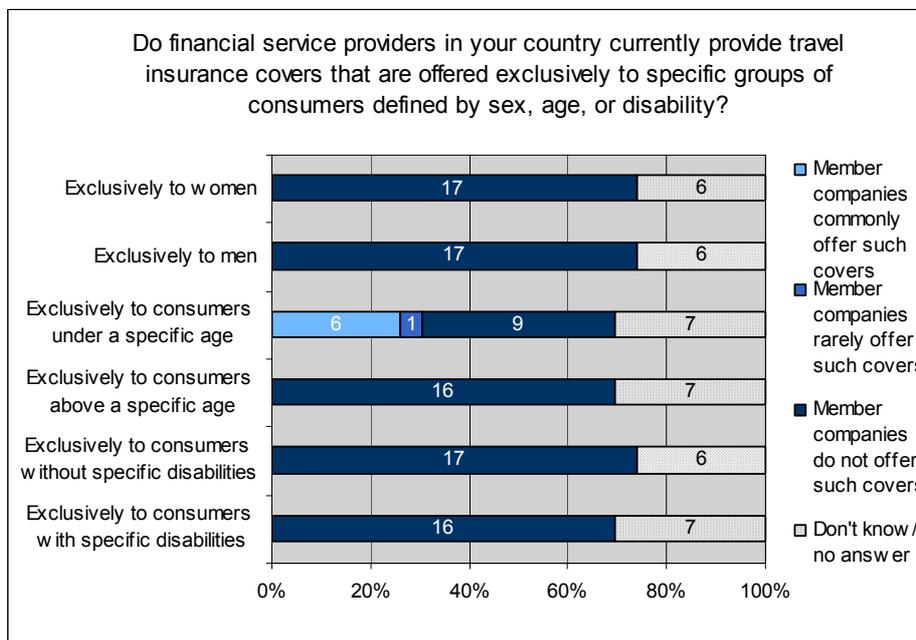
A few insurers provide cover only for older people or target this group. There is no evidence of restrictions being applied to young people or the explicit targeting of them, though a few insurers design special policies for groups of persons (such as *au pairs*, students, those on 'adventure' holidays or 'backpackers') which are more likely to contain young people (see Figure 7).

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<sup>52</sup> The UK actuarial profession has said that this would be quite possible (see the UK Actuarial Profession response to the Equality Bill – Age Discrimination in General Insurance, 13 August 2008).

<sup>53</sup> Age 65 in the case of one respondent. Another respondent cited an age limit of 45 for 'student' insurance.

**Figure 7: Provision of travel insurance covers to specific groups of consumers**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23).

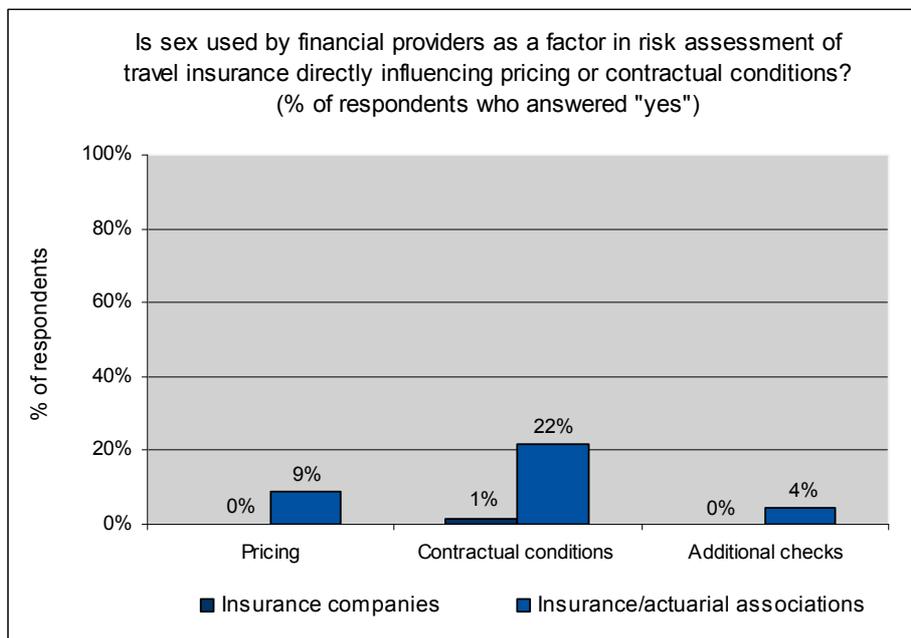
### The use of sex as a factor

The evidence suggests that most (but not all) insurers disregard the sex of the insured in the pricing and provision of travel insurance (see Figure 8 below). However, cover for medical expenses is sometimes restricted for pregnant women.<sup>54</sup>

No travel insurer in our survey offered travel insurance exclusively to a specific gender (see also Figure 7 above).

<sup>54</sup> See footnote 161.

**Figure 8: Use of sex in risk assessment of travel insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

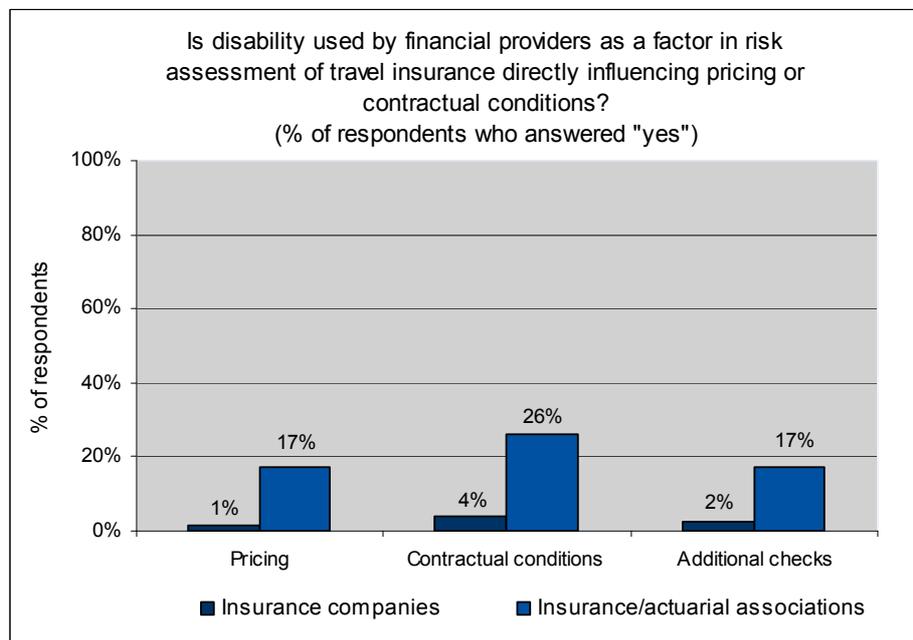
### The use of disability as a factor

The survey answers provided by insurance firms and associations to questions on this topic suggest that disability is rarely used by travel insurers as a factor in risk assessment (see Figure 9 below), whereas many other stakeholders clearly believe that it is used.<sup>55</sup> We believe that this discrepancy arises from a fact noted earlier in connection with motor insurance, which is that insurers distinguish between disability on the one hand (which they do not regard as important in itself) and underlying health conditions that might affect claims (which are important to them). By contrast, other stakeholders take the view that insurers which take health conditions into account are effectively basing their decisions on disability. This apparent difference in interpretation is supported by the fact that most, if not all, travel insurers readily admit to taking pre-existing medical conditions into account yet at least some of these simultaneously declare that they disregard disability.<sup>56</sup>

<sup>55</sup> With regard to Belgium, for example, see the responses of CBFA, the Insurance Ombudsman, *Test-Achats* and the CEOOR to the survey. Similarly, in Germany, while interviewed insurance companies declared there to be no differentiation because of disability, the *Verbraucherzentrale Bundesverband* (association of consumer organisations) stated that insurance companies differentiate by sex, age and disability also.

<sup>56</sup> One text response (by a national industry association) to our survey made this point clearly: "Disability is not a factor in risk assessment; however, an underlying medical condition independently of disability for which treatment is being received by the policyholder is a risk factor".

**Figure 9: Use of disability in risk assessment of travel insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

If a travel policy provides no medical cover (which is sometimes the case), then disability, however defined, is unlikely to be an important factor. However, when cover for medical expenses is provided, the client's health status or disability does become significant. As noted above, to avoid the cost of individual medical screening for each applicant, insurers very commonly exclude pre-existing medical conditions generally, or at least certain defined pre-existing conditions except, perhaps, in cases where the condition has 'stabilised'.<sup>57</sup> While no insurers in our survey offered travel insurance products exclusively to persons with or without specific disabilities (see Figure 7) a significant number of insurers offer cover at extra cost for those with such pre-existing medical conditions.

In summary, we can note that travel insurance is readily available at low cost to those who are young and in good health, but there are significant potential problems in terms of cost, if not availability, for those who are elderly, or in poor health, or both.

<sup>57</sup> Stabilisation must occur at least two months before booking, according to one respondent to the survey (a Belgian insurer specialised in travel insurance).

This leads to the following conclusion:

4. ***Travel insurance is readily available at low cost to those who are young and in good health, but there are significant potential problems in terms of cost, if not availability for those who are elderly, or in poor health, or both.*** Travel insurance is a low-cost product for which insurers generally issue standardised contracts and use simplified procedures and relatively few rating factors. Because expected average medical claims cost tend to rise with age, travel insurance can be markedly more expensive for older people, age being used by travel insurers as a proxy for health. Most (but not all) insurers disregard the sex of the insured in the pricing and provision of travel insurance. If a travel policy provides no medical cover (which is sometimes the case), then disability is unlikely to be an important factor. However, when cover for medical expenses is provided, the client's health status or disability does become significant.

### 3.3.3 **Term life insurance**

Term (or temporary) life insurance is the most fundamental and simple form of life insurance. Under a term policy, the insurer agrees to pay the sum (amount) insured if the life insured should die within the policy term (which could be anything from 1 year or less to 40 years or more). Under a basic term policy there is no savings or investment element. If the person insured does not die during the stipulated period nothing is returned to the policyholder. The essential function of term life insurance is to provide financial protection in the event of untimely death. There are many possible applications, including the payment of funeral expenses, the protection or guarantee of a loan (e.g. policies which provide funds to discharge a mortgage or other loans if the borrower should die before the loan is repaid), and the protection of family income (i.e. policies which provide money to support a surviving partner and/or children if the insured person should die and their income be lost to the family). Term life insurance is an important part of many people's basic financial planning. Therefore, the inability to obtain it could have serious consequences for many individuals; for example, it may be extremely difficult to secure a mortgage or other essential loan without life insurance cover.

The CEA identified 1290 life insurance companies operating in Europe in their latest (2008) survey of the European insurance market<sup>58</sup> and it can be safely assumed that the majority of these write term life insurance. Distribution channels for life insurance vary considerably in Europe, with banks and financial institutions dominating in a number of markets (especially those of Southern Europe) and agents in others (e.g. Poland, Netherlands). In the UK, which is the biggest life insurance market in Europe, accounting for nearly one third of premiums,<sup>59</sup> distribution is dominated by Independent Financial Advisers (in effect, brokers).<sup>60</sup>

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<sup>58</sup> CEA 2008. The survey covers 31 European countries, including Turkey.

<sup>59</sup> CEA 2009.

## **The use of age as a factor**

### ***Age as a factor in pricing and availability of cover***

Life insurance, and particularly term life insurance, is the form of insurance where the age of the life insured most obviously operates as a key risk factor. It is used by the large majority of insurers (see Figure 10), though not, according to survey results, by all. The risk covered – that of death within the term of the policy – is clearly linked to the age of the person concerned at the time when the insurance begins. Age is an obvious proxy for mortality<sup>61</sup> because people inevitably become more susceptible to illness, disease and accidents as they get older and also more vulnerable to their effects. Furthermore, life insurers have access to data which is likely to be fuller and more convincing than in any other line of insurance. This takes the form of extensive mortality statistics, with different data sets for men and women. These enable insurers to calculate the premium for a ‘normal’ person of a given age with a high degree of precision,<sup>62</sup> with the consequence that premiums for term life insurance get more expensive with increasing age of the person at the time of conclusion of the contract.<sup>63</sup> The basic rate of premium can be adjusted to take account of factors which increase the mortality risk for a given client (e.g. their family and medical history, tobacco or alcohol consumption, occupation, etc.).

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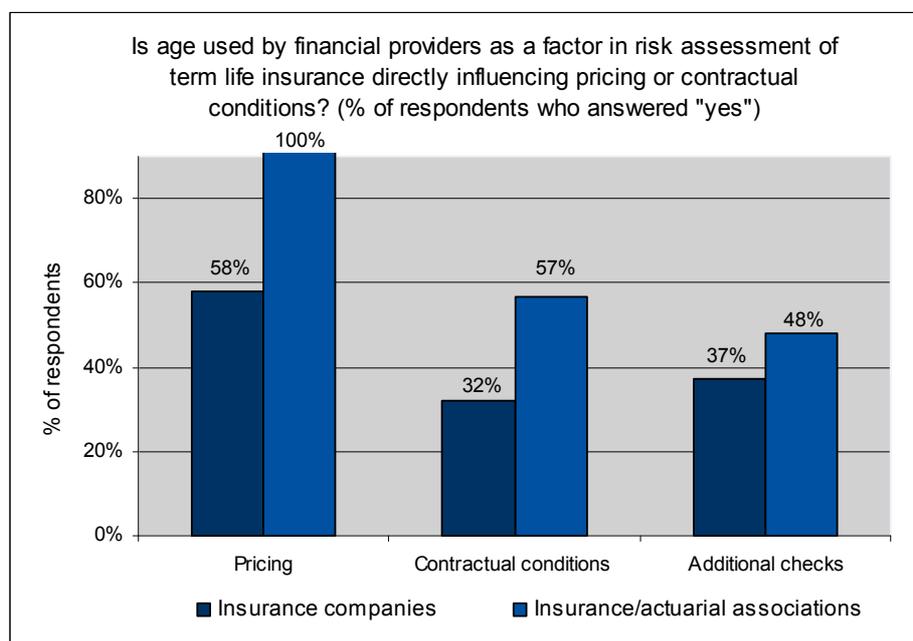
<sup>60</sup> CEA 2008.

<sup>61</sup> Mortality is a measure of the number of deaths in a given population.

<sup>62</sup> The basic source of data is mortality tables. The origin of these varies from one country to another. For example, in the UK responsibility for producing them lies with the Office for National Statistics (ONS). They can be viewed on the website of the actuarial profession at [http://www.actuaries.org.uk/knowledge/publications/life\\_tables](http://www.actuaries.org.uk/knowledge/publications/life_tables) and also on the Government Actuary Department’s website. In Belgium tables are based on statistics provided by the National Institute for Statistics, supplemented by the insurance companies’ own experience figures. In Germany insurers use DAV (German Actuaries Association) statistics and the mortality tables of the Federal Authority for Statistics (Statistisches Bundesamt). See also Annex 4.

<sup>63</sup> An insurer quoted the example of the premium for a customer of age 20 that can be 10 times cheaper than a premium for a 65 years old customer (for a term life insurance concerning the payment of a death benefit of 100,000 € if the insured dies during a period of 10 years).

**Figure 10: Use of age in risk assessment of term life insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

Life insurance age limits vary considerably across Europe. Respondents in our survey suggested upper age limits ranging from 55 to 90 years with most falling within the 70-85 age range and 70 or 75 being most common. However, many respondents made the point that maximum age limits had to take into account the length of the policy term, with a lower age limit applying in the case of clients requiring cover for a long period. Alternatively, the duration of cover available would tend to reduce with age, so that elderly policyholders would be offered only (relatively) short-term covers.

Minimum age limits for life insurance cover also appear to vary considerably, ranging in our survey from 4 years to 18 years. In some countries the law imposes a relatively low minimum age limit for life insurance.<sup>64</sup> However, in practice it seems that few insurers provide cover for very young children in any event; 18 years was by far the most common lower age limited quoted by our respondents.

A number of respondents stated that the age of the life insured was likely to influence the need for additional medical checks (see Figure 10), with age 55 being quoted by one (industry association) respondent as a typical age at which a requirement for additional medical screening would be triggered. However, it is understood that age is only one of a number of factors which insurers consider for this purpose, and that additional medical checks are likely to be required when the sum insured is high or where the client discloses medical conditions which may indicate a poor state of health.

<sup>64</sup> E.g. 5 years in Belgium and 7 years in Austria for insurance cover in excess of funeral costs.

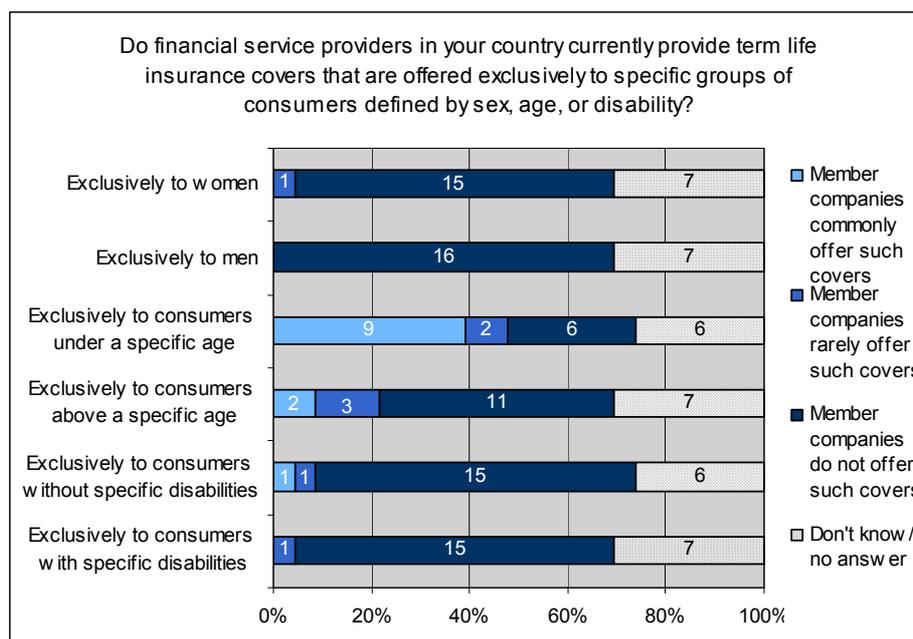
**Age as a factor in contractual terms**

Some respondents suggested that age might influence the contractual terms of a life policy (see Figure 10) in terms of exclusions and/or benefits. While few respondents elaborated on this, we believe that age is unlikely to influence exclusions, since life insurance policies exclude few causes of death as such, and none that are obviously age-related.<sup>65</sup> However, it is quite likely that some insurers would wish to restrict the amount of cover granted (i.e. benefits) to elderly policyholders (especially in cases where cover is offered without medical screening), or offer limited cover only for very young lives.<sup>66</sup>

**Age as a factor in marketing and business strategy**

A number of insurers in Europe actively promote insurance plans for older people (e.g. over 50s life insurance), sometimes offering insurance for a particular purpose which might appeal to the elderly, e.g. to pay funeral expenses<sup>67</sup> (see Figure 11). However, as noted earlier, insurers are more likely to require medical screening in the case of older applicants, especially if the amount to be insured is large. Although a significant number of insurers offer life cover for older people *without* medical screening, there is normally a restriction on the amount of cover that can be bought on this basis.

**Figure 11: Provision of term life insurance to specific groups of consumers**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23)

<sup>65</sup> Possible exclusions include suicide (but, usually, only if it occurs within one or two years of the inception date of the policy), war risks and, possibly, participation in specified extra-hazardous sports or activities.

<sup>66</sup> E.g., cover for small children may be restricted to the amount required for funeral expenses – see footnote 64.

<sup>67</sup> *Sterbegeldversicherungen* in Germany.

### The use of sex as a factor

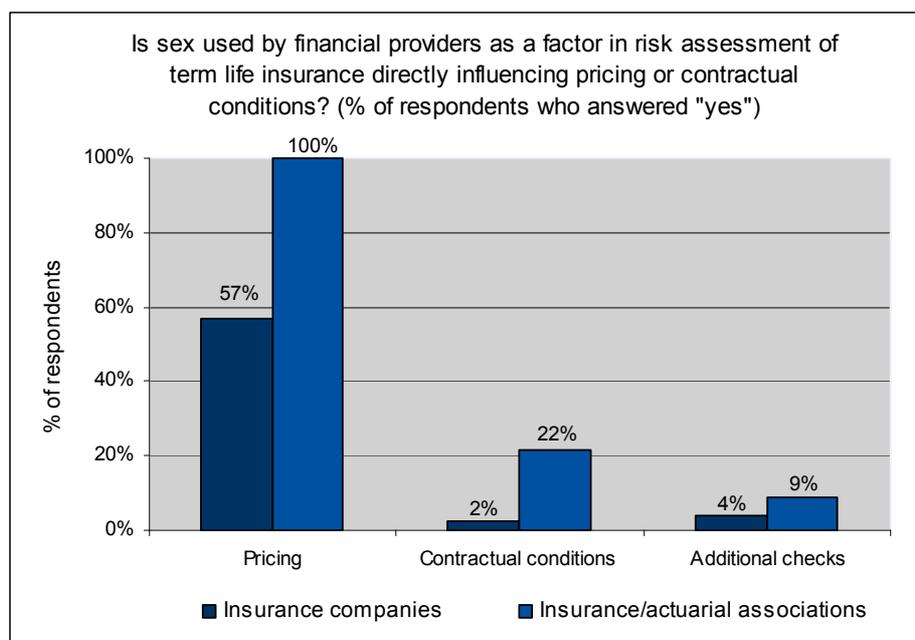
The fact that women tend to live longer than men in Europe is uncontroversial. It is evidenced by the extensive mortality data available to insurers, discussed above. Insurers are not precluded by law from using sex as a rating factor in life insurance in any European country, including those countries where the use of sex is prohibited as a rating factor for some or all forms of non-life insurance. Not surprisingly, the majority of insurers in Europe use sex as a rating factor in term life insurance with the effect that women policyholders pay lower premiums than men of the same age or receive higher benefits than men for the same amount of premium. Of course, in the case of annuity products the position is reversed, with men paying lower premiums or having higher benefits.

It is clear from our survey that a minority of insurers offer unisex premiums for term life insurance even though the law does not require them to do so. One respondent noted that they did not use sex as a basis for pricing in what they described as ‘mass-market’ term life insurance, which implies that sex might be used for more unusual risks or those where a high amount of cover was requested, but we are unable to verify this.

A small number of respondents suggested that sex might influence contractual conditions or influence the need for additional medical checks (see Figure 12 below) but, again, we are not able to elaborate on this.

Finally, it is clear that the sex of prospective clients plays little part in the marketing and business strategies of insurers that sell term life insurers, very few of which target their products at either men or women (see Figure 11).

**Figure 12: Use of sex in risk assessment of term life insurance**



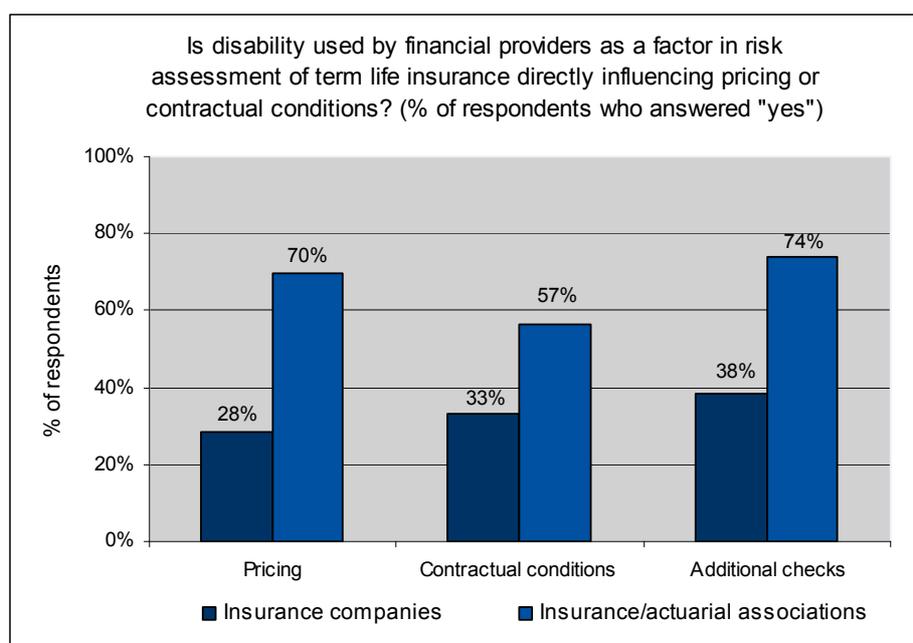
Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

### The use of disability as a factor

As in the case of motor insurance, (medical) travel insurance and health insurance, discussed earlier, insurers are not concerned with disability per se but rather with underlying medical conditions which may affect the risk insured, in this case the mortality risk. As we can see from Figure 13, a number of respondents, including insurance companies and national insurance or actuarial association, claim that they do not take disability into account as a factor which directly influences the assessment of the risk. However, we believe that these responses are based on a narrow definition of disability and do not imply that the insurers concerned disregard the applicant's state of health. This is confirmed by a large number of text responses to our questionnaire, and comments made in the course of interviews, to the effect that while disability in itself is disregarded, the health condition of the applicant is a key factor for term life insurance and, indeed, for any form of life insurance.

Application forms for term life insurance almost invariably contain questions, often quite detailed, which are designed to establish if the insured is suffering from any serious illness or has suffered from one in the past. In some cases insurers will also ask for a report from the applicant's own physician and/or ask the applicant to undergo a medical examination. As mentioned above, these measures are more likely to be taken if the amount to be insured is large or if initial answers given by the applicant disclose possible health problems. The age of the applicant is also a factor in determining the type of health screening required by the insurer which is more likely to ask for a medical examination in the case of older applicants.

**Figure 13: Use of disability in risk assessment of term life insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

If an applicant for life insurance is in poor health cover may be refused.<sup>68</sup> As alternatives, the amount of cover may be restricted or some causes of death may actually be excluded from the policy. However, the latter measure is generally unsatisfactory and relatively uncommon in the provision of term life insurance. This is so because, first, it does not give the insured the full protection that they seek, and second, because it raises the possibility of a claim dispute when the insured dies if, as is quite common, the cause of death is not absolutely clear and simple. For these reasons, insurers generally prefer to deal with the problem by raising premiums for those with adverse health conditions.

As we can see from Figure 11 above, life insurers rarely target clients with particular disabilities or health conditions or offer products especially adapted for them.<sup>69</sup>

This leads to the following conclusion:

**5. Life insurance, and particularly term life insurance, is the form of insurance where the age of the life insured most obviously operates as a key risk factor.** It is used by the large majority of insurers though not, according to survey results, by all. The risk covered – that of death within the term of the policy – is clearly linked to the age of the person concerned. Age is an obvious proxy for mortality because people inevitably become more susceptible to illness, disease and accidents as they get older and also more vulnerable to their effects. Also, the majority of insurers in Europe use sex as a rating factor in life insurance because women tend to live longer than men, with the effect that women policyholders pay lower premiums for term life insurance than men of the same age or receive higher benefits than men for the same amount of premium. Of course, in the case of annuity products the position is reversed, with men paying lower premiums or having higher benefits. As in the case of other products, insurers are not concerned with disability per se but rather with underlying medical conditions which may affect the risk insured. The health condition of the applicant is a key factor for term life insurance and, indeed, for any form of life insurance.

### **3.3.4 Private health insurance**

It is very difficult to give a brief and succinct summary of the role of private health insurance in Europe because its nature and functions are far less uniform than those of the lines already discussed – motor, travel and term life insurance. These latter lines belong almost wholly in the realm of private insurance and cover risks against which the state (at least in Europe) provides little protection. Conversely, all European Member States have some form of public provision for health care needs, so that private health insurance inevitably forms part of a wider system in which the state has

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<sup>68</sup> One insurer respondent to our survey claimed to be able offer terms to 98% of applicants for term life cover, another stated that only about 1% of applications were refused.

<sup>69</sup> One respondent in our survey said that they were looking at the possibility of developing a life insurance product for breast cancer sufferers.

significant involvement. The relationship between private health insurance and public provision varies considerably among Member States. Private insurance can form an integral part of an essentially public scheme (as in the Netherlands), duplicate such a scheme (as in the UK), complement it (as in France), or provide an alternative to it for some people (as in Germany), although this simplification does not fully represent all the possible variations.<sup>70</sup>

At a very general level, it is probably fair to say that private health insurance is playing an increasingly important role in European people's health-care needs. Demographic factors (e.g. ageing populations), together with restraints on public spending, appear to be dictating a gradual shift in the relationship between 'social' and 'private' insurance provision in Europe, with the latter becoming increasingly prominent. In turn, increasing reliance on private health insurance in Europe implies that problems of availability or affordability will have a greater impact on the individuals who need it.

Some evidence for the increasing importance of private medical insurance is found in data produced by the CEA. Noting that the accident and health insurance sector is in fact dominated by health insurance (which accounts for two-thirds of the total), the CEA says that accident and health premiums grew by 3% in 2008<sup>71</sup> to 128 billion Euro, making it the leading line of non-life insurance and surpassing motor insurance in importance for the first time. CEA observes:

*"This trend confirms that the accident and health market remains one of the most dynamic non-life insurance business lines, mainly due to rising consumer demand fuelled primarily by population ageing".*<sup>72</sup>

Recent growth has been strong in all three of the biggest EU markets, which are Germany, the Netherlands and, to a lesser extent, France. These together represent more than 70% of the total.<sup>73</sup>

A discussion of the impact of age, sex and disability on the provision of private health insurance is further complicated by the fact it can be purchased individually or as part of a group scheme. In the latter case, age, sex and disability are unlikely to affect the price for individuals within the scheme, rather the price will depend on the profile (with regard to these factors) for the group as a whole. Furthermore, while providers in some Member States are able to reject applicants and price private health insurance as they wish (subject, that is, to the general provisions of non-discrimination law which are the subject of this study), in other cases they are obliged to accept all applicants and charge the same premiums for them, regardless of their individual characteristics. This

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<sup>70</sup> For a full description, see LSE Health and Social Care 2009.

<sup>71</sup> Nominal growth at constant exchange rates. Nominal growth at current exchange rates was 2% (CEA 2009).

<sup>72</sup> Accident and health insurance now account for about 12% of total insurance premiums in Europe and 31% of all non-life insurance. Much of the substantial recent increase is explained by the implementation of a new health regime in the Netherlands in January 2006 (CEA 2009).

<sup>73</sup> In fact, three European markets shrank in 2008: Ireland (-19%), the UK (-12%) and Romania (-8%). However, as these three countries represent jointly only 5% of the total, the impact on the CEA average is insignificant.

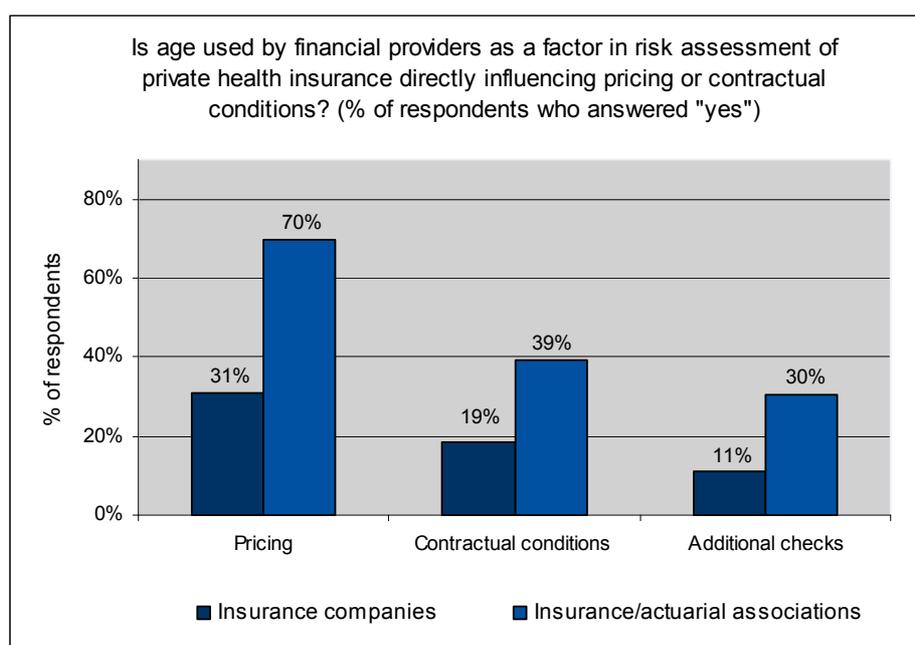
is the practice in Ireland (where it is known as ‘community rating’) and the Netherlands, where premiums are set at a flat rate for all purchasers regardless of their health status or age. Risk variances between insurance providers, arising from the different risks contained in their insured portfolios, are compensated through risk equalisation<sup>74</sup> and a common pool. Finally, we can note a yet further variation, in terms of who pays the premium for private health insurance. Depending on the scheme, this could be the individual policyholder, their employer, or the state, or any combination of these in some defined proportion.

All these things need to be born in mind when we consider the information provided by the respondents in our interviews and surveys, who may be commenting on products and schemes that are different in nature and therefore difficult to compare.

### The use of age as a factor

It is clear that age is a significant factor in the provision of private health insurance, at least in schemes where there are differentiated individual premiums (see Figure 14).

**Figure 14: Use of age in risk assessment of health insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

Premiums tend to rise with age to reflect increasing morbidity.<sup>75</sup> However, some private health insurers include ‘age reserves’ in their premiums, which means that the higher

<sup>74</sup> In fact, the Irish Supreme Court (in 2008) declared the risk equalisation scheme used in Ireland at the time to be unconstitutional, resulting in its withdrawal pending fresh legislation on the subject.

<sup>75</sup> The term morbidity refers to a diseased state, disability, or poor health due to any cause. The morbidity rate indicates the incidence or prevalence of a disease or medical condition in a given population.

risk of future years is factored into the premium at the point of entry into the scheme, so that clients have stable premiums from the inception of the contract until its termination.<sup>76</sup>

It appears that there are no commonly used minimum ages for private health insurance cover, although a few respondents suggested a minimum age of 16 or 18. Maximum age limits are often applied and varied in our survey from 59 to 80 years. Age limits may refer to the maximum age to conclude a new policy, or to the age at which coverage ends.<sup>77</sup>

Our survey suggests that age may affect the contractual conditions of private health insurance or benefits provided to a limited degree and also trigger a requirement for extra medical checks in some cases (see Figure 14). We were able to obtain few specific examples of the former, although one respondent suggested that waiting periods for pre-existing conditions vary according to age. As regards the latter, it appears that in countries where medical screening is not usual for private health insurance (such as the UK), it may nevertheless be required in the case of elderly applicants (e.g. those who are 75 or older).<sup>78</sup> Evidence from Belgium also suggests that medical questionnaires in private health insurance are more likely to lead to exclusions from coverage as age increases.<sup>79</sup>

There is not much evidence of private health insurers targeting specific groups defined by age (see Figure 15) but one (national insurance industry association) respondent mentioned the existence of health insurance products only for children or for different needs at different stages of life (e.g. 'rooming-in' for children in hospitals) and one (insurer) respondent mentioned a product that had been developed exclusively for those over 55 years of age.

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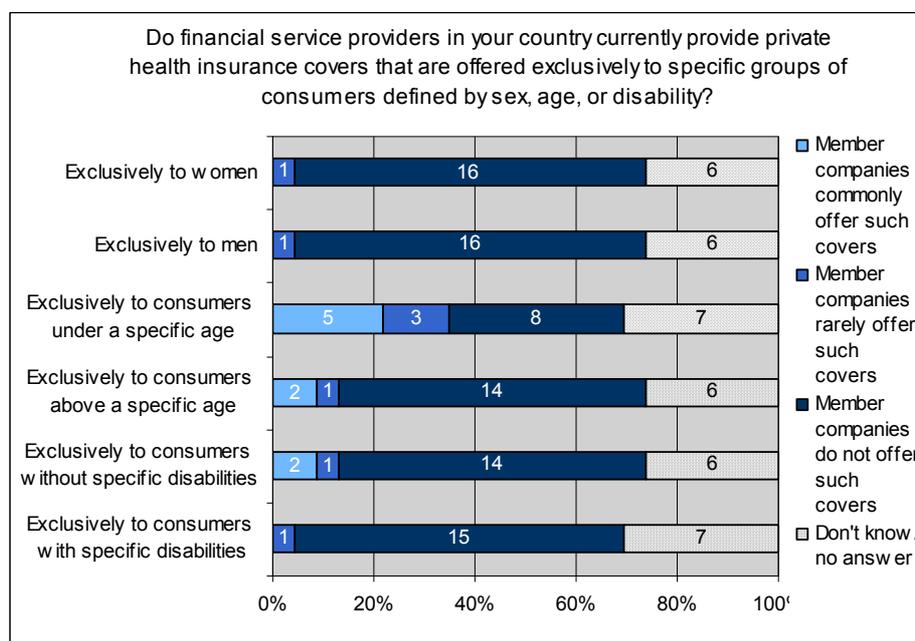
<sup>76</sup> Age reserves are used in the (very large) German health insurance market. Recent (2009) legislation in Germany allows clients who change to another private health insurer to 'keep' their age reserves so that they do not have to pay a higher premium because of their greater age when entering the new contract. However, this legislation applies only to new contracts (since 2009). Furthermore, the client's current health is relevant, so that for people whose health has deteriorated, a change to another insurance company may result in higher premiums and may not be possible for economic reasons (see the country report on Germany). In Belgium, too, some companies take account of age only at the moment of subscription, so that the premiums remain stable through the term of the policy, while other companies let premiums increase when the insured, in the course of the contract, proceeds to another age band. In Belgian 'work-related' private health insurance contracts, age does not have an important influence on pricing. Nonetheless, there can still be considerable increases in premium when people who retire switch to individual (non-work related) health insurance contracts (see the Belgian country report).

<sup>77</sup> In some cases where age limits exist regarding conclusion of a contract, once the policy has been purchased, it can be renewed if the policyholder wants to do so until the death of the insured.

<sup>78</sup> See the UK country report.

<sup>79</sup> J.-P. Coteur, A. Moriau and I. Nauwelaers 2009.

**Figure 15: Provision of private health insurance covers to specific groups of consumers**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23).

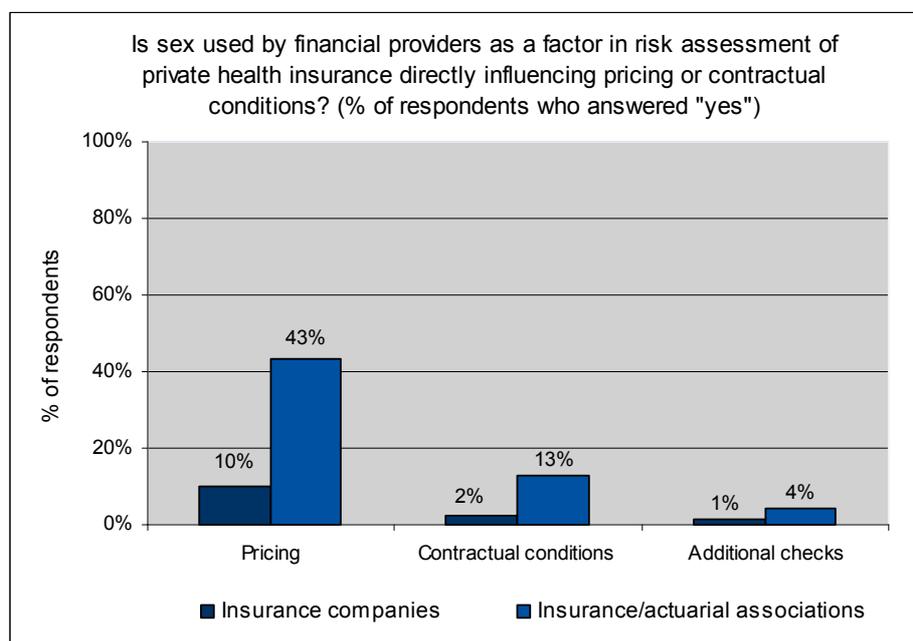
### The use of sex as a factor

There is evidence that levels of morbidity vary between men and women of the same age as well as among people of different ages.<sup>80</sup> Whether private health insurers take this into account depends on a number of factors, including the funding basis of the scheme (i.e. whether there are flat premiums as a consequence of ‘community rating’ or whether premiums are individualised), the applicable law on gender discrimination, and the practice of individual insurers. Thus, for example, sex is not a factor used by health insurers in the Netherlands or Ireland (where ‘community rating’ applies), nor in Cyprus and Belgium, where the Gender Directive has been implemented so as to require unisex premiums, but it is used in Germany. In the UK, insurers may, if they wish, use sex as factor in the provision of health insurance in accordance with the Gender Directive and while some firms do so, others do not.<sup>81</sup>

<sup>80</sup> For example, available UK data suggests that claims cost under private health insurance policies is significantly higher for women in the 31-60 age bracket than for men of the same age. See ABI 2009a. In a country such as Germany, where insurers include aging reserves into the premium calculation for private health insurance, women must pay more for aging reserves than men because of the differences in life expectancy. See also Annex 4.

<sup>81</sup> See the country reports for the Germany, Belgium and the UK.

**Figure 16: Use of sex in risk assessment of private health insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

Sex may occasionally influence the contractual conditions of private health insurance (see Figure 16). Childbirth and pregnancy is one area where this may be the case. For example, in Germany the costs for pregnancy and birth are now – after the implementation of the Gender Directive – equally distributed among men and women, which tends to flatten the differences between the premiums for men and women (although premiums for women are still higher). Nevertheless, pregnant women who apply for a new contract have to agree to an exclusion of costs for the current pregnancy; and women have to accept a ‘waiting period’ of one year from the inception of the policy before the insurance company will cover costs for pregnancy and birth.<sup>82</sup> Again, in Belgium some private sickness funds (the so-called ‘mutualities’) offer contracts where benefits relating to pregnancy and maternity are capped to a certain level.<sup>83</sup> Cases are also reported where, as in Germany, waiting periods of one year are used for pregnant women.<sup>84</sup>

There is little evidence of health insurers offering contracts to men or women or targeting either sex (see Figure 15 above).

<sup>82</sup> Interview VZBV; compare the court decision concerning AG Hannover, 26.08.2008; AZ: 534 C 5012/08 (complaint DE-7, see Part III, Annex 3).

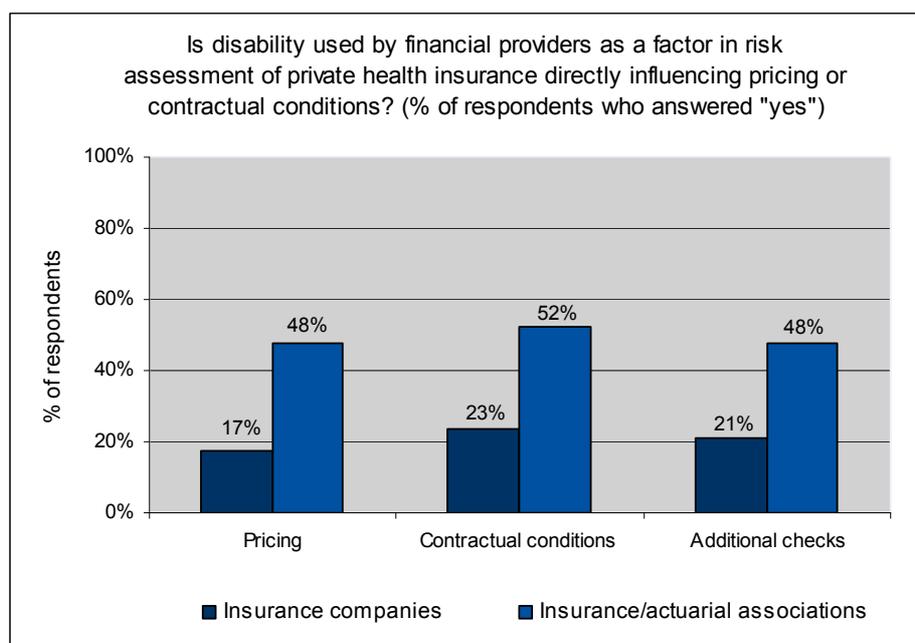
<sup>83</sup> J.-P. Coteur, A. Moriau and I. Nauwelaers 2009.

<sup>84</sup> See survey of the Belgian Gender Equality Institute. See also case BE-9 of the documented complaints, collected by the Institute (see Part III, Annex 3). See also footnote 161.

### The use of disability as a factor

As with other insurance of this type, private health insurers are concerned with underlying health conditions which may affect claims cost rather than disability as such. In any event, this is a significant factor for health insurers (see Figure 17).

**Figure 17: Use of disability in risk assessment of health insurance**



Source: Civic Consulting surveys of national insurance/actuarial associations (N=23) and insurance companies (N=81).

Disability (or health condition) can affect either the price of private health insurance, or its contractual conditions, or both.<sup>85</sup> Our survey suggests that it is slightly more likely to affect the latter than the former. This is no doubt because a number of insurers (including most health insurers in the UK) prefer to deal with clients presenting adverse health conditions by excluding the condition concerned rather than by raising the price of the cover. This form of contractual variation – the exclusion of pre-existing conditions – is particularly important and is widespread in markets where individual underwriting of health insurance is allowed. It is common for insurers to provide cover for pre-existing conditions if there has been no recent recurrence of the illness or to impose a ‘waiting period’ on the policy, whereby cover for the condition in question does not commence until the insured has been free of it for a stipulated time (which could be from 1 month to 18 months). Restrictions of this sort can obviously reduce significantly the usefulness and value of private health insurance cover for those with a history of

<sup>85</sup> As well as the denial of any cover at all in some cases.

illness or for chronic sufferers.<sup>86</sup> Besides the common restriction on cover for pre-existing conditions, we encountered a few other examples of contractual variations relating to disability or health condition.<sup>87</sup>

Finally, most health insurers do not target clients who suffer from particular disabilities or have special products for them, but a few insurers do specialise in providing cover to those with significant health problems, for example cancer sufferers.

This leads to the following conclusion:

6. ***Private health insurance is playing an increasingly important role in European people's health-care needs, but the relationship between private health insurance and public provision varies considerably among Member States.*** Increasing reliance on private health insurance implies that problems of availability or affordability will have a greater impact on the individuals who need it. While providers in some Member States are able to reject applicants and price health insurance as they wish, in other cases they are obliged to accept all applicants and charge the same premiums for them, regardless of their individual characteristics (as is the practice in Ireland and the Netherlands). Age and disability (or health condition) are significant factors in the provision of private health insurance, at least in schemes where there are differentiated individual premiums. Whether private health insurers take sex into account depends, among others, on the applicable law on gender discrimination and the practice of individual insurers.

### 3.3.5 **Mortgage loans**

In the case of mortgage loans, as with other forms of credit, the central risk for the provider is that of customer default. Risk assessment will therefore focus on the borrower's income status and the ability to pay, which means that factors such as age, sex and disability are likely to be relevant only to the extent that they impinge on this.

#### **Age as a factor**

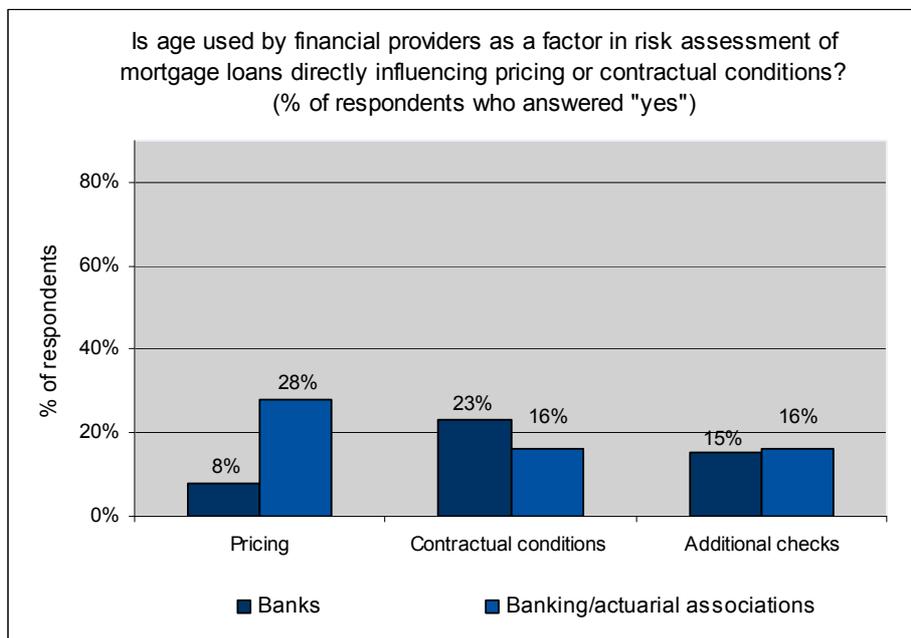
The age of the borrower is clearly a relevant factor in the availability of mortgage credit (see Figure 18). Legal restrictions on the offering of credit to minors and on enforcing debts against them mean that mortgage (and other) lenders are reluctant to contract with persons under the age of 18, which is the usual age of majority in Europe. However, some mortgage providers require applicants to be at least 20 or 21 years of age.

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<sup>86</sup> In Belgium, there are plans for a legally constituted *conciliation board* (which is not yet in force at the time of writing) to judge the proportionality and technical soundness of exclusions relating to pre-existing conditions. See the Belgian country report for more detail on this.

<sup>87</sup> For example, in Belgium, some 'mutualities' exclude the costs of a stay in a psychiatric facility and there are also differences in the extent of coverage for ambulant care for critical illnesses such as Alzheimer's, Parkinson's, Multiple Sclerosis, etc. (see the Belgian country report for more detail).

**Figure 18: Use of age in risk assessment of mortgage loans**



Source: Civic Consulting surveys of national banking/actuarial associations (N=25) and banks (N=39).

Generally, young people find it more difficult to secure mortgage credit than older people owing to assumptions about their (generally lower) earning capacity and the fact that their credit history will be thinner. The credit-scoring models commonly employed by mortgage (and other) lenders generally assume that the risk of default reduces with age, making younger borrowers a greater risk.<sup>88</sup> However, most of the respondents in our survey and interviews who commented on these models suggested that age is a relatively minor component in them. It also appears that the age of the borrower is less significant in (secured) mortgage credit than in unsecured lending.<sup>89</sup> The issue of credit scoring is further discussed in the following box, which focuses on the situation in Germany.

<sup>88</sup> Conversely, young people may sometimes be able to obtain banking products on preferential terms, because banks hope to keep their young customers for life. For example, in Germany banking companies offer current accounts on preferred conditions to young people such as students, trainees or apprentices under 27 or 30 years (see the country report for Germany) and, in the UK, the public Student Loans Company provides credit to students on advantageous terms.

<sup>89</sup> See, for example, H.M. Treasury 2008. According to this document, this reflects, in part, the fact that the average age of a first time buyer is, at the time of publication of the report, 27 to 28.

### **Credit scoring in Germany**

Credit scoring is a point-based system which uses various factors to determine a person's ability to repay a credit, or their so-called "credit worthiness". Credit scores are calculated by using mathematical models based on a consumer's saved data for determining if, and to what extent, a person is qualified to access credit. Banks use their own data and data saved by external credit information agencies.<sup>90</sup> Every institution uses different scoring criteria and models depending on the nature of the credit. Poor credit ratings can have serious consequences, such as higher interest rates if credit is granted and even possible credit refusal.<sup>91</sup> According to one recent study, common complaints from consumers and consumer organisations in Germany often related to lack of transparency in the calculation process for scoring. In the past, consumers would receive a final credit score, but not have access to information on how this score was calculated.<sup>92</sup>

The German Data Protection Act (Bundesdatenschutzgesetz, BDSG) is the main federal legislation for protecting consumer data in Germany. On 1 April 2010 an amendment to the Act came into force which gave individuals the right to have access to their credit score, the origin of the saved data and to the factors that are used in the calculation. Additionally, this information must be provided in a comprehensible way for the consumer and has to be offered once a year free of charge. Time periods for saved data depend on the credit scoring agency and the content being saved and this information is now also available to consumers.

In an interview, one credit scoring agency confirmed that information on name, sex, age, current address and credit history (including negative factors such as previous defaults of payment and debt) is saved; sex and age combined can equal up to 20% of the overall credit score. Neither disability nor health conditions are used as factors. Credit scoring institutions also do not have access to information about an individual's income, current assets, place of birth or periods of unemployment and therefore these factors do not influence credit scoring. Additionally, paragraph 3(9) of the German Data Protection Act makes it illegal to include nationality, racial and ethnic origin, political or religious belief, world view, sexual orientation, union membership and health in credit scoring.

Reportedly, the use of a person's address has occasionally led to indirect discrimination in the past. Neighbourhoods were sometimes classified as being either "good" or "bad" based on particular socio-demographic traits of its population. Areas mainly inhabited by certain groups of ethnic minorities, for example, could be considered a "bad" neighbourhood, which in turn could have a negative impact on credit scoring,<sup>93</sup> and vice versa. After the recent amendment to the BDSG, a person's address can be used only in restrictive terms.

In the case of ordinary mortgage loans, an upper age limit generally applies, particularly if the mortgage period is likely to extend into a period of retirement when the income of the mortgagor is likely to drop, calling into question their ability to pay. According to our survey, mortgage finance is rarely available to persons over 70 years of age at entry and the term of the mortgage loan available is likely to reduce according

<sup>90</sup> Korczak, D. & Wilken, M. (2009), *Verbraucherinformation Scoring*, GP Forschungsgruppe, p.4.

<sup>91</sup> Korczak, D & Wilken, M. (2008), *Scoring im Praxistest: Aussagekraft und Anwendung von Scoringverfahren in der Kreditvergabe und Schlussfolgerungen*, GP Forschungsgruppe, p. 24-25.

<sup>92</sup> Korczak & Wilken (2009).

<sup>93</sup> Korczak & Wilken (2008).

to the age of the borrower at its start. A number of respondents quoted a maximum 'exit' age (i.e. age at which the mortgage had to be discharged), age 65 or 70 being common. Similarly, elderly persons may be granted shorter repayment periods than younger customers for other forms of credit.<sup>94</sup> The age of the customer may also affect the need for further (financial) 'check-ups'.<sup>95</sup> Finally, we should note that in a number of EU Member States there are special mortgage credit schemes where age is either irrelevant or operates in a different way as an assessment factor.<sup>96</sup>

### **Sex and disability as factors**

These two factors are considered together because the vast majority of respondents in our interviews and surveys stated that they play no part in the provision of mortgage credit. However, there were exceptions, as reflected in Figure 19 and Figure 19.

There seems to be some conflict of opinion on the use of sex as a factor. No individual bank in our survey said that sex played a part in the provision of mortgage loans but a few national associations stated that sex was relevant. Sex can also be used as factor in credit scoring, see box above.

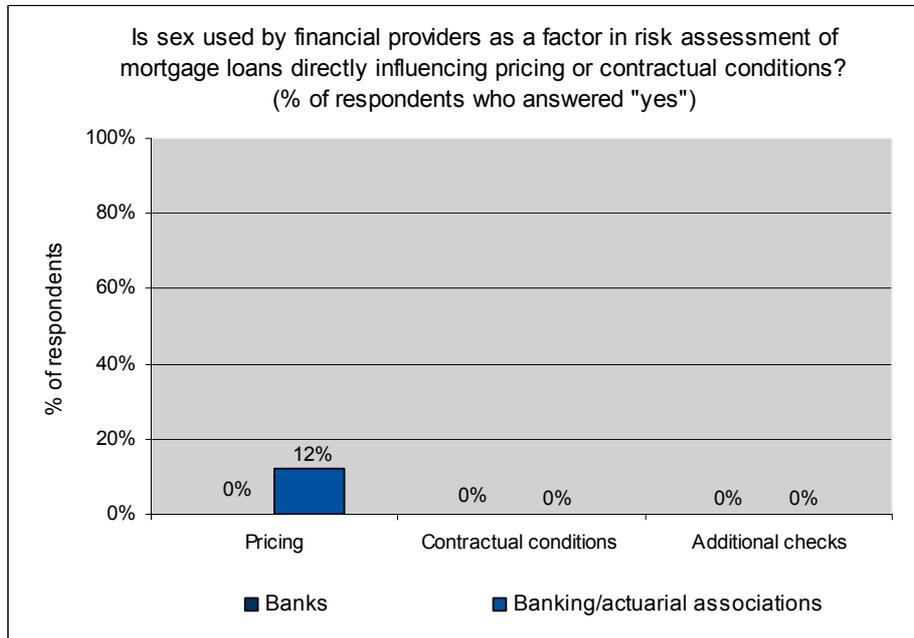
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<sup>94</sup> See the country report for Germany and interview with *Sparkasse Hanau*.

<sup>95</sup> For example, a representative of an insurance company in Belgium stated that most banks carry out an additional assessment by a credit analyst for people above a certain age (the respondent insurance company uses the age of 75 years) or for people who want to subscribe for a loan with a term that runs beyond this age (see, further, the country report for Belgium).

<sup>96</sup> For example, in Germany the *Bausparvertrag* is a popular product. This combines a saving account with a mortgage loan. Once a certain sum on the saving account has accrued, the customer is entitled to a mortgage loan under fixed conditions for the purpose of building or renewing a house. These loans do not depend on the age of the borrower; see the country report for Germany. In the UK, 'equity release' mortgages are common. There is always a *minimum* age for these mortgages, under which borrowers forfeit some of the equity value in their homes in exchange for either a lump sum or regular monthly instalments. There is no maximum age limit for equity release, although applications are not usually granted for anyone under the age of 55. In all instances, age is also the primary factor in determining the percentage of the value of the home that can be released. A person of greater age can release a higher percentage of the value of their home than a younger person, as they are not expected to live as long.

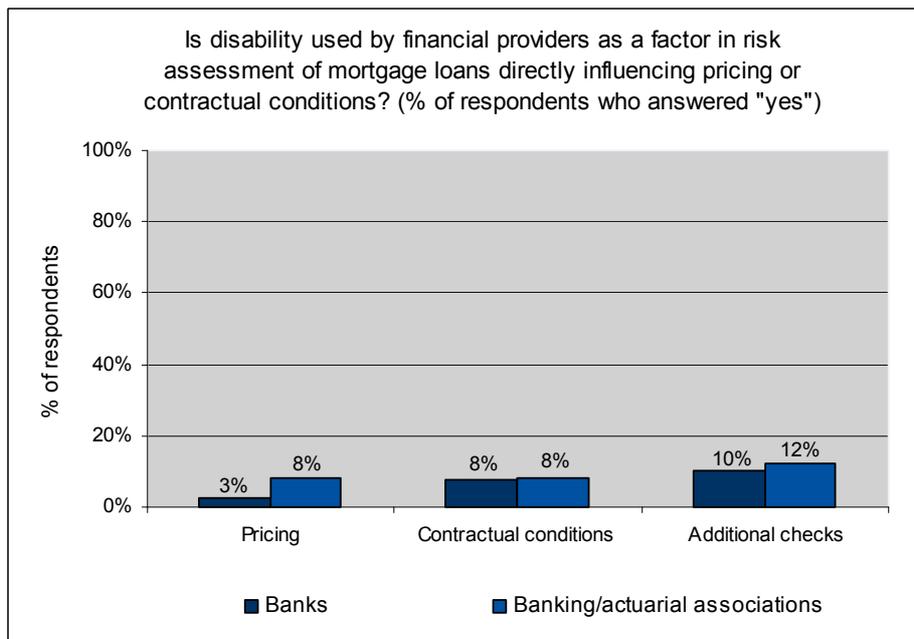
**Figure 19: Use of sex in risk assessment of mortgage loans**



Source: Civic Consulting surveys of national banking/actuarial associations (N=25) and banks (N=39).

Evidence suggests that the disability or adverse health condition of a borrower may be a relevant factor for at least some mortgage lenders, see Figure 19.

**Figure 20: Use of disability in risk assessment of mortgage loans**



Source: Civic Consulting surveys of national banking/actuarial associations (N=25) and banks (N=39).

Once again, there appears to be some conflict of opinion on this issue, with most providers and national associations declaring disability to be irrelevant while (a few) others disagree. However, interviews and text responses to our questionnaires suggest that disability is likely to be relevant only in cases where it may restrict the earning capacity of the borrower (and hence their ability to repay the loan) or in cases where the borrower is required to arrange insurance in connection with the mortgage. For example, mortgage lenders in a number of EU Member States require the borrower to put life insurance in place to back a loan, in which case not only the health status of the borrower but also their age and sex may become (indirectly) relevant to the decision of the credit provider if, for any reason, the borrower is unable to obtain or afford the supporting insurance cover.<sup>97</sup>

This leads to the following conclusion:

**7. Age of the borrower is clearly a relevant factor in the availability of mortgage credit.** Mortgage finance is rarely available to persons over 70 years of age at entry and the term of the mortgage loan available is likely to reduce according to the age of the borrower at its start. Similarly, elderly persons may be granted shorter repayment periods than younger customers for other forms of credit. The vast majority of respondents in interviews and surveys stated that sex and disability play no part in the provision of mortgage credit, although there were also some conflicting views. Disability is likely to be relevant in cases where it may restrict the earning capacity of the borrower (and hence their ability to repay the loan) or in cases where the borrower is required to arrange insurance in connection with the mortgage.

### 3.4 Practices of financial service providers to ensure that differences in treatment related to sex, age or disability are proportionate

In the introduction to this study (see chapter 1) we already have referred to the limited exception, or 'opt-out' clause, of the Gender Directive which Member States may carry into their own law if they so decide. Article 5 (2) of the Directive states:

*"... Member States may decide ... to permit proportionate differences in individuals' premiums and benefits where the use of sex is a determining factor in the assessment of risk based on relevant and accurate actuarial and statistical data".*

This language is echoed in the exception foreseen for the use of age and disability in the provision of financial services in the Draft Directive.<sup>98</sup> European law thus requires

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<sup>97</sup> This is documented in several complaints of affected consumers that were collected in the framework of this study, see section 4.4 below.

<sup>98</sup> Art. 2(7) of the Draft Directive. The proposal and thus the wording of the exception for the use of age and disability in the provisions of financial services was still subject to negotiations at the time of finalising this report. For analysing this provision, we have assumed that the exception for age and disability would closely follow the example of the Gender Directive.

insurers, (or would require in the case of age and disability if the Draft Directive were to be adopted), to satisfy a test which has three connected elements. First, the test demands that the factors sex, age and disability, if used by a provider to inform its decisions, should be a ‘determining factor in the assessment of risk’; second, that risk assessment should be ‘based on relevant and accurate actuarial or statistical data’;<sup>99</sup> and, third, the Directives require that differences in premiums (in the Draft Directive: ‘differences in treatment’) should be ‘proportionate’.

### **Determining factor**

Our initial concern is with the first element of the test, which allows insurers to employ age, sex and disability in underwriting only when it is a ‘determining factor in the assessment of risk’. ‘Determining’ can be interpreted in various ways and there is little to guide us on the subject. The word, and its variants, is often found in the language of causation, in which case ‘determining factor’ becomes ‘causal factor’. However, this interpretation is problematic, because the test refers not to a ‘determining factor in the risk’, but to a determining factor in the *assessment* of the risk, and matters such as the age, sex, etc., of the applicant clearly cannot ‘cause’ the insurer to assess the risk in a particular way, rather they are factors in the assessment process itself. Even if we interpret ‘determining factor in the assessment of risk’ to mean a ‘causal factor in the risk which insurers assess’ the problem is not solved because, as discussed earlier, age, sex and the like are never in themselves causes of insured losses, or causes of the risk of insured losses, rather they are proxies for other things which cause losses or make them more likely to happen, such as illness or driving skills. This leaves us with the other common meaning of ‘determining’, which is ‘decisive’. In this case a determining factor becomes one which enables the insurer to reach a firm decision (e.g. about the premium to charge). This interpretation still leaves various shades of meaning. Should we infer that the factor must be conclusive or essential, or merely very important? Alternatively, does ‘determining’ mean merely significant but not of the highest importance? A recent briefing note produced for the European Parliament’s committee on Civil Liberties, Justice and Home Affairs suggests that a ‘determining’ factor must be one which is ‘overwhelming in its impact’.<sup>100</sup> However, the wording of the Gender Directive itself (‘a determining factor’) makes it clear that sex need not be the only ‘determining’ factor in the assessment of risk, clearly implying that the ‘determining’ does not mean uniquely decisive. However, insurers use many underwriting factors for some lines of insurance – perhaps twenty or more in the case of motor insurance – and it cannot be said in the case of motor insurance that any is ‘overwhelmingly’ important, i.e. dominates all the others. Rather, each plays its part in measuring the risk, as do the correlations between the various factors. Even if we take ‘determining’ to mean simply ‘very important’ or even just ‘important’ there would be difficulties, which can be illustrated with the use of sex in the case of motor insurance.

<sup>99</sup> At the time of writing of this report, it was not finally clarified which types of evidence would be listed in the exception foreseen for the use of age and disability in the provision of financial services.

<sup>100</sup> Briefing note PE 410.670, February 2009.

The importance of the rating factor sex in motor insurance is limited, at least compared with the age of the driver, the type of vehicle insured, where it is driven and the use to which it is put. Furthermore, the importance of this factor in motor insurance appears to vary with age, because the very significant difference in claims cost between young men and women appears to reduce progressively as we move up the age range.<sup>101</sup> Clearly, it is quite impossible to say whether or not sex is a ‘very important’ or even just ‘important’ factor in motor insurance without addressing further questions. Perhaps the interpretation of the term ‘determining’ as meaning ‘significant’ would be a better choice? Rather obviously, this would prevent insurers from using insignificant factors but would still allow them to develop sophisticated rating models. On the other hand, financial service providers might argue they never use insignificant factors in risk assessment, so an interpretation of ‘determining’ as meaning ‘significant’ would probably not imply much limitation in the use of the factors sex, age and disability, if not further clarified.

Because of this unclarity, it is not surprising that Member States have interpreted the term ‘determining factor’ in the implementation of the exception of the Gender Directive differently, which has led to a situation where Member States have used the ‘opt-out’ provision in an inconsistent way (see section 5.1, below). Other than this, there is little indication that the requirement of sex being a ‘determining factor’ in the Gender Directive so far had much influence on the use of sex as a rating factor by financial services providers. Also, decisions of equality bodies, ombudsmen and courts concerning relevant complaints have only rarely concerned this aspect (see section 4.4.4).

### **Proportionate differences**

The second and third elements of the test in the Gender Directive require differences in premiums to be ‘proportionate’ and to be ‘based on relevant and accurate actuarial or statistical data’. There is little guidance available at EU and national level on what exactly is meant by ‘proportionate differences’ in the context of financial services (see sections 4.5.2 and 5). For the following analysis we will understand this provision (and a broadly similar test in the Draft Directive referring to ‘proportionate differences in treatment’) here as requiring that there should be a clear relationship between the effect of the factor on the risk and the resulting differences in premiums/treatment (so that where age, say, is only a minor factor there should be little or no change in the terms offered) and that insurers should be able to justify their decisions by reference to accurate and relevant data.

According to current EU and national non-discrimination law (covering in many Member States not only sex but also age and disability, see section 5.2) individuals have the right to challenge providers over the ‘proportionality’ of their underwriting and

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<sup>101</sup> See footnote 39 referring to UK data which suggest that in the 21-25 age band the claims cost for men is 60% greater than for women. According to this data the difference in claims cost reduces progressively until we reach the 56-60 age band when it disappears completely (in the 61-80 age band the claims cost for men is between approximately 15% and 2% greater than for women). See ABI 2009b.

pricing decisions and obtain compensation or other redress if the provider is unable to support its decisions, the burden of proof being on the provider. The central issue here is the level of generality at which providers are expected to prove that their use of the factor concerned is proportionate. In the case of the relatively simple, low-cost personal lines of insurance, such as motor insurance and travel insurance, insurers cannot hope to assess each risk individually; rather, they only assess the overall risk presented by groupings of individuals. For these lines of insurance, 'risk' means very little at individual level, being an abstraction based on the proportion of people within a group that is likely to claim and the average size of the claims that are likely to be made. *Who* exactly within the group will claim, and for how much, is simply unknown and unknowable. It follows from this that policyholders cannot reasonably expect to assert their rights under non-discrimination legislation merely by proving that they as individuals are 'better' risks than the average (e.g. better drivers than other people of the same age and sex). One must assume, rather, that insurers which are challenged need only prove that their pricing structures use valid data which adequately capture the risk at 'group' level (a view, which is supported by the approaches of equality bodies, ombudsmen and courts in deciding on the merits of a particular complaint, see section 4.5).

### **Sources of data**

As discussed before, premiums are generally arrived at by the statistical analysis of loss data and actuarial modelling, also taking into account other factors.<sup>102</sup> Concerning the data used, the Gender Directive requires them to use only 'relevant and accurate actuarial or statistical data'. The respondents to our questionnaires and interviewees who commented on this matter referred to a number of possible sources which providers use, the main ones being:

- 1 Statistical data which is in the public domain;
- 2 Providers' own performance data (e.g. data based on their own loss experience in the case of an insurer);
- 3 Data at industry level provided by an association which collects and collates information (e.g. loss data) from individual firms;
- 4 Data furnished by reinsurers.

Our research indicates that most providers use a combination of these. Commenting on each in turn, it appears that data in the public domain (source 1)<sup>103</sup> is sometimes of limited use, because it is often of a rather general nature and not sufficiently segmented for, say, insurance pricing purposes. There is also a so-called 'basis' risk, meaning that the provider's own portfolio of risks might be of a different composition

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<sup>102</sup> See footnote 14 for a list of relevant factors. Insurers also reported in our survey to make use of medical knowledge and relevant actuarial principles for the purpose of risk assessment and pricing.

<sup>103</sup> For example, road accident figures, data on the incidence of disease produced by public bodies and 'official' mortality tables.

than the general population on which the 'public' data is based. Providers' own performance data (source 2) is generally regarded as superior, because of the absence of basis risk and the possibility, at least, of a fine level of detail. However, this data will not be available to a new provider, or one which begins to write a completely new line of business. Again, as mentioned earlier, the data may be rather thin in relation to unusual risks (such as very elderly drivers or persons suffering from rare diseases). Industry level data (source 3) may share some of the problems of public data (1) in terms of lack of detail and basis risk, but can be useful as a supplement to other sources. Finally, data furnished by reinsurers (source 4) can be helpful in relation to large risks or those which are extra hazardous or unusual (such as risks associated with rare diseases). The scale and international scope of reinsurance, reinsurers' specialisation in unusual risks, and their wider statistical base gives reinsurance firms the ability to assess and advise on risks about which ordinary direct insurers (and especially small or new insurers) have only limited knowledge.

### **Problems of providers in ensuring 'proportionate differences'**

In our survey and interviews financial services providers very frequently made the point that proportionality of differences in premiums and benefits was very difficult to demonstrate because insurers do not use a simple (in the mathematical sense), strictly proportionate approach to underwriting with regard to sex, age and disability, or indeed any other factor used in risk assessment. The following points are a summation of the most common observations by respondents and interviewees on the difficulties which surround this issue:

- Published data or provider's own loss data may not be a reliable guide to risk but may need to be adjusted to take account of forward-looking trends and forecasts, such as expected changes in health care costs or longevity, movements in interest rates and investment yields, or the effect of new laws and court decisions. Also non-statistical data, such as medical knowledge and experience may be taken into account in the risk assessment;
- Age, sex and disability are only three of a multitude of risk factors used in underwriting models: many other factors are taken into account and the correlations between them have to be ascertained as well as the effects of each. This makes it difficult for factors such as age, etc., to be isolated as the key determinant behind a change in premiums;
- Premiums are not based on risk alone. They also take into account such factors as operational costs, levels of cover and projected investment returns;
- In small markets the lack of local data makes it difficult to build meaningful statistics (see also section 5.1.1);
- Strict mathematical pricing would also be difficult to implement for small or new firms entering the market, because these firms may have less statistical data, or no data at all, on which to price their products, even in medium or large markets where relevant data is available to other providers;

- It would be difficult for an ordinary insurer covering a wide spread of risks to use strict mathematical techniques where there is limited or no data about a particular group (as in the case of very old people, those suffering from rare diseases, etc.).<sup>104</sup>
- Insurers' decisions on pricing may be affected by strategic issues, such as the desire to enter or grow in a particular business sector or the need to rebalance an unbalanced portfolio. This might lead, say, to insurers charging less than the true 'actuarial premium' for a particular group (e.g. young male drivers).

This summary of statements illustrates the complexity of the issue of proportionality from a financial service providers' point of view, aggravated by the lack of guidance available at EU level. The complexity is reflected in the difficulty for equality bodies, ombudsmen or courts to decide whether or not differences in premiums/treatment are proportionate in a particular case or not. Calibrating premiums accurately to age, sex and disability along with many other rating factors, and accounting for the correlations between them, is likely to require complex mathematics and algorithms which are hard to explain to non-experts. This difficulty became apparent in a recent Irish case<sup>105</sup> in which an individual had complained of excessive rates for motor insurance. A member of the actuarial profession was called as a witness but the mathematics behind the calculation of the premium proved too involved and complicated to present to the court, so only a much simplified explanation could be given. Resolving this sort of information problem in a satisfactory and cost-effective way is by no means easy.

This leads to the following conclusion:

8. ***There is little guidance available for financial services providers on what exactly is meant by the requirement of the Gender Directive that differences in premiums have to be 'proportionate'.*** According to services providers, proportionality of differences in premiums and benefits is very difficult to demonstrate because insurers do not use a simple (in the mathematical sense), strictly proportionate approach to underwriting with regard to sex, age and disability, or indeed any other factor used in risk assessment. This complexity is reflected in the difficulty for equality bodies, ombudsmen or courts to decide whether or not differences in premiums/treatment are proportionate, in case provider behaviour is challenged on basis of non-discrimination legislation.

<sup>104</sup> Some respondents made the point that allowing 'niche' insurers to concentrate on specific groups was an efficient way of addressing problems of access for groups of this sort.

<sup>105</sup> See Equality Tribunal, complaint IE-3. It should be noted that the case was brought under Section 5 (2) (d) of the (Irish) Equal Status Act 2000 which predates the Gender Directive and explicitly allows insurers to make reasonable use not only of actuarial or statistical data but 'other relevant underwriting or commercial factors'.

### **3.5 The extent to which innovation in the market for financial products may change the use of sex, age, and disability**

We examine here the possibility of new developments which might enable insurers to price and underwrite risks without relying upon age, sex and disability (or health condition) as proxies for the risks they cover, or without relying upon them so heavily. We have seen that insurers base their decisions on the fact that there is a correlation between age and various causes of insured loss (e.g. young drivers tend to be more impetuous and less careful than those who are older, older people are more prone to illness and disease than younger ones, etc.). There are also correlations relating to sex (e.g. young women tend to be more careful drivers than young men, women generally live longer than men but, for some age groups at least, they are more prone to illness). Equally, there are clear correlations between existing adverse health conditions and the likelihood of a person becoming ill again in the future or dying prematurely. The question we consider here is whether it might be possible in future to identify these various tendencies in other ways, without relying on the proxies of age, sex, etc., to the same degree. By definition, this is a matter of speculation. However, it is not inconceivable that medical advances will enable predictions to be made about a particular person's predisposition to, say, illness, which are more accurate than a crude assessment based on their age and sex and which allows the latter factors to be disregarded completely by insurers. The real issue however, is whether such 'tests' could be as near costless and as unobtrusive as a simple enquiry about a person's age and gender and a few questions about health, and they also raise other ethical questions. Relatively expensive and obtrusive medical procedures are already available, but insurers (and insured persons) are reluctant to use them in the case of small policies and simple risks, for both economic and personal reasons. It remains to be seen whether these procedures can be improved on.

Perhaps the most realistic possibility of progress lies in the field of motor insurance. As already discussed in section 3.3.1.<sup>106</sup> it is already possible to fit motor vehicles with a 'black box' which uses GPS technology to monitor the use of the vehicle and, indirectly, driver behaviour, on a continuous basis. This opens up the possibility of 'pay as you drive' insurance where premiums are closely aligned to the individual risk presented by each driver in terms of where, when, how and how much they drive. Many companies worldwide now offer cover under such schemes, which vary in terms of their sophistication. Theoretically, however, insurance under such schemes could be priced without regard to age, sex (and possibly health condition) of the driver. The issue here is the ability on the part of providers of such schemes to allay people's concerns over personal privacy. In the absence of compulsory introduction of this technology,<sup>107</sup> rapid growth in their use seems unlikely.<sup>108</sup>

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<sup>106</sup> See footnote 16 and accompanying text.

<sup>107</sup> Compulsion is possible. Environmental concerns and road congestion have led a number of governments to contemplate road pricing systems, which could be based on in-vehicle technology rather than external camera systems. If this was forced on people by legislation, the extra intrusion of monitoring for insurance purposes might be regarded as insignificant.

Finally, we can note that ‘innovation’ could in theory take the form of a complete re-shaping of private insurance practice and a move towards ‘community rating’ models with flat premiums which do not vary according to individual risk. We have already discussed these in the context of health insurance, which is priced on this basis in some European countries. At the present time a more general move towards ‘socialised’ models of insurance (especially for lines such as motor or life insurance) looks very unlikely. The trend in Europe, for a number of years now, has been in the opposite direction, with a growth in private insurance at the expense of social insurance systems. Nevertheless, a reversal of this trend in the longer term cannot be ruled out.

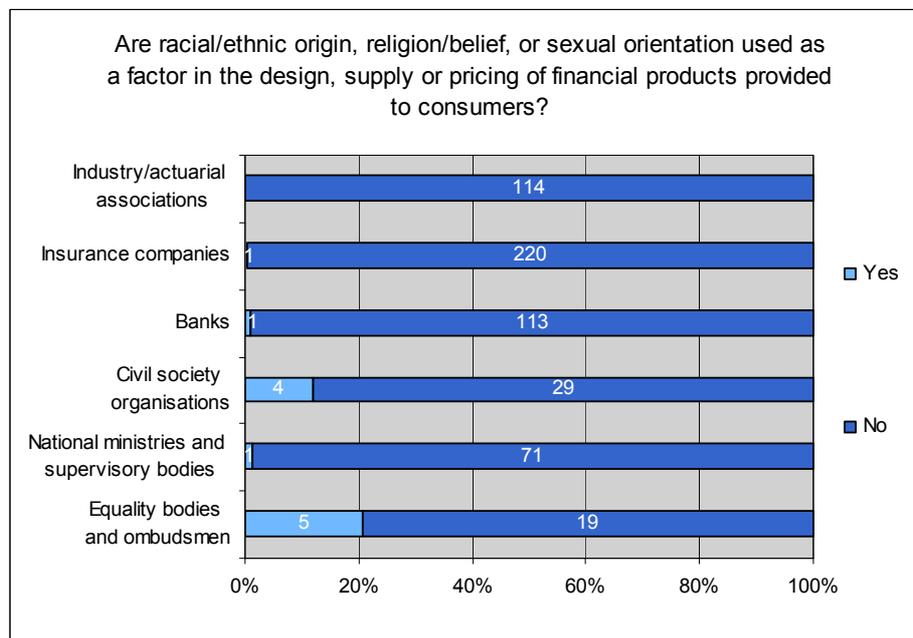
### **3.6 The use of racial/ethnic origin, religion/belief and sexual orientation as a factor in the design, supply or pricing of products**

Our research suggests that financial service providers make very little direct use of racial/ethnic origin, religion/belief or sexual orientation as factors in the design, supply or pricing of financial products. Almost universally, providers (insurance companies and banks) said in their interview and questionnaire responses that these factors play no part at all in their business. This was reiterated by all national industry associations (see Figure 21 below). The sole exceptions were two respondents (one bank and one insurer) which mentioned the development in Europe of special products which are compliant with Islamic (Sharia) law. It is a little surprising that more respondents did not make mention of these products – which are obviously targeted at a particular religious group – because they are becoming increasingly prominent in Europe. However, as far as we are aware, providers do not refuse to sell such products to non-Muslims, so there does not seem to be any issue of discrimination.

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<sup>108</sup> One early UK entrant into this field, Norwich Union/Aviva, has withdrawn its scheme because of low take-up.

**Figure 21: Use of racial/ethnic origin, religion/belief or sexual orientation**



Source: Civic Consulting surveys of national industry/actuarial associations (N=40), insurance companies (N=81), banks (N=39), national ministries and supervisory bodies (N=26), equality bodies and ombudsmen (N=20) and civil society organisations (N=17). Figures indicate the sum of answers for the three factors (racial/ethnic origin, religion/belief, sexual orientation). “Don’t know” and “No answer” not considered in graph.

It is also true that some well-established banks and insurance companies were associated originally with a particular religion, religious order or sect, and in some cases these associations persist. These firms often began as mutual associations, which ran savings schemes or provided other financial benefits for a particular religious group (e.g. savings clubs, insurance policies to pay for funeral expenses or insurance cover for church buildings, church schools etc.). Most of these companies have now diversified and offer their products to a much wider range of customers. In any event, we are not aware of any company which refuses to supply customers who do not adhere to a particular religion.

The stance of national authorities, equality bodies and civil society organisations on this whole topic was broadly similar to that of banks, insurance companies and their associations, but with a slightly greater number of exceptions (see Figure 21). The reservations of those who dissented from the general view concerned, variously, the use by providers of sexual orientation with regard to legal expenses insurance, and the use of ethnic origin in relation to motor insurance and consumer credit.

The factor racial/ethnic origin may be used indirectly, e.g. through requirements concerning nationality and residence. Residence was mentioned by one or two respondents; for example a request for documentation for residence or citizenship in

case of clients not born in the country of the consumer credit supplier concerned, and the refusal of mortgage finance on the grounds of temporary residence.<sup>109</sup> Indirect use of the factor racial/ethnic origin may also occur if insurers employ a 'zone rating' system. In this case premiums vary according to postcode, so that insurance may be more expensive (or cheaper) in areas dominated by certain ethnic groups and/or religions. Again, insurance claims handlers often use 'fraud scoring' models to identify claimants who, they believe, are more likely than others to make a fraudulent or exaggerated claim. The claimant's postcode is one (of many) factors taken into account, which means that claims relating to certain localities may undergo a more stringent investigation than is usual, making it more difficult for people who live there to claim. Similarly, life insurers often ask questions about periods of residence in foreign countries, where there is a greater chance of contracting illness, and such questions may impinge on certain ethnic groups more heavily than others.<sup>110</sup>

All in all, our research suggests that the use by financial service providers of factors relating to racial/ethnic origin, religion, belief or sexual orientation is quite small and is usually peripheral rather than central to their operations.

This leads to the following conclusion:

9. ***Financial service providers make very little direct use of racial/ethnic origin, religion/belief or sexual orientation as factors in the design, supply or pricing of financial products.*** Almost universally, insurance companies and banks said in their interview and questionnaire responses that these factors play no part at all in their business. This was reiterated by all national industry associations. The sole exceptions mentioned were the development in Europe of special products which are compliant with Islamic law. The stance of national authorities, equality bodies and civil society organisations on this topic was broadly similar to that of providers, but with a slightly greater number of exceptions. The reservations of those who dissented from the general view concerned the alleged use of ethnic origin and sexual orientation by providers.

### 3.7 Conclusions

In this concluding section we provide a brief general summary of the use by financial services firms of each factor covered by our study across various types of insurance and banking products, including the five lines that we have examined in some detail. We also include a summary in tabular form (Table 3) at the end of this section, based on frequency of reported use of the factors sex, age and disability for a total of 16

<sup>109</sup> For a discussion of discrimination on grounds of racial/ethnic origin, see section 4.4.3 below.

<sup>110</sup> Life and health insurers frequently ask questions relating to the applicant's risk of exposure to HIV infection and may also ask questions relating to individual personal behaviour (e.g. indulgence in unsafe sex or drug use), but they do not generally ask questions relating directly or indirectly to the applicant's sexuality. In a number of countries there are industry guidelines on this – e.g. those issued by the ABI in the UK (see ABI 2008).

product categories. Finally, we discuss potential problems that may arise from insurers' practices.

### **3.7.1 Use of age as a factor**

Before we summarise how financial providers make use of the age of the client when offering their products we should emphasise that this factor differs from all others under consideration in one significant way. The difference lies in the fact that age is not an immutable state like sex, racial/ethnic origin, etc., but rather a continuum along which we all pass – nobody is forever old or forever young. It follows from this that while young people are, for example, likely to pay more for their motor insurance, they will enjoy cheaper premiums later in life. Conversely, people of their parents' generation, who are enjoying lower motor premiums now, will have paid more in the past. So, over a lifetime, everyone will pay much the same. Of course, there is a further element of balancing-out in that young people will be able to obtain life, health and travel insurance more cheaply than their more mature contemporaries, even though the latter will get cheaper motor insurance and better terms for consumer and mortgage credit. Of course, the fact that things will be better in the future (or were better in the past) will not give much comfort to people who, as a consequence of their age, find it difficult now to obtain or pay for a financial product which they need.

- ⇒ *As we have seen, age is an important factor in a number of key financial products.* These include *motor insurance*, where age can make a very significant difference in terms of price and which can be more difficult (though by no means impossible) to obtain for the very young and the very old.
- ⇒ *Much the same is true for travel insurance, although there is little evidence that the young are penalised to any degree.* As we have seen, there is also some evidence that the pricing of travel insurance can be rather crude, with some insurers at least using relatively wide age bands which result in steep rises in premium as clients move from one age bracket to another.
- ⇒ *The cost of term life insurance rises remorselessly with age at entry.* However, because premiums are flat throughout the duration of the contract this is likely to be less of a problem, at least for those who buy the product at an early stage in life. In fact, the need for term life insurance is greatest in the case of relatively young people (who may, for example, buy cover to discharge a mortgage loan or provide support for a young family in the event of untimely death). The older people are, the less likely they are to need such cover, although there are cases where older people do need term life insurance for taking on a loan, e.g. in case of a bridging loan that covers the period between buying of a new flat and selling the currently inhabited one. Age plays an equally important role in the provision of other forms of life insurance.
- ⇒ *As morbidity increases with age, premiums can also rise significantly for older people who buy private health insurance.* This type of cover can also become increasingly difficult to obtain with age. However, as we have seen, this is not the case with schemes that use 'community rating' principles. The potential problem of rising premiums is also alleviated in countries, like Germany, where suppliers

charge clients level premiums through the use of age reserves. Again, potential problems for older people associated with the rising cost and reducing availability of cover diminish to the extent health care is available through a public system. Nevertheless, as we have suggested, demographic factors point to an increasing role for private health insurance in future and, perhaps, lower levels of publicly funded health care, in which case problems of availability and affordability for older buyers of health insurance may become more acute. Much the same considerations apply to other forms of insurance which respond in the case of accidents or illness. These include critical illness insurance, income protection insurance, loan insurance, long-term care insurance and accident insurance. In each case age is a significant factor in pricing and availability, but, once more, the impact of this on individual purchasers depends on the pricing method used (i.e. flat or rising premiums) and on the availability of publicly funded support to mitigate the effects of illness, accidents or infirmity.

- ⇒ *The age of the borrower is clearly a relevant factor in the availability of mortgage credit.* However, other factors (especially income status) are much more significant. Much the same is true for other banking products, including credit cards and deposit accounts, although it appears that the age of the borrower is less significant in (secured) mortgage credit than in unsecured lending.
- ⇒ *Finally, we can note the existence of a few financial products where the age of the consumer plays, at most, a small role.* These include home insurance and private liability insurance.

### **3.7.2 Use of sex as a factor**

- ⇒ *Sex is a relatively significant factor in motor insurance though less significant than age, with greater variation in the practice of insurers.* There are three main categories. First, cases where the use of sex as an underwriting factor is forbidden by law; second, cases where there is no such legal restriction but where sex is not used in practice, and third, cases where it is used. Those insurers that do price according to sex typically allow female policyholders lower premiums with the greatest differences being observed between young male and young female drivers. Sex is unlikely to affect contractual terms of motor insurance other than price.
- ⇒ *Most (but not absolutely all) insurers disregard the sex of the insured in the pricing and provision of travel insurance* but cover for medical expenses may be restricted in the case of pregnant women.
- ⇒ *Sex is a significant factor in the pricing of term life insurance*, since women tend to live longer, and the same is true for other forms of life insurance, including whole of life contracts. Conversely, and for the same reason, women will pay more than men for annuity products providing similar benefits or receive lower benefits for the same purchase price. As we have seen, the law does not demand unisex premiums for life business in any EU Member State.

- ⇒ *There is evidence that levels of morbidity vary between men and women of the same age, but whether private health insurers take this into account in pricing their products depends on a number of factors, including the funding basis of the scheme (i.e. whether there are flat premiums as a consequence of ‘community rating’ or whether premiums are individualised), the applicable law on gender discrimination, and the practice of individual insurers. Thus, sex is not a factor used by health insurers in the Netherlands or Ireland (where ‘community rating’ applies), nor in countries such as Cyprus and Belgium, where the Gender Directive has been implemented so as to require unisex premiums, but it is used in some countries, such as Germany. In other cases, such as the UK, insurers may, if they wish, use sex as factor in the provision of health insurance in accordance with the Gender Directive and while some firms do so, others do not. Sex may occasionally influence the contractual conditions of private health insurance, childbirth and pregnancy being the most common areas where this may be the case.<sup>111</sup> Much the same considerations as to sex apply to other forms of insurance which respond in the case of illness. These include critical illness insurance, income protection insurance, loan insurance, and long term care insurance. In each case sex may be a factor in pricing and availability, with premiums reflecting the greater longevity and (for some ages at least) higher morbidity of women. However, once more, the impact of this on individual purchasers depends on the availability of publicly funded support to mitigate the effects of illness or infirmity.*
- ⇒ *Sex plays only a relatively minor part in the provision of mortgage (and other) credit. Other factors (especially income status) are much more important and most (but not all) providers say that the sex of the borrower is irrelevant. The same is true for other banking products, including credit cards and deposit accounts.*
- ⇒ *Sex plays only a very minimal role in the provision of home insurance and private liability insurance.*

### **3.7.3 Use of disability as a factor**

We begin with a point which has been made on a number of occasions in our discussion of various individual products, which is that financial firms are not concerned with disability as such, but rather with any underlying health condition which may affect the risk assumed by the provider – e.g. the risk of accidents, illness, premature death or inability to repay a loan. In some cases a person may be ‘disabled’ for one or more legal purposes (e.g. entitlement to state benefits) but present no extra risk to a provider. Conversely, a person may have a health condition which represents a significant extra risk for the provider, but may not be deemed disabled for other purposes.

The multitude of possible adverse health conditions that exist and their many different degrees of severity can make risk assessment difficult for insurers. This is so because a clear and simple classification framework will be less easy to achieve than in the

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<sup>111</sup> See footnote 161.

case of factors such as gender and age. For this reason disability/health condition is often regarded as an 'underwriting' rather than a 'rating' issue, meaning that it is something which has to be assessed individually rather than something accommodated automatically within a pricing model, like age or sex. Of course, an individual assessment may take significant extra time and money, which is one of the reasons why insurers sometimes exclude specific disability/health conditions from cover rather than attempt to price them. Practice in relation to motor insurance is based on these considerations.

- ⇒ *Motor insurers do not 'price' disability in a systematic way, rather they consider the (relatively rare) cases where a health condition might affect a person's driving on an individual basis and load premiums if they think it necessary. As mentioned earlier, the screening process which most countries employ when issuing driving licences reduces the need for motor insurers themselves to carry out such health screening.*
- ⇒ *When cover for medical expenses is provided within a travel insurance policy, the client's health status or disability can become significant. Travel insurance is a line of business where, as suggested above, insurers commonly avoid the cost of individual medical screening by excluding pre-existing medical conditions generally, or at least certain defined pre-existing conditions, except, perhaps, in cases where the condition has 'stabilised'.*
- ⇒ *The health condition of the applicant is a key factor for term life insurance and, indeed, for any form of life insurance. If the answers given to questions asked by life insurers suggest that applicant may be in poor health, additional health reports and/or medical examinations are likely to be requested and premiums may well be raised. These measures are more likely to be taken if the amount to be insured is large.*
- ⇒ *Disability (or health condition) can affect either the price of private health insurance, or its contractual conditions, or both. Our survey suggests that it is rather more likely to affect the latter than the former. This is because, as suggested earlier, a number of insurers prefer to deal with clients presenting adverse health conditions by excluding the condition concerned rather than by raising the price of the cover. This form of contractual variation – the exclusion of pre-existing conditions – is particularly important and is widespread in markets where individual underwriting of health insurance is allowed.*
- ⇒ *The considerations which apply to private health insurance as regards disability apply also to related forms of insurance such as critical illness insurance, income protection insurance, loan insurance and (to a lesser extent) long-term care insurance and accident insurance. In each case, disability may result in higher premiums, or the exclusion of one or more conditions or, in some cases, the denial of cover altogether.*
- ⇒ *Our research suggests that disability/health condition in itself plays little or no part in the provision of mortgage loans or consumer credit, other banking products*

*(including credit cards and deposit accounts), home insurance or private liability insurance.*

In some respects at least, the attitude of providers to adverse health conditions can be more problematic for buyers of financial (especially insurance) products than any distinctions based on sex or age. Premiums may vary somewhat according to whether one is male or female but contractual terms do not change significantly and cover is never denied on gender grounds. Again, younger and (especially) older people may also pay more for their insurance cover and the elderly, in particular, can find it more difficult to get insurance. However, the need for at least some forms of insurance does diminish with age. On the other hand, people in poor health or with a disability which may affect the risk assumed by the provider, whatever their age, are quite likely to find that they simply cannot be insured for risks related to their particular health condition, or cannot be insured at all.

#### **3.7.4 Use of racial/ethnic origin, religion/belief and sexual orientation**

Our research suggests that there is very little direct use of racial/ethnic origin, religion, belief or sexual orientation as factors in the supply of financial products. Some providers have affiliations with religious bodies and some products have been developed specifically for certain religious groups (e.g. Islamic insurance and banking products), but we found no strong evidence of the use of these factors by suppliers on any of these grounds.

#### **3.7.5 Potential problems arising from the practice of insurers**

As a prelude to the chapter which follows, we conclude by discussing, at a very general level, the problems which can arise for consumers from the practices of insurers with regard to the various factors discussed in this study.

The arguments which are advanced to support the current practices of insurers in relation to the factors sex, age and disability (to the extent that they are permitted by law) are essentially economic. They suppose that consumers as a whole will be served best by allowing the price of financial products and the terms on which they are offered to be determined by competition between providers and the forces that operate in a free market. This, in theory, should produce prices based on an optimum balance between accurate alignment to risk and economy in risk assessment which, in turn, should lead to insurance being bought at optimum levels, with no undue distortion in buying patterns caused by adverse selection or moral hazard. It is then argued that laws which prevent insurers from relying on, or restrict their ability to use, factors such as age, sex and disability will tend to dislocate prices from risk and thereby distort the market by increasing moral hazard and adverse selection, causing insurance to be bought at non-optimal levels. In theory, this could also create incentives which lead to higher rates of accidents and losses: for example, if high-risk drivers are under-priced and low-risk drivers overpriced the former may become more dominant in their use of the road, or drive vehicles which create more risk for others. Alternatively, the argument runs, if providers are not allowed to calibrate prices to risk by the use of such factors as age, sex and disability, they will be obliged to use more expensive means of

acquiring risk information, thus raising the overall cost of cover to the whole risk community.

The problems that can arise for consumers from the practices we have described are various in their nature and origins. First, the (economic) arguments outlined above presuppose that markets for financial products are competitive and efficient whereas, as we have seen, some EU markets are more competitive than others, with only a handful of providers in some smaller Member States. Lack of competition can weaken the natural incentive of market players to align premiums accurately to risk. Furthermore, even in a market where there is plenty of choice, information problems might make it difficult for consumers to find easily the best providers for their needs. This point is considered in more detail in chapters 5 and 6, where we discuss ‘signposting’ as a measure to direct people who are refused insurance from standard providers to specialist companies.

Second, we have seen that fine-tuned differential pricing can weaken the risk-spreading function of insurance and lead to ‘red-lining’, with very high risk individuals (e.g. very old or very ill people) being priced out of the market or denied cover altogether. An economist might argue that this phenomenon is quite consistent with overall market efficiency, in the sense that such individuals cannot be efficiently insured. However, at this point the argument shifts from the language of economics to the language of rights, with critics of current insurer practices arguing that it is wrong to deny services to a person as a consequence of something which they are powerless to change. Weighing these opposing views against each other is impossible, because they are simply incommensurable. Whether individual human rights should trump market efficiency is a policy matter, not an economic question. However, once it is decided that high risk individuals should have the right to secure cover, it is then possible to compare different ways of achieving this aim and weigh the benefits of each. For example, if it is thought right that people of any age should be able to obtain motor insurance, there might be a number of ways of achieving this end. Forbidding insurers to deny cover on grounds of age, with or without a ban on age-based pricing, would achieve the desired aim, but a declined risk pool<sup>112</sup> might achieve it more efficiently. Again, in a competitive market where specialist ‘niche’ insurers are allowed to flourish, the aim might be achieved without any legal intervention at all.

A third problem for consumers arises not from fine-tuned segmentation of risk, but from an (almost) opposite situation where high risk assessment costs discourage such segmentation and lead to relatively crude classifications of risk. We find examples in (medical) travel insurance and in health insurance where insurers commonly issue standardised contracts and deal with people in poor health by excluding pre-existing

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<sup>112</sup> Declined risk pools (or ‘assigned risk pools’) vary in terms of their detail but typically allow high risk individuals who cannot obtain insurance from individual insurance companies to buy cover (often at high cost) from an insurance industry-run pool. The risks which are allocated to the pool are usually shared among all insurers in the market that write the line of business concerned, in proportion to their market share. Thus, larger insurers take a bigger share of the risks concerned. These pools are found in many countries world-wide. They are especially common for compulsory lines of insurance, such as motor insurance.

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conditions. This avoids (or at least reduces) the need for individual underwriting and enables insurers to speedily deliver relatively inexpensive cover to those in good health. However, as we have seen, this practice can create quite severe difficulties for those whose health is impaired. Among this last-mentioned category there are likely to be some who are simply not insurable in relation to the medical condition in question. Insurance can cover things which may happen but not things that must, so insurance can hardly be provided when a renewed and severe onset of the condition in question is imminent and inevitable. In other cases it may be possible to provide insurance, at a higher price. Separating these categories and sub-dividing the latter for pricing purposes will involve an expensive process of medical screening. The problem could be by-passed by abandoning the principles of private insurance altogether and substituting an open-access scheme supported by community funding – which is a proven and workable option in the case of health insurance at least. If this option is rejected the only remaining question is who should bear these extra screening costs and how widely should they be spread among the insured population.

**Table 3: Reported use of factors for risk assessment by product (based on frequency of reported use by stakeholders)**

Product category	Definition of product category	Factors		
		Sex	Age	Disability
<i>Insurance products</i>				
<b>Private health insurance</b>	Private health insurance - insurance that covers health risks in addition to (or for those not covered by) the national health care system	++	++	++
<b>Critical illness insurance</b>	Critical illness insurance - insurance policy that pays a benefit if the insured is diagnosed with a specified critical illness during the policy term	++	++	++
<b>Disability/income protection insurance</b>	Disability/income protection insurance - insurance that provides payments to replace lost income when the insured is unable to work because he/she becomes disabled	++	++	++
<b>Life insurance</b>	Life insurance - insurance which provides, in particular, payment on survival to a stipulated age or payment on the death of the insured to their beneficiaries	++	++	++
<b>Annuity products</b>	Annuity products (including private pensions) - insurance that provides regular payments in the future in exchange for the payment of a lump sum or a series of regular payments prior to the onset of the annuity	++	++	+
<b>Motor insurance</b>	Motor insurance - insurance for private cars covering at least third party liability	++	++	+
<b>Travel insurance</b>	Travel insurance - temporary insurance that covers, for the duration of the trip only, at least medical expenses and potentially financial and other losses incurred while travelling	+	++	+
<b>Accident insurance</b>	Accident insurance - insurance that covers losses caused by a bodily accident or expenses of medical treatment necessitated after a bodily accident	+	+	+
<b>Long term care insurance</b>	Long-term care insurance - insurance policy that covers costs of long-term care beyond a predetermined period not covered by health insurance	+	+	+
<b>Loan insurance/Payment protection insurance</b>	Loan insurance/Payment protection insurance - insurance that protects monthly loan payments if holders become unemployed or suffer an accident or sickness	+	+	+
<b>Home insurance</b>	Home insurance - property insurance policy that covers losses occurring to private buildings and to their contents	o	+	o
<b>Private liability insurance</b>	Private liability insurance - insurance that provides protection against third party claims, i.e., payment is typically to someone suffering loss caused by the insured	o	+	o
<i>Banking/Loan products*</i>				
<b>Mortgage loans</b>	Mortgage loans - loan secured against a property	o	+	o
<b>Consumer credit**</b>	Consumer credit - short-term loan to consumers for the purchase of goods, including credit accounts at retail outlets, personal loans, hire purchase, but excluding credit cards	o	+	o
<b>Credit cards</b>	Credit cards - card entitling holders to buy goods and services based on the holders' promise to pay for these goods and services at a later stage	o	+	o
<b>Deposit account</b>	Deposit account - current or savings account, or other type of bank account, at a banking institution that allows money to be deposited and withdrawn by the account holder	o	o	o

Notes: ++ = Frequently reported to be used (by 50 % or more of all responding industry associations, actuarial associations and competent authorities and equality bodies).  
+ = Occasionally reported to be used (by 10 % to 50 % of all responding industry associations, actuarial associations and competent authorities and equality bodies).  
o = Rarely reported to be used (by less than 10 % of all responding industry associations, actuarial associations and competent authorities and equality bodies).  
In case that frequency of reported use led to deviations between the three groups on which the assessment is based (industry associations/actuarial associations/competent authorities and equality bodies), the assessment in the table represents the results of the two groups falling into the same category.  
Product categories may include a variety of different types of products offered on the market. Bundled products are not covered (e.g. the combination of a current account with an insurance product).  
\* Age and sex are sometimes used in credit scoring and this may affect the provision of banking/loan products.  
\*\* Consumer credit includes motor finance and personal loans.

## 4 Actual and potential problems of discrimination

This section identifies and analyses problems of discrimination related to the use of age, disability, sex, racial/ethnic origin, religion/belief and sexual orientation in the provision of financial services. It focuses on discrimination problems experienced by individual consumers, rather than on issues such as financial exclusion<sup>113</sup> or preferential offers including positive action.<sup>114</sup>

Actual and potential problems of discrimination in the context of financial services are identified and analysed as follows:

Consumer complaints concerning discrimination in financial services are discussed in sections 4.2 to 4.4, which also present complementary evidence concerning denial of access to specific financial services experienced by some consumers.

The extent to which documented complaints constitute discrimination in the legal sense, i.e. are considered to be infringements of non-discrimination law by courts, ombudsmen and other bodies with inquisitorial powers in the Member States, is discussed in section 4.5.

Before presenting and analysing this evidence, we summarise in the following section 4.1 the methodology used in this study to identify problems of discrimination in the provision of financial services.

### 4.1 Methodology for the identification of problems of discrimination

There is significant disagreement among stakeholder organisations concerning the question whether consumers currently experience problems of discrimination in the provision of financial services, and which definition of ‘discrimination’ should be used in this context. Therefore, a first draft of the methodological approach for this study was presented by Civic Consulting at the second meeting of the Dialogue on the use of age and disability in financial services held in Brussels on 8 December 2009. Stakeholders were given a discussion paper and invited to submit comments in case of disagreement. Comments received were considered when finalising the methodological approach outlined below.<sup>115</sup>

#### 4.1.1 *The legal definition of discrimination*

The point of reference for the study is the definition of discrimination as provided in EU legislation. The term ‘discrimination’ is defined in a similar way in all directives in the field of non-discrimination.<sup>116</sup> Taking into account all protected grounds listed in Article

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<sup>113</sup> Financial exclusion was subject to a previous study by DG Employment, see Financial Services Provision and Prevention of Financial Exclusion, European Commission, 2008.

<sup>114</sup> I.e. “specific measures to prevent or compensate for disadvantages linked to sex” Art. 6 of the Gender Directive.

<sup>115</sup> Two stakeholders from industry provided comments (see Part III, Annex 8).

<sup>116</sup> The terminology used in this study follows the terminology of the Gender Directive and other relevant directives except in cases that diverging stakeholder concepts of ‘what constitutes a discrimination problem’ are discussed.

19 of the EU Treaty,<sup>117</sup> the concept of direct and indirect discrimination in EU legislation can be summarised as follows:

- Direct discrimination occurs where one person is treated less favourably than another is, has been or would be treated in a comparable situation on the grounds of sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.
- Indirect discrimination occurs where an apparently neutral provision, criterion or practice would put persons of a particular sex, a particular racial or ethnic origin, a particular religion or belief, a particular disability, a particular age, or a particular sexual orientation at a particular disadvantage compared with other persons, unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary.

Sex, disability and age are directly used as actuarial factors in the provision of insurance and credit. Because of this widespread use Article 5(2) of the Gender Directive provides, as has been discussed before, Member States the discretion to permit “proportionate differences in individuals' premiums and benefits where the use of sex is a determining factor in the assessment of risk based on relevant and accurate actuarial and statistical data”. This wording is echoed in the exception provided in Article 2(7) of the Draft Directive regarding the use of age and disability.<sup>118</sup> The exception of the Gender Directive is not applicable regarding the costs of pregnancy and maternity,<sup>119</sup> and no similar exceptions exist in the Draft Directive regarding the grounds sexual orientation and religion or belief, nor in the Racial Equality Directive.<sup>120</sup>

This allows differentiating two categories of direct discrimination according to EU legislation in force/proposed, depending on the protected grounds:

- a. The use of racial or ethnic origin, religion or belief, or sexual orientation which is considered to be discriminatory under all circumstances.
- b. The use of sex, disability, or age, which is considered to be discriminatory if (for the product in question):<sup>121</sup>

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<sup>117</sup> Treaty on the Functioning of the European Union, Article 19 (ex Article 13 TEC) states “the Council ... may take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation”.

<sup>118</sup> For a discussion of how Member States address the use of the factors age and disability in financial services in their legislation, please refer to section 5.1.

<sup>119</sup> Article 5(3) of the Gender Directive provides that “costs related to pregnancy and maternity shall not result in differences in individuals' premiums and benefits”. See also footnote 161.

<sup>120</sup> Council Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin.

<sup>121</sup> The final wording of the test regarding age and disability was not known when finalising this report, because negotiations on the Draft Directive in the Council were still ongoing. The wording of the test presented here is largely based on the Commission Proposal for the Draft Directive and the Gender Directive.

- Sex, disability, or age are not determining factors in the assessment of risk;
- The assessment of risk is not based on relevant and accurate actuarial and statistical data.
- Differences in treatment/individuals' premiums and benefits are not proportionate (or originate from costs related to pregnancy and maternity);

Indirect discrimination problems occur according to the definition of the concept in EU legislation if an apparently neutral practice of a financial service provider would put persons of a particular sex, a particular racial or ethnic origin, etc. at a particular disadvantage compared with other persons, and this is not objectively justified by a legitimate aim and the means of achieving that aim are not appropriate and necessary. A hypothetical example for indirect discrimination would be that a consumer is declined a loan or insurance cover because of his or her nationality (which is covered by Article 18 of the EU Treaty and therefore does not fall under protection grounds of Article 19), and this practice would put a person of a particular racial or ethnic origin at a disadvantage which is not justified (depending on the circumstances).

Although problems caused by indirect discrimination are not irrelevant in practice, as exemplified in section 4.4.3 below, the concept of direct discrimination is central to this study, due to the direct use of the protected grounds sex, age and disability by financial service providers.

#### **4.1.2 Stakeholder views concerning what constitutes a discrimination problem**

While there is general consensus among stakeholders that it is not appropriate to use racial or ethnic origin, religion or belief, or sexual orientation for the supply and design of financial products, stakeholder views differ widely concerning what constitutes a discrimination problem in the direct use of sex, age and disability in the provision of financial services. There are two main lines of argument concerning what constitutes discrimination on the grounds of sex, age and disability.

According to the first group of stakeholders, any use of sex, age and disability in the design and supply of financial services constitutes discrimination. Organisations bringing forward this line of argument are civil society organisations, as is illustrated in the following table:

**Table 4: Exemplary stakeholder views on what constitutes a discrimination problem - first group**

Organisation	Summary of stakeholder view
AGE (EU stakeholder)	The general rule to apply in order to decide whether a complaint constitutes a case of discrimination is considering whether the discriminatory factor is a characteristic on which the individual can decide upon (e.g. lifestyle choices, individual behaviour). If not (e.g. age, sex), lack of access or penalising conditions constitute a problem of discrimination.
European Women Lobby (EU stakeholder)	Using the sex of a person to define an insurance premium or pension constitutes a breach of the fundamental right to equality between women and men as guaranteed by the European Treaty.

Source: Interviews Civic Consulting.

In contrast, according to the second group of stakeholders it depends on the circumstances whether the use of sex, age and disability for the provision of financial services constitutes discrimination – broadly in line with the approach in current and planned EU legislation.

Organisations bringing forward this line of argument include a wide range of organisations, including industry associations. Their arguments, which are quite different in substance and understanding of a discrimination problem, are summarised in the following table:

**Table 5: Exemplary stakeholder views on what constitutes a discrimination problem – second group**

Organisation	Summary of stakeholder view
CEA - the European insurance and reinsurance federation (EU stakeholder)	The starting point is Art. 19 of EC Treaty that does not foresee an absolute prohibition to differentiate. The principle of non-discrimination states that persons equally situated must be treated equally, but also that persons unequally situated must be treated differently. Consequently, <u>discrimination would then mean that equals are treated unequally and that unequals are treated equally</u> . So the starting point is the comparability of situations. Different risk exposures are different situations. These different situations need to be treated differently according to the non-discrimination principle. On that basis, risk differentiation does not represent discrimination. An eventual denial of coverage is the result of risk assessment, but is not discriminatory.
European Mortgage Federation (EU stakeholder)	The criteria to distinguish a case of harmful discrimination from a case of objective refusal would be to investigate whether a <u>proper risk assessment</u> has been carried out and whether the refusal is motivated by an objective analysis.
AGE Concern and Help the Aged <sup>122</sup> (UK stakeholder)	Age discrimination can constitute a problem if it is not a proportionate means of achieving a legitimate aim. The aim must reflect a real and objective need which is not discriminatory in itself. The means of achieving the aim must be: - justified by <u>relevant and accurate evidence</u> – which could include actuarial or statistical data or a bona fide professional opinion in the case of insurance, for example. - a <u>proportionate response</u> – that is, the same aim could not be achieved by less discriminatory means, and/or the justification is important enough to override the impact of the discriminatory treatment.

Source: Interviews Civic Consulting.

All arguments presented above refer in one way or other to the evidence base and the circumstances on which financial service providers base their decisions, either explicitly by referring to actuarial or statistical data, which is needed to justify differential treatment, or implicitly by referring to the comparability of situations, the assessment of which would require some objective evidence.

<sup>122</sup> Since April 2010, the organisation Age Concern England/Help the Aged is known as Age UK. Source documents received from this organisation predate the renaming, and therefore we refer in this study to the organisation with the short name 'Age Concern'.

However, there are significant differences in opinion concerning the character of the evidence/data required, and whether – in line with the Draft Directive – differences in treatment have to be proportionate and what that means in practice. At a simplified level, one can identify in the views voiced by the second stakeholder group two sub-groups with significantly different perspectives of what constitutes a discrimination problem:

- According to the first sub-group, the use of sex, age and disability in the supply and design of financial products is discriminatory if differences in treatment are not based on relevant evidence, and if these differences are not proportionate;
- According to the second sub-group, the use of sex, age and disability in the supply and design of financial products is discriminatory if differences in treatment are not based on relevant evidence or if equal situations do not lead to equal treatment. There is no further proportionality criteria.

Although both perspectives appear to be relatively similar, and both consider the use of sex, age and disability in the supply and design of financial products to be discriminatory if differences in treatment are not based on relevant evidence, the first perspective goes further in its proportionality requirement. This could lead to significant differences in practice: for example, in line with the view of the first group and depending on the definition of proportionality applied and the individual circumstances, denial of access to a specific service could be considered to be not proportionate in some or all cases. In contrast, a denial of access to a specific service would be perfectly legitimate and generally not be considered to constitute discrimination in the view of the second group, if done evidence-based and consistently, e.g. by denying a specific service to all consumers above a specific age, or to all persons with a specific disability (in line with the principle that equal situations lead to equal treatment).

The table on the following page illustrates the differences between the different stakeholder views concerning what constitutes a discrimination problem on the basis of hypothetical situations.

**Table 6: Stakeholder views to identify discrimination problems**

Ground	Type of problem	Hypothetical examples of problems	Is this a discrimination problem?						
			<i>Discrimination, if any ground is used in the supply and design of financial products</i>	<i>Discrimination, if differences in treatment are not based on evidence, or if these differences are not proportionate</i>	<i>Discrimination, if differences in treatment are not based on evidence or if equal situations do not lead to equal treatment</i>				
<b>Sex, age, disability</b>	<i>Differential conditions of access</i>	Higher motor insurance premiums for young men (based on higher risks)	<b>Discrimination</b>	<b>No discrimination</b>	<b>No discrimination</b>				
		Lower annuity payment to women (due to longer life expectancy)							
		Use of wide age bands for premium definition in travel insurance				<i>Depends on concept of proportionality and circumstances (e.g. how wide age bands are)</i>			
		Excessively higher insurance premiums for elderly drivers without risk assessment based on proper evidence				<b>Discrimination</b>	<b>Discrimination</b>		
		Higher interest rates for women for loans without indications that risk of default is higher							
	<i>Denial of access</i>	Refusal to provide a quote for a travel insurance because of age thresholds		<b>Discrimination</b>	<i>Depends on concept of proportionality and circumstances</i>	<b>No discrimination</b>			
		Lack of access to bundled products such as bank accounts offering free travel insurance, but only to customers of a certain age							
		Excessively long waiting periods to obtain a quote for a disabled person					<b>Discrimination</b>	<i>(Likely discrimination, but no clear criteria)</i>	
		<b>Racial or ethnic origin, religion or belief, sexual orientation</b>					<i>Differential conditions of access</i>	Higher insurance premiums for homosexuals	<i>Not applicable - any use of racial or ethnic origin, religion or belief, or sexual orientation is considered to be discrimination</i>
								Higher credit interest rates for ethnic minorities	
<i>Denial of access</i>	Denial of insurance cover or loans for ethnic minorities								

Source: Civic Consulting

#### **4.1.3 Data collection to identify actual and potential problems of discrimination**

Table 6 above illustrates how the definition of ‘discrimination problem’ by stakeholders (and the concept of proportionality used) affects the identification of actual and potential problems of discrimination in the field of financial services. It also shows that the analysis concerning the use of sex, age and disability is most simple under the view of some stakeholder organisations, where any differential treatment on these grounds constitutes discrimination. From this perspective, only the use of one of these factors has to be documented to identify a discrimination problem.

In contrast, under the diverging view of other stakeholders – which is also the approach enshrined in EU legislation – it is more difficult to diagnose a discrimination problem, and related issues to be scrutinised revolve around the questions of evidence and proportionality. Relevant questions are:

- What is the type and quality of evidence used?
- Is the evidence sufficient?
- What is the concept of proportionality used?
- What are the individual circumstances of the case in question?

We have already discussed the difficulties to clarify the meaning of ‘proportionate differences’ in practice (see section 3.4 above). Any assessment of a particular complaint regarding discrimination that takes into account this aspect can therefore only be a case-by-case decision taken by a body with inquisitorial powers, be it a court, an equality body, an ombudsman, or any other consumer complaints body. This approach is therefore used in section 4.5 to identify problems of discrimination.

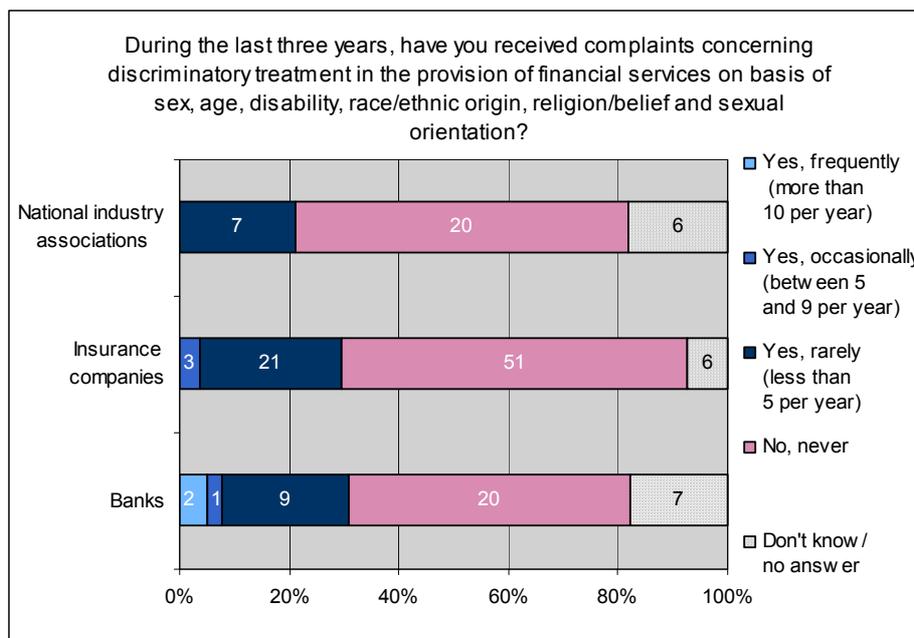
Data about the number and type of complaints regarding discrimination in the provision of financial services and complementary consumer research are rare. This is true in many countries. The only country where we could find meaningful quantitative consumer research regarding access to specific financial products is the UK, and that focuses on age only; it was triggered by the debate over proposed legislation – now the Equality Act, and the consequent need to measure the extent of the problem caused by differential treatment on grounds of age. In other countries, all that exists is anecdotal evidence, and in some cases a frequency count of numbers of complaints recorded by relevant bodies. The following analysis is therefore mainly based on evidence concerning the number of consumer complaints about discrimination in financial services collected through our survey of national authorities, equality bodies, ombudsmen, civil society organisations, and industry, as well as detailed information concerning decisions of investigating bodies and courts regarding such complaints across Europe that we have documented.

## 4.2 Complaints concerning discriminatory treatment of consumers

### 4.2.1 Complaints received by industry

In our survey, insurance companies, banks and their industry associations were asked if they had received complaints about discriminatory treatment in the last three years. The majority of responding companies said they had *never received complaints* on these grounds, with a minority saying they received such complaints *rarely* (see Figure 22 below). Many industry bodies stressed that the number of complaints on grounds of discrimination was tiny compared to the overall volume of complaints they received. Indeed some companies reported that due to low volumes, discrimination complaints might be categorised as “other” rather than receive a nominated category thus making identification difficult.

**Figure 22: Receipt of complaints concerning discrimination reported by industry associations, insurers and banks**

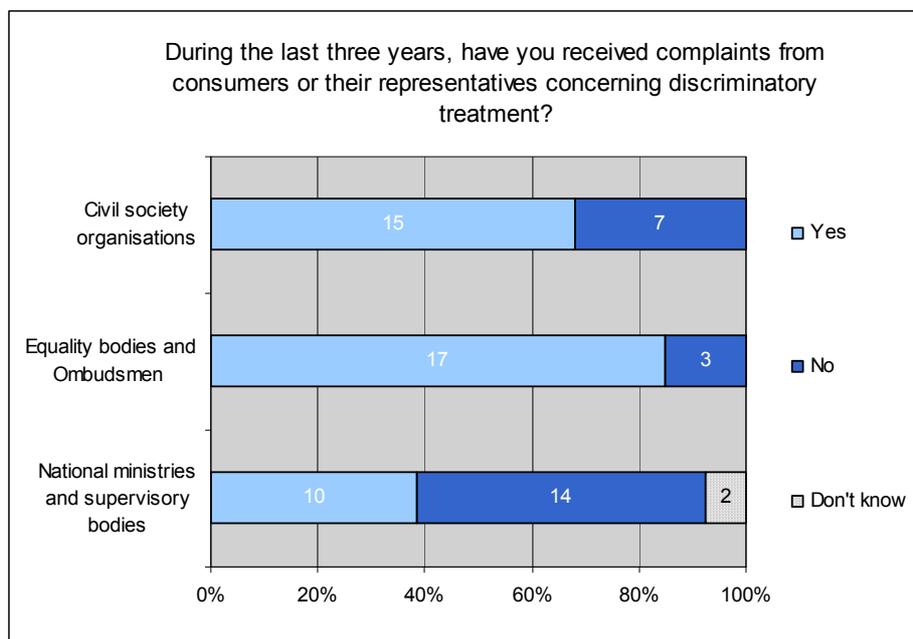


Source: Civic Consulting surveys of national industry associations (N=33), insurance companies (N=81) and banks (N=39).

### 4.2.2 Complaints received by civil society organisations, national authorities, and equality bodies

Civil society organisations, national authorities, equality bodies and ombudsmen were asked in the questionnaire if they had received complaints from consumers regarding discriminatory treatment in financial services in the last three years. The majority of responding organisations reported that they *had received complaints* about discrimination in the last three years (see Figure 23 below).

**Figure 23: Receipt of complaints concerning discrimination reported by civil society organisations, authorities and equality bodies (including ombudsmen)**



Source: Civic Consulting surveys of national ministries and supervisory bodies (N=26), equality bodies and ombudsmen (N=20), civil society organisations (N=22).

#### 4.2.3 Number of complaints reported

The responding organisations were also asked how many complaints they had received by product category. The responses are summarised in Table 7 on page 99. The results in this table must be interpreted with some caution. Not all responding organisations submitted an answer to this question, so some countries are not represented in the table at all. Other countries are over-represented as a number of bodies from that country responded. This means that a product category which creates many complaints in one country can have an undue effect on the overall complaint totals. For example there were a large number of complaints about private health insurance in Belgium, and four organisations in Belgium responded to this question, therefore the total for complaints about private health insurance appears high.<sup>123</sup> The only other country which reported many complaints about private health insurance was Germany. In Finland there were a relatively large number of complaints about accident insurance. This seems to be a country-specific case as similar problems are not repeated elsewhere.<sup>124</sup> A French and a Belgian organisation reported a relatively large

<sup>123</sup> It has to be noted that one of the four organisations in Belgium, the Insurance Ombudsman, specified that private health insurance, critical illness and long-term care have been considered together. Therefore complaints classified under the category private health insurance include a number of complaints related to other products.

<sup>124</sup> The civil society organisation who reported such complaints specifies that, "the accident insurance have been discussed and improved after the complaints".

number of complaints about loan insurance. Organisations from Portugal and Belgium reported high levels of complaints regarding life insurance.

In total, responding organisations (civil society organisations, national authorities, equality bodies and ombudsmen) from 17 countries gave figures about numbers of complaints. The product areas that generated complaints in the greatest number of countries were life insurance, private health insurance and mortgages (all gave rise to complaints in at least 8 countries). These were followed by motor insurance, travel insurance, disability insurance, and consumer credit which gave rise to complaints in 6 countries. Annuities, accident insurance, credit cards and deposit accounts gave rise to complaints in 5 different countries.

Turning to the overall number of complaints reported to us by category, accident insurance was responsible for the highest number (321 complaints in the three-year period 2007-2009); however 300 of these were reported from one country (Finland). Loan insurance accounted for 193 complaints; however 150 of these were reported from France and 42 from Belgium. Life insurance gave rise to 147 complaints with 62 being from Belgium and 66 from Portugal. Private health insurance was responsible for 126 complaints with 85 of these being from Belgium. All other product categories accounted for less than 80 complaints.

**Table 7: Number of complaints reported in the last three years (total of 2007- 2009) <sup>(a)</sup>**

Reporting organisation	Country	Life insur.	Private health insur.	Mortgage loans	Motor insur.	Travel insur.	Disability insur.	Consumer credit	Annuity products	Accident insur.	Credit cards	Deposit accounts	Loan insur.	Home insur.	Private liability insur.	Long term care insur.	Critical illness insur.	Other
Flemish Advisory Council of Older People	BE		20															
Ombudsman des Assurances Belgique (b)	BE	59	20	2	9	1	4			3								
Centre for Equal Opportunities and Opposition to Racism	BE	1	42	4	14	2	10	8	1		5	5	42		1			6
L'Institut pour l'Egalité entre des Femmes et des Hommes	BE	2	3			1	1		1									
Insurance Companies Control Service	CY				1													
ZIVOT 90	CZ					4												
Federal Anti-Discrimination Agency	DE	5	25	1	7	4	9	25	4	11	1	29			2	4		
Board of Equal Treatment	DK							2										
Office of the Gender Equality and Equal Treatment Commissioner	EE	1																
Ombudperson's Office for the Equality of Women and Men	ES		1															
The Association of Swedish-Speaking Pensioners in Finland	FI				10	55	15		6	300	2			10				
Gender Equality Ombudsman	FI	3	3		6						2							
Autorité de Contrôle des Assurances et des Mutuelles	FR												150					
Hungarian Financial Supervisory Authority	HU	2		3														
Office of Equal Opportunities Ombudsmen	LT		2			3							1					
Centre pour l'Egalité de Traitement	LU											1						
Dutch Equal Treatment Commission	NL	1	2	2			2	1	2	1								
Campaign Against Homophobia	PL		2	1														
Polish Financial Supervision Authority	PL	1		2														
Instituto de Seguros de Portugal	PT	66																
Swedish Equality Ombudsman	SE	3	6	3	4		2	1	1	6	1	8		2				
Equality Commission for Northern Ireland	UK	3		2	6	1	1	6			1	8						
<i>Total number of complaints</i>		147	126	20	57	71	44	43	15	321	12	51	193	12	3	4	0	6
<b>Number of Member States from which complaints were reported</b>	<b>17</b>	<b>10</b>	<b>8</b>	<b>8</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>3</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>1</b>

Source: Civic Consulting surveys of competent authorities, equality bodies and civil society organisations. Notes: (a) Table sorted according to number of Member States from which relevant complaints were reported; (b) The Insurance Ombudsman (BE) specified that private health insurance, critical illness, long term care have been considered together, as well as life insurance, annuities and loan insurance.

Altogether, organisations from 17 Member States reported 1,125 complaints by category in the three-year period 2007-2009, or 375 complaints on average per year.<sup>125</sup> This figure does not, however, include data from a small number of organisations that could only provide an estimate regarding the total figure of relevant complaints, without differentiating by product categories. In total, these organisations estimated to receive 700 to 1300 complaints relating to alleged discrimination in financial services per year. Taking these estimates into account, the average figure of complaints reported by participating organisations is approximately 1,075 to 1,675 per year.<sup>126</sup>

This is a relatively low figure, and particularly so when compared with other consumer complaints in the area of financial services. A basis for comparison can be, for example, the total number of reported cases by nine major alternative dispute resolution schemes in the EU that exclusively deal with financial services, which was approximately 169,000 on average in the years 2007/2008.<sup>127</sup> If this figure is used as reference, discrimination complaints reported to us by category (not including estimated complaint numbers) would roughly be equal to 0.2% of cases reported by major alternative dispute resolution schemes in the Member States specialised in financial services. If estimated complaint numbers are included, that are not specified by product category, this figure rises to 0.6% to 1.0%. The experience of two specialised bodies in EU Member States that address consumer complaints in the area of financial services supports the higher estimate: The German regulator BaFin (*Bundesanstalt für Finanzdienstleistungsaufsicht*) estimates that complaints of alleged discrimination represented roughly 1% of the total complaints that BaFin received in 2008, and according to data provided by the Belgian Insurance Ombudsman 0.9% of all complaints received in the same year concerned alleged discrimination.<sup>128</sup>

<sup>125</sup> This figure refers to the total number of complaints received during the last three years by the relevant organisations providing such data in our survey. Because not all of these complaints were followed up by the reporting organisations, the analysis presented in the following sections of this report focuses on those complaints that were followed up and documented in detail, taking into account the decisions of relevant bodies concerning the merits of the complaint, where such decisions were taken.

<sup>126</sup> For example, the financial regulator in Germany (BaFin) told us it received less than 10 complaints regarding discrimination in banking and ten times more regarding insurance, in total between approximately 100 to 150 complaints in 2008. The German consumer organisation *Verbraucherzentrale Bundesverband* reported it received between 500 and 1000 complaints about discriminatory treatment in financial services every year. An authority and the equality body from France, that did not provide detailed statistics, reported a total of 100 to 150 complaints per year.

<sup>127</sup> These nine schemes are: Financial Ombudsman Service (UK), *Ombudsmann für Versicherungen* (DE), *Ombudsmann der privaten Banken* (DE), *Ombudsmann für die Private Kranken- und Pflegeversicherung* (DE), *Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin)* (DE), Insurance Ombudsman (PL), Financial Ombudsman Services (IE), *Médiateur de la Fédération Française des Sociétés d'Assurances* (FFSA), and Banking Ombudsman (IT). 2008 complaints data according to Civic Consulting 2009, except for BaFin and *Ombudsmann für die Private Kranken- und Pflegeversicherung*, which were retrieved from the annual reports for 2008.

<sup>128</sup> 3,600 complaints were received by the Belgian Insurance Ombudsman in total in 2008, of which 31 related to alleged discrimination.

This leads to the following conclusions:

10. ***The overall number of complaints about alleged discrimination in financial services appears to be low compared to other types of consumer complaints.*** Organisations from 17 Member States reported detailed statistics concerning relevant complaints, in total 375 complaints were received on average per year for the period 2007-2009. This figure does not include data from a small number of organisations that could only provide an estimate regarding the total figure of relevant complaints. Taking these estimates into account, the average figure of complaints concerning alleged discrimination in financial services reported by participating organisations is approximately 1,075 to 1,675 per year. This is roughly equal to 0.6% to 1.0% of cases reported by major alternative dispute resolution schemes in the Member States specialised in financial services.

#### **4.2.4 The scale of the problem**

Although the figures presented in the previous section are the best possible estimates of the number of complaints that can be reached on basis of the data collected, the evidence base does not allow us to come to a firm conclusion about the likely scale of the problems of perceived discrimination in financial services or the total numbers of complaints involved across the EU. There are a number of reasons for this:

- In spite of intensive communication with civil society organisations in Member States and their EU umbrella organisations, we were unable to identify many civil society organisations that are addressing discrimination complaints in financial services. Several organisations representing the views of older consumers participated, but a lower number of organisations representing disabled people, women, gays and lesbians or ethnic minorities responded.<sup>129</sup> For some countries no response was submitted from civil society organisations.<sup>130</sup> This seems to indicate that in many Member States civil society organisations which work on issues of discrimination in financial services do not exist.
- Even where relevant civil society organisations do exist, we discovered that they may either not collect complaints data or may not classify complaints in a way that makes it possible to retrieve data based on type of complaint.<sup>131</sup> Industry bodies also reported that due to the low volume, discrimination

<sup>129</sup> Seven responses were received from organisations representing older/younger people, five from organisations representing persons with disabilities, one from an organisation in the gender equality area, and nine either from organisations representing general consumer interests or marking "other" (see Annex 6 in Part III).

<sup>130</sup> Bulgaria, Cyprus, Denmark, Estonia, France, Greece, Hungary, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Netherlands, Norway, Slovakia, Slovenia, and Spain.

<sup>131</sup> A number of bodies told us that there are no statistics about complaints. For example, a civil society body in Poland reported that there are no statistics reflecting formal or informal complaints.

complaints might not be classified as such, and are possibly put in a general “other” category.

- National equality bodies play a key role in this area, but some national equality bodies within the EU have been formed within the last two years and so have not yet built up data on complaints. Others have been restructured recently and this has led to disruption in the way complaints are collected.<sup>132</sup>
- Barriers exist that may prevent problems experienced by consumers turning into actual complaints. Many reported problems occur *prior* to a contract being entered into (as the consumer is denied access to a product, see section 4.3 below) and this limits the availability and visibility of usual redress mechanisms. In certain EU countries, once a financial services contract is agreed there is an obligation to signpost a complaints procedure; however prior to purchase there is no such obligation.<sup>133</sup> Prior to entering into a contract a consumer may be unaware of the option of registering a complaint. Furthermore, it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur *prior* to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations.
- People in groups that potentially face discrimination may be vulnerable, or they may find the fact that they are refused a service humiliating. As a result they may be less likely to pursue a complaint than the wider population. They may be unaware of their right to complain, or not know who to complain to.

Due to the reasons outlined above, obtaining an accurate picture of the number of complaints in the area of discrimination is difficult. It is possible that the mentioned factors, some to do with lack of complaints structure and some to do with the way consumers deal with rejection, mitigate against consumers complaining in this area even if they have encountered a problem. The European handbook on equality data recognises this phenomenon more generally in its analysis of all forms of discrimination, saying that:

*“Complaints data represents the ‘tip of the iceberg’ level of information. As such, it describes only the nature and extent of reported discrimination, whereas many studies have shown that only a small portion of all discrimination is reported”*.<sup>134</sup>

It is not possible for us to speculate with any confidence about the number of complaints regarding discrimination in financial services that are unreported. It would, however, be possible to conduct quantitative consumer research in this respect. A

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<sup>132</sup> According to responses to Civic Consulting survey, this is the case, for example, in Basque Country, Luxembourg and others; the Swedish Equality Ombudsman is a recent merger of 4 Ombudsmen; the situation is similar for the UK (see Part II).

<sup>133</sup> This is the situation in the UK for example.

<sup>134</sup> European handbook on equality data p.8, European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities - Manuscript completed in November 2006.

representative consumer survey covering all Member States (such as the Eurobarometer surveys) could examine the incidence of people failing to find affordable services and assess the resulting consequent detriment. As an example, research done in the UK provides insight into problems related to access to insurance (see box below).

**Conducting research into alleged discrimination: the UK experience**

Even within the UK, despite the fact that a number of studies have been conducted to assess the level of problem of alleged age discrimination, there is still disagreement about the conclusions, particularly regarding the extent of the problem.<sup>135</sup> Also, although these studies all attempt to measure the extent to which access to insurance is limited or denied on grounds of age, only one examines the impact and consequences of that for older people in terms of reduced ability to travel.

These UK studies looked at the experiences of older people in accessing motor and travel insurance. Whilst there is agreement that for some people a problem does exist in that they are rejected by at least one insurer and can find it difficult to obtain cover, there is no agreement about the severity or scale of the problem. For example a report for the Government Equalities Office found that “no age group is excluded from the market in the sense that there is no provider at all that is willing to supply them”. According to the study, 3% of respondents in a consumer survey aged 80 or over have been refused travel insurance cover in the last year because of their age; for motor insurance, the percentage of refusals experienced by those aged 80 or over is 1.5%. In both cases, these figures were significantly lower for 60- to 69- and 70- to 79-year-olds. The study also found that most of those refused insurance because of their age subsequently find an insurer willing to provide cover.<sup>136</sup> Research by the organisation Age Concern found a higher level of problem. For example, Age Concern’s research points to between 5% and 13% of over 70s having “ever been put off travelling due to insurance access, cost or fears about insurance cost”, compared to 4% in the 30-49 age group.<sup>137</sup> As the questions asked in the surveys were quite different, results are not directly comparable.

<sup>135</sup> Within the UK three studies have been carried out by a civil society group representing older people, by the government and by the major insurance industry body: Age Concern and Help the Aged 2007; Government Equalities Office 2009; ABI 2009b.

<sup>136</sup> Government Equalities Office 2009 p.ii., p.18 (the Oxera-Report).

<sup>137</sup> 5% of 70-74 age group, 7% of 75-79 age group and 13% of 80+ age group had been put off travelling due to insurance access, cost or fears about insurance cost. This compares to 4% in the 30-49 age group. Age Concern and Help the Aged 2007, p. 26.

This leads to the following conclusions:

11. ***Because of likely underreporting of complaints, it is not possible to come to a firm conclusion about the scale of the problems of perceived discrimination in financial services.*** Reasons for underreporting of complaints include the lack of civil society organisations which work on issues of discrimination in financial services in many Member States and the relatively recent setting up or restructuring of several national equality bodies. Furthermore, it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations. Quantitative consumer research is needed, e.g. in the framework of a Eurobarometer survey, before a conclusion can be drawn about the scale of the problems (see chapter 6).

#### **4.2.5 Documented examples of complaints**

In parallel to the survey, civil society organisations, ombudsmen, equality bodies and national authorities were asked to document relevant examples of complaints received between 2007 and 2009, and a separate form for this purpose (presented in Part III, Annex 11) was circulated to all relevant bodies across the EU. In this process, we have documented 72 detailed examples of complaints of alleged discrimination from 18 Member States, mainly relating to the use of age, sex, and disability (referred to in the following sections as 'documented complaints'). Of these documented complaints, 13 led to court cases, while 30 complaints were subject to an inquiry by an ombudsman or equality body but did not lead to a court case. The database including all complaints and court cases is included in Part III, Annex 3 of this report.

The level of detail of the documented examples of alleged discrimination received by Civic Consulting differs considerably. For example, some responding organisations reported individual complaints, but with very little detail because they were not followed up by the reporting organisation. In contrast, other complaints were followed up and decided by an authority, equality body or ombudsmen, and documented in great detail with reference to the arguments and evidence submitted by the financial providers involved in the dispute and the motivation of the decisions by the authority/equality body.

The majority of the documented examples of alleged discrimination received by Civic Consulting relate to motor insurance, private health insurance, deposit accounts, consumer credit (including credit cards), life insurance and mortgage loans. This is illustrated in the table below:

**Table 8: Number of documented complaints and court cases concerning alleged discrimination by product**

Product category	Number of court cases	Number of complaints subject to an inquiry <sup>(b)</sup>	Other complaints	Total
Motor insurance	1	6	4	<b>11</b>
Private health insurance	5	2	3	<b>10</b>
Deposit account	-	3	7	<b>10</b>
Consumer credit (including credit cards)	2	6	2	<b>10</b>
Life insurance	1	5	3	<b>9</b>
Mortgage loans	-	3	5	<b>8</b>
Travel insurance	1	1 <sup>(c)</sup>	2	<b>4</b>
Loan protection insurance	-	3	-	<b>3</b>
Accident insurance	-	1	1	<b>2</b>
Disability (income protection) insurance	1	-	1	<b>2</b>
Critic illness insurance	-	-	-	<b>0</b>
Other	2 <sup>(a)</sup>		1 <sup>(d)</sup>	<b>3</b>
<i>All product categories</i>	<i>13</i>	<i>30</i>	<i>29</i>	<i><b>72</b></i>

Source: Civic Consulting.

Notes:

(a) Includes complaints related to money transfer services (SE-2) and debit card (UK-3).

(b) Does not include court cases.

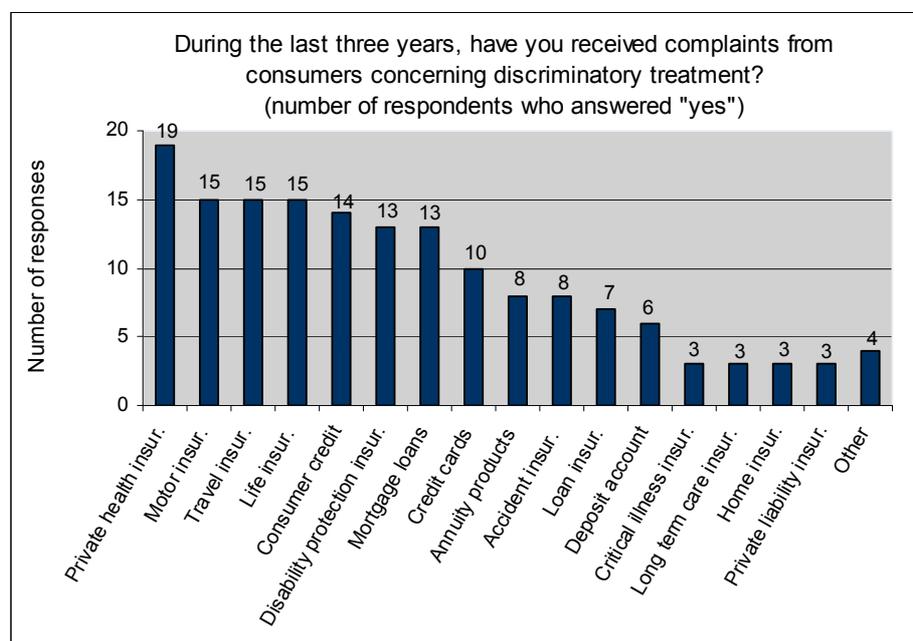
(c) One complaint relates to both travel insurance and motor insurance (CY-3) and it has been counted under motor insurance only to avoid double counting.

(d) Complaint relates to car break-down insurance (UK-5).

The table above confirms that some product categories are more often subject to complaints than other, as has already been indicated by survey results. Because there is so far no harmonised data collection system in place for collecting data concerning consumer complaints across the EU,<sup>138</sup> looking at numbers of complaints by product category is imperfect. It is therefore also useful to analyse the number of responding organisations who indicated in the survey that they had received complaints about a specific product category. This is expressed in graph below.

<sup>138</sup> However, this issue has been addressed by a recent Commission Recommendation on the use of a harmonised methodology for classifying and reporting consumer complaints and enquiries, C(2010)3021 final. Consumer complaints data may therefore easier be collated in the mid- to long-term.

**Figure 24: Number of stakeholders reporting discrimination complaints within the last 3 years by product category**



Source: Civic Consulting surveys of national authorities, equality bodies, and civil society organisations (N=68, multiple answers possible, “Don’t know” and “No answer” not included in figure).

In the sections above, we analysed three separate threads of information relating to complaints:

- Number of complaints received between 2007-2009 by national authorities, equality bodies, ombudsmen and civil society organisations, by product category;
- Number of complaints documented in detail by Civic Consulting;
- Number of responding organisations who received complaints, by product category.

Based on these three data sets, the following picture emerges: *Insurance products* are more likely to be subject to complaints than credit and banking products. Within the insurance area, product categories most often subject to complaints are:

- Private health insurance;
- Life insurance;
- Motor insurance; and
- Travel insurance.

Within the *banking* area, the data show that the product categories most often subject to complaints are:

- Consumer credit (including credit cards);

- Mortgage loans; and
- Deposit accounts.

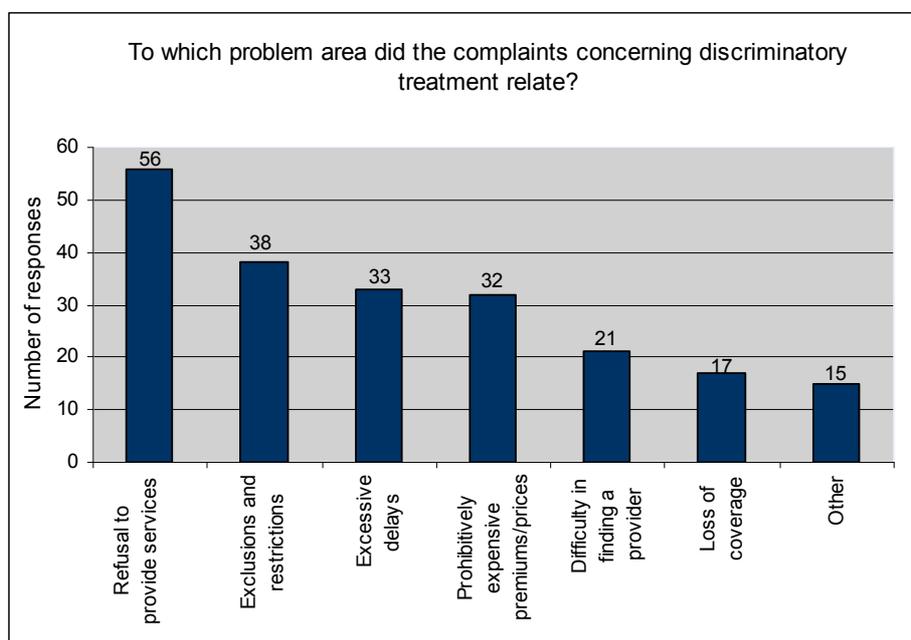
This analysis leads to the following conclusion:

**12. Insurance products are more likely to be subject to complaints concerning alleged discrimination than credit and banking products.** Within the insurance area, product categories most often subject to complaints are private health insurance, life insurance, motor insurance and travel insurance. Within the banking area, consumer credit and mortgage loans are the two product categories most often subject to complaints (with complaints concerning deposit accounts also being relatively frequent).

### 4.3 Problem areas to which complaints relate

Organisations responding to our survey most frequently indicated that complaints related to a refusal to provide requested services (see Figure 25 below). This was consistent across all types of respondents (industry, national authorities, equality bodies, ombudsmen, civil society organisations). It was also reflected in the complaints documented in detail.

**Figure 25: Problem areas to which complaints mainly relate**



Source: Civic Consulting surveys of national industry associations, insurance companies, banks, national authorities, equality bodies, ombudsmen, civil society organisations (N=221, multiple answers possible, “Don’t know” and “No answer” not included in figure).

Issues to do with the cover itself, such as exclusions or restrictions and expensive premiums, were also common areas of complaint in both our survey and the documented complaints.

This leads to the following conclusion:

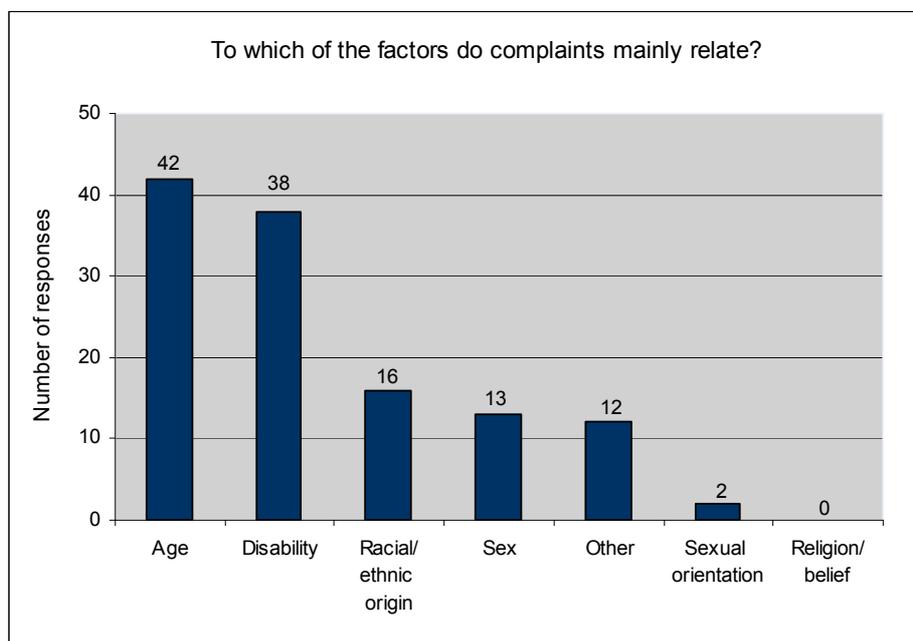
**13. Denial of access to financial services is the main reason for complaints.**

Organisations responding to our survey most frequently indicated that complaints related to a refusal to provide requested services. This was consistent across all types of respondents (industry, national authorities, equality bodies, ombudsmen, civil society organisations). It was also reflected in the complaints documented in detail. Exclusions or restrictions and expensive premiums were also common areas of complaint in both our survey and the documented complaints.

**4.4 Discrimination grounds to which complaints relate**

Age and disability were most frequently mentioned as discrimination grounds or factors to which complaints mainly relate by respondents to our survey (see Figure 26).

**Figure 26: Factors to which complaints mainly relate**



Source: Civic Consulting surveys of national industry associations, insurance companies, banks, national authorities, equality bodies, ombudsmen and civil society organisations (N=221, multiple answers possible, "Don't know" and "No answer" not included in figure).

The importance of the factor age is confirmed by the documented complaints, which show that alleged age discrimination is the most frequent cause for complaints. However, more complaints about use of racial/ethnic origin and sex were documented

in detail than regarding disability. This could be due to the nature of the responding organisations providing these complaints – groups representing consumers with disabilities that could document individual complaints only participated to a limited extent, as has been discussed before. Survey results depicted in the figure above may provide a better overview of the relevance of the different factors than documented complaints, if one takes into account the importance of disability (or rather the underlying health condition) for travel, life and health insurance, see sections 3.3.2, 3.3.3 and 3.3.4 above.

*Racial/ethnic origin* ranked as third most important factor according to survey results. This is reflected in several documented complaints that often revolve around denial of access to banking services due to issues regarding nationality and citizenship. This is discussed further below.

According to the survey results, *sex* is also a relevant factor in terms of complaints, whereas *sexual orientation* was marked by few organisations as a factor to which complaints mainly relate, which is also reflected in a lower number of documented complaints regarding this issue. The factor *religion/belief* was not mentioned by any organisation and only one complaint regarding this factor was documented.

Different sectors of financial services revealed a difference in the factors that complaints related to, reflecting the difference in their business and the different weight given to types of personal information. For example, insurance companies reported that the factor disability generated most complaints, closely followed by age issues. Banks reported that most complaints related to questions of racial/ethnic origin followed by age.

Within the following sections the main grounds of alleged discrimination are examined in order of relevance as source of complaints, focusing on documented complaints that have been subject to a court inquiry or investigation by a relevant body such as ombudsman or equality body.

#### **4.4.1 Age**

Perceived age discrimination was a major cause of complaints both in the survey and in documented complaints. This is not surprising when we consider that the evidence from chapter 3 shows that for the five financial products analysed for this study, age is the factor which is used most commonly in risk assessment. Within the documented complaints, 23 out of 72 complaints related to use of age.

Unlike *sex*, differential treatment on the grounds of age is not restricted by law at present in about half of the EU Member States (see section 5.2 below) and this may contribute to related complaints regarding financial services. Being turned down for motor and travel insurance, mortgages and credit, and high premiums for private health insurance and travel insurance were key problem areas reported for older people in the documented complaints provided for this study.

### **Denial of access to insurance**

Both in Belgium and the UK responding civil society organisations reported problems for older people caused by denial of access to motor and travel insurance. In Belgium, the Insurance Ombudsman reported complaints of older or younger people who were denied access to motor insurance.<sup>139</sup> These complaints were resolved by providing adapted and (more) affordable motor insurance policies, imposing certain conditions, such as a prohibition of driving during weekend nights (for younger people) or driving ability check-ups (for people above 75).<sup>140</sup>

### **Denial of access to credit**

#### ***Mortgages***

Responding organisations in a number of countries reported problems with customers being refused mortgages on grounds of their age. Organisations from the UK, Poland and Czech Republic reported cases of older people being refused mortgages due to their age. Examples are presented in the following box:

#### **Age and mortgages – two case studies<sup>141</sup>**

*United Kingdom:* Age Concern reported the case of an older man who wanted to move house. He had a mortgage in his existing house which he wanted to transfer to the property he was intending to buy. His income consisted of a private and state retirement pension. However, allegedly the provider refused to take his state pension into account when assessing his income even though he had been repaying his existing mortgage in this way.

*Czech Republic:* The organisation Zivot 90 reported that in general new mortgages were not available to consumers over the age of 55. According to the organisation, this prevents older inhabitants from buying their own flats at a good price as part of the so called 'privatisation of housing'.

#### ***Consumer credit***

There were documented complaints from a range of countries of people being turned down when applying for consumer credit on grounds of age. As lenders are not obliged to disclose how they conduct credit checks, it can be difficult for consumers to challenge these decisions. As with mortgages it appeared from these complaints that

<sup>139</sup> See Insurance Ombudsman, Carnet 2007, o.c., 84.

<sup>140</sup> See Insurance Ombudsman, Report Annual 2004, o.c., 26, referring to the 29/29 agreement between Assuralia and the Minister for Economic Affairs. See also "Gentlemen's agreement tussen Minister van Economie Fientje Moerman en de BVVO betreffende de problematiek van de jongere en oudere bestuurders in de BA-Motorrijtuigenverzekering", <http://users.telenet.be/Fientje.Moerman/gentlemenagreementjongeren.htm>.

<sup>141</sup> See Age Concern and Help the Aged, complaint UK-6 and Zivot 90, complaint CZ-1 (see Part III, Annex 3) Neither case was investigated by authorities, as related legislation was not in place.

age was often used as a proxy for ability to repay, without a detailed assessment of the individual's financial circumstances. There was often a lack of transparency about these age limits which exacerbated the situation (see also the following box).

**Age and credit – a case study<sup>142</sup>**

The Belgian Centre for Equal Opportunities and Opposition to Racism (CEOOR) reported a case concerning credit products. A department store offers 'customer cards' with a credit function which is issued by a bank. The Centre reportedly received two identical complaints from single customers whose application for this card was turned down because of their age (70+). Due to the denial of access, the customer could also not enjoy the 'best prices and promotions' and 'extra benefits' offered to promote the use of this card. Being contacted by the Centre, the bank referred to the Belgian Consumer Credit Act stating that the creditor can only enter into a credit agreement if, given the information he has (or should have), it can reasonably assume that the consumer will be able to meet the obligations under the contract. The financial institution further referred to the average life expectancy in Belgium and stated that there exist 'more appropriate' credit arrangements (with limited duration) for elderly people.

**High premiums**

In Belgium, complaints about price increases for older people concentrate on private health insurance. For example, the Insurance Ombudsman received complaints from older people who switched from a work-related (collective) private health insurance contract, to a non-work related (individual) private health policy and were confronted with high premium increases.<sup>143</sup> In the UK, responding organisations reported that age-related price increases and the use of age bands in travel insurance where the jump between one band and the next is large generated complaints.<sup>144</sup>

Our analysis of reported complaints concerning discrimination on the grounds of age leads to the following conclusion:

**14. Alleged age discrimination is the most frequent cause for complaints.** This is confirmed by survey results and documented complaints. Being turned down for motor and travel insurance, mortgages and credit, and high premiums for private health insurance and travel insurance were key areas of complaint.

**4.4.2 Disability**

Perceived discrimination on grounds of disability was a major cause of complaints both in the survey and in documented complaints. As discussed in chapter 3, the term

<sup>142</sup> See complaint BE-1 (see Part III, Annex 3). See also country report Belgium, Part II.

<sup>143</sup> See country report Belgium, Part II.

<sup>144</sup> See country report UK, Part II.

'disability' can be interpreted differently. The definition used for the purposes of this survey was a broad one:

*"A person with a disability is understood as someone who has a physical, mental or sensory impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities".*

This is broadly in line with the definition used in the UN Convention on the Rights of Persons with Disabilities<sup>145</sup> and takes in chronic illness as well as physical impairment.

Within the documented complaints, 14 out of 72 complaints related to use of disability or chronic diseases. Many of the problems reported in the survey and documented complaints were to do with illness and previous health conditions rather than physical impairment.

### **Denial of access to insurance**

Respondents from the European Disability Forum reported that they have had complaints from people with disabilities who cannot access insurance and credit. In the UK, a cancer charity reported difficulties that people who have had cancer in the past can face when trying to obtain travel insurance.<sup>146</sup> In Belgium, both the Insurance Ombudsman and the consumer organisation *Test-Achats* reported that they received complaints of pre-existing health-conditions being excluded from coverage in travel insurance and private health insurance contracts.<sup>147</sup> Problems occur with vaguely formulated contractual clauses excluding any (direct and indirect) consequence of the pre-existing condition.<sup>148</sup>

Examples for complaints are provided in the following box:

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<sup>145</sup> See section 5.2.2.

<sup>146</sup> See country report UK, Part II.

<sup>147</sup> See country report Belgium, Part II.

<sup>148</sup> See J.-P. Coteur, A. Moriau and I. Nauwelaers 2009b.

### Disability and insurance – two case studies<sup>149</sup>

*Belgium:* The Insurance Ombudsman reported a case, involving a woman who previously suffered from hepatitis C and who encountered difficulties in finding loan insurance. According to the Ombudsman, the refusal of coverage or specific conditions of acceptance should be based on a so-called 'objective and reasonable justification'.<sup>150</sup> After being addressed by the Ombudsman, the insurer proposed to cover this woman through a surcharge, based on and justified by statistics. During negotiations, the Ombudsman learned that the surcharge was fixed on the oral recommendation of the advisory physician of the insurance company. Documentary proof was however not available. Unable to accept this justification, the Ombudsman asked to review the case. After new analysis, the company agreed to cancel the surcharge. The Ombudsman further reports cases (around half of all complaints received in 2008) where (ex-)cancer patients and diabetes patients were denied access to loan insurance. In most cases, sometimes after lengthy negotiations, the insurer has proposed a contract with a surcharge.<sup>151</sup>

*Sweden:* The Equality Ombudsman reported the case of a young boy (1 year old at the time of the complaint) who was denied health insurance, because of an undefined hearing loss (the hearing loss was established but the reasons for it could not be found). The insurance company offered an accident insurance and the possibility of a renewed evaluation after 18 months of observation. The Equality Ombudsman filed a complaint at the district court of Stockholm, arguing that it should have been possible for the insurance company to grant insurance, with the exception of future damages related to the established hearing loss.

### Denial of access to mortgages

Respondents to our survey reported problems with mortgage payment protection insurance and other forms of loan insurance. Health conditions led to some customers being refused the underlying insurance which meant they could not take out the loan product. For example in Belgium patient organisations specifically point at difficulties in finding affordable loan insurance (hindering them to conclude mortgage loans) for disabled and people with chronic illness.

### High premiums

In Belgium, the Insurance Ombudsman reported complaints where people are faced with a high premium because of current or former health conditions.

<sup>149</sup> See complaints BE-4, SE-1 (see Part III, Annex 3).

<sup>150</sup> Under the former general anti-discrimination law of 2003, (Act of 25 February 2003) distinctions on the basis of inter alia sex, age and disability, could be saved by a so called '*justification objective et raisonnable*'.

<sup>151</sup> See country report Belgium, Part II.

This analysis leads to the following conclusion:

15. ***On the grounds of disability, denial of access or high premiums were the more common causes for complaints reported.*** Many of the complaints about denial of access due to disability or health condition related to whether the refusal was a reasonable response to the individual's circumstances. Complainants felt that insurers or lenders were too quick to deny access without fully understanding their case or ensuring their refusal was based on sound data.

#### **4.4.3 Racial/ethnic origin**

In the survey, perceived discrimination on the grounds of racial/ethnic origin was reported less frequently to be a main cause of complaints than perceived discrimination concerning age and disability, but still causing a significant number of documented complaints. 16 out of 72 documented complaints related to alleged discrimination because of racial/ethnic origin.

##### **Denial of access to banking accounts, consumer credit and mortgages**

In Belgium, Luxembourg, Finland and Germany, documented complaints about discrimination because of racial/ethnic origin referred in most cases to the denial of access to banking accounts, consumer credit and credit cards due to nationality, identity and length of residency requirements. For example, in Finland there were a number of reports of non-Finnish customers being denied access to bank accounts on the grounds of not having the correct identifying documents (such as passport). This reportedly can present problems, for example, for asylum seekers who have the right to work but without a bank account cannot have their salary paid in.<sup>152</sup>

In the case that consumer credit is denied to applicants, this is often a consequence of credit scoring which is central to the risk assessment process of credit providers to predict borrowers' default risks. This process can lead to complaints, because the credit scoring process is not transparent. The scores and their relative weights are not available to the consumer and in many cases the company may not divulge the reason for their refusal. This can lead to a perception on the consumer's part that discrimination takes place. For example, in Belgium, one bank reported complaints concerning the refusal to provide loans on the basis of racial or ethnic origin. The bank, however, submits that in reality the reasons to refuse are mostly linked to a high debt to income ratio and creditworthiness (behavioural scoring) of a person. They would not be racially related. According to the bank, this would be merely a perception of the client. Because of related complaints, credit scoring has been a matter of discussion in some Member States, including in Germany (see also box in section 3.3.5, above).

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<sup>152</sup> Ombudsman for Minorities, complaints F-1, F-3, F-4, F-5 (see Part III, Annex 3).

The credit risk assessment process can also lead to problems related to mortgages, which have led to an investigation in the Netherlands (see following box).

#### **Dutch investigation into mortgage financing<sup>153</sup>**

The Dutch Equal Treatment Commission conducted a study into mortgage financing. The Commission had received reports that it was difficult or sometimes impossible for members of an ethnic minority to obtain mortgage finance. Mortgage lenders were excluding applicants with a temporary residence permit and/or those who had not been resident in the Netherlands for a minimum number of years. Some lenders were using post codes and a pricing policy of excluding houses below a certain value to refuse to finance mortgages in big cities (with large communities of ethnic minorities). This was found to be indirect discrimination (i.e. “discrimination on the ground of a neutral criterion, requirement or action that affects people particularly in connection with one or several of the grounds mentioned in the Equal Treatment Act”). The Commission found that “where indirect discrimination is applied, it could have serious consequences ... in particular the exclusion from mortgage financing of categories in certain postcode areas could ... result in a downward spiral that could lead to dwellings becoming un-sellable below a given threshold value in the postcode areas in question where a relatively large number of ethnic minority communities live”. Whilst the Commission accepted that lenders had a legitimate aim (limiting financial risk), the means to achieving that aim were deemed not appropriate and ‘unnecessarily coarse-meshed’. Alternative means could be found which would result in less discrimination. As a result, the Commission recommended changing the residence requirements, and removing provisions relating to postcodes and areas from the lenders’ acceptance policy.

#### **High premiums**

Few documented complaints of alleged discrimination because of racial/ethnic origin concerned insurance products. An example is a complaint reported by the Austrian Ombudsman for Equal Treatment, brought by a woman and her partner, who did not have Austrian citizenship and wanted to obtain motor insurance. An insurer said they would have to pay higher premiums than Austrian citizens, and recommended that the car only be insured in the woman’s name because, she being Slovenian, was qualified for a better premium than her partner, who is Bosnian. The Ombudsman for Equal Treatment found this to be a case of discrimination on the ground of ethnic origin.<sup>154</sup>

In another case reported from the Office of the Commissioner for Administration Cyprus, complainants claimed that insurance companies refused to offer to Greek-Pontiacs the same conditions for motor insurance that they offer to Greek-Cypriot citizens. The insurance companies were said to either not insure Pontiacs or insure

<sup>153</sup> The Dutch Equal Treatment Commission (CGB) 2006, p 35.

<sup>154</sup> Ombudsman for Equal Treatment, complaint AT-4 (see Annex 3, Part III).

them at a higher premium compared to other clients. The investigation of the Office confirmed the allegation.<sup>155</sup>

This analysis leads to the following conclusion:

**16. Perceived discrimination on the grounds of racial/ethnic origin was reported less frequently to be a main cause of complaints than perceived discrimination concerning age and disability, but still causing a significant number of documented complaints.** One in five documented complaints related to alleged discrimination because of racial/ethnic origin. Most of the documented complaints related to banking products, and involved problems caused by questions over citizenship, lack of passport or length of time in residence, implying indirect discrimination.

#### **4.4.4 Sex**

##### **Discriminatory treatment in general**

According to the survey results, sex is also a relevant factor in terms of complaints. Within the documented complaints, 13 out of 72 complaints related to use of sex.

##### **Discriminatory treatment on grounds of gender reassignment**

In the survey, five national authorities and equality bodies reported that they had received complaints regarding gender reassignment. The Belgian Gender Equality Institute reported a case where a transsexual who wanted to conclude a life insurance contract was asked to pay a surcharge.<sup>156</sup> The insurance company defended the surcharge on the basis of a supposed increase in health risk for transsexuals. Further information on or evidence for the increased health risk was not provided. The Dutch Equal Treatment Commission reported some complaints from male transsexuals who claim that they cannot receive reimbursement for breast augmentation, while breast removal for female transsexuals is reimbursed under the basic health insurance (which is provided by private insurers). The Commission confirmed that the problem lies in the coverage of the basic health insurance in the Netherlands, which is determined by the government and indirectly discriminates between male to female transsexuals.<sup>157</sup>

##### **Discriminatory treatment on grounds of pregnancy and maternity**

Thirteen national authorities, equality bodies and ombudsmen and one civil society organisation reported in the survey that they had received complaints regarding

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<sup>155</sup> Office of the Commissioner for Administration (Ombudsman), complaint CY-1 (see Annex 3, Part III).

<sup>156</sup> See country report Belgium, Part II. See also case BE-6 of the documented complaints collected by the Institute for Gender Equality (see Annex 3, Part III).

<sup>157</sup> The Dutch Equal Treatment Commission therefore asked the government to change this situation.

pregnancy and maternity. Some complaints related to waiting periods and exclusions in travel insurance products.<sup>158</sup>

In Germany, the consumer association VZBV reports complaints of pregnant women who apply for a new contract for private health insurance and have to agree to an exclusion of costs for the current pregnancy, or they have to agree to 'waiting times': only a year after signing the contract will the insurance company cover costs of pregnancy and birth.<sup>159</sup> Similarly, in Belgium, the Gender Equality Institute reported complaints where the costs of pregnancy were either excluded from coverage or where the right of coverage was postponed. One of the complaints involved an income protection insurance contract where a pregnant woman could not get coverage during the period of her pregnancy.<sup>160</sup> These complaints indicate a need to clarify whether such exclusions and restrictions are in line with the general rule of non-discrimination for reasons of pregnancy and maternity in the Gender Directive.<sup>161</sup>

This leads to the following conclusion:

**17. According to the survey results, sex is also a relevant factor in terms of complaints.** Within the documented complaints, 13 out of 72 complaints related to use of sex. Complaints in the insurance field partly concern the issue of pregnancy and maternity, mainly relating to denial of access and exclusions, with examples of complaints coming particularly from Belgium and Germany. This indicates a need to clarify whether such exclusions and restrictions are in line with the general rule of non-discrimination for reasons of pregnancy and maternity in the Gender Directive.

#### 4.4.5 Other factors

Only very few complaints were received concerning religion/belief or sexual orientation. Out of 72 documented complaints, only 3 complaints related to sexual orientation and 1 related to religion/belief.

<sup>158</sup> Other listed complaints appear to relate to employment issues and fall outside the remit of this study.

<sup>159</sup> See country report Germany, Part II.

<sup>160</sup> See Country report Belgium, Part II. See also case BE-8 of the documented complaints collected by the Institute for Gender Equality (see Annex 3, Part III).

<sup>161</sup> The stakeholder organisation European Woman's Lobby (EWL) emphasised in a comment that "denial of access, exclusion or discrimination on the basis of pregnancy and maternity [is] contrary to the [Gender D]irective". Article 5(3) of the Directive provides that "In any event, costs related to pregnancy and maternity shall not result in differences in individuals' premiums and benefits." This wording seems to indicate that financial service providers are not allowed to differentiate premiums on basis of pregnancy and maternity but does not specifically prohibit exclusions and restrictions. On the other hand, the exception of Article 5(2) also refers to premiums and benefits only without explicitly mentioning exclusions or restrictions, so it can be argued that the general rule of non-discrimination for reasons of pregnancy and maternity in Article 4(1)(a) should apply.

An example of a complaint related to sexual orientation concerns life insurance. The Hellenic Data Protection Authority fined an insurer, which used the military service record of an applicant to deny him life insurance coverage. The service record stated that he had not served because of his sexual orientation. The Authority held that the company did not have the right to use the personal data concerning the man's sexual orientation in order to decide whether to conclude a contract with him, as this violated the man's right to privacy.<sup>162</sup>

The only documented complaint regarding alleged discrimination based on religion/belief was reported by the Equality Commission for Northern Ireland. The complainant was refused membership to a members' based organisation providing consumer credit. The Equality Commission concluded that the anti-discrimination legislation did not extend to the actions of the provider and closed the case.

#### **4.5 Problems of discrimination identified**

Complaints concerning discrimination in a specific area can be an indicator for problems experienced by consumers, but the existence of complaints is in itself not a sufficient proof that there is indeed a problem, because not all complaints are necessarily justified. This section analyses the decisions regarding documented complaints that have been subject to an inquiry by an equality body, an ombudsman or a court, focusing on the decision itself and the criteria for judgement applied. In line with the methodology presented in section 4.1 above we first provide an overview of decisions concerning the evidence used by financial service providers to justify differential treatment and then review the issue of proportionality of the behaviour of the provider as judged by the body conducting the inquiry. Because several of the complaints have already been described to illustrate specific areas of complaints, some overlap between this section and previous sections has been unavoidable, but is limited as much as possible.

##### **4.5.1 Evidence provided to justify differential treatment**

An inquiry of a relevant body concerning a specific complaint often involves an assessment of the evidence provided by the financial services provider to justify the behaviour that caused the complaint. Of the total of 43 complaints that were subject to a court case or inquiry documented in detail for this study, about one quarter specifically related to the evidence base. In some cases the provider could not provide adequate evidence. In other cases, the inquiry concluded that the provider's underlying evidence for the risk assessment was insufficient and finally, in several cases the evidence provided was considered to be sound. In the following paragraphs, we will provide examples for all three situations and discuss issues that have been raised.

Cases in which a complaint was investigated and the provider concerned was unable to provide evidence to justify its allegedly discriminatory treatment, are reported, for example, from Belgium and France. When the Belgian Centre for Equal Opportunities

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<sup>162</sup> Hellenic Data Protection Authority, complaint GR-1 (see Part III, Annex 3). The decision was apparently not based on non-discrimination law, but is relevant in the context of the study.

and Opposition to Racism (CEOOR) conducted an inquiry concerning a complaint that a person had the application for a motor insurance turned down because of age (over 75 years of age), the sales agency of the insurance company that denied the cover did not provide any statistical or other relevant information to support their refusal. According to the agency, the decision was based on internal guidelines from the insurance company. The management of the company, however, denied the existence of such guidelines.<sup>163</sup> In another case regarding denial of a point-of-sales consumer credit in France, allegedly because of age, a provider gave no justification but invoked his contractual freedom.<sup>164</sup>

In some cases, the quality and reliability of the evidence used by the financial service provider was challenged by the complainant, with various degree of success. In one of such cases concerning denial of services in motor insurance because of age from Ireland, the data were found lacking due to inconsistencies (see box below). In a previously described case reported from Belgium the Insurance Ombudsman considered the oral recommendation of the advisory physician of an insurance company to be an insufficient base for a surcharge proposed to a woman who applied for loan insurance and had previously suffered from hepatitis C (see case study disability and insurance in section 4.4.2 above).

In contrast, there are several cases reported where complaints involving evidence were found to be baseless by the inquiry conducted. This concerned, for example, the use of statistics to justify premium differences (see next section).

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<sup>163</sup> Centre for Equal Opportunities and Opposition to Racism, complaint BE-2 (see Part III, Annex 3).

<sup>164</sup> *Haute Autorité de Lutte contre les Discriminations et pour l'Égalité*, complaint FR-1 (see Part III, Annex 3).

### **The use of evidence in two cases of motor insurance**

Two cases reported by the Equality Tribunal (Office of the Director of Equality Investigations (ODEI) in Ireland illustrate the importance of underlying evidence in reaching decisions about alleged discrimination. In Ireland the Equal Status Act of 2000 outlaws differential treatment because of age. However there is an exception for insurance related financial products (annuities, pensions, insurance policies or any other matters related to the assessment of risk).<sup>165</sup>

In one case, a 31-year-old man alleged age discrimination. He had obtained quotes for car insurance for a 31- and 41-year-old and found the difference in premiums to be “excessively wide”. The investigation involved extensive analysis of the risk assessment model and underlying statistical data used by the insurer in calculating its premiums. The Equality Officer decided that the quotations were based “on actuarial or statistical data from a source on which it is reasonable to rely” and the complaint was not upheld.<sup>166</sup>

The same Tribunal had decided the previous year that a 77-year-old man who was refused motor insurance on the grounds of age had suffered discrimination. In this case the insurer failed to meet the conditions for the exception. One of the grounds for the decision was that the insurer was not able to produce in full detail the actuarial or statistical data that guided their over-70s policy. This data was shown to contain ‘black holes’ where the relevant data relied on was incomplete or no longer available and there were questions about its integrity. It therefore was not deemed to be “from a source on which it is reasonable to rely”.<sup>167</sup>

It is notable that there are also some cases where the investigating body reported that it wanted to challenge the evidence, but it was unable to do so. In one case reported from Austria, the Ombudsman for Equal Treatment lacked the actuarial knowledge needed to investigate the correctness of the use of data in an inquiry concerning a health insurance complaint and indicated that it would commission an external expertise on the issue.<sup>168</sup> In another case from Belgium which concerned refusals to issue customer cards with a credit function to customers aged over 70, the investigating body (CEOOR) challenged the service provider’s allegation that 25% of their customers over the age of 70 are behind on their payments (as opposed to a general average of 1%). Another source, the National Bank of Belgium, which provided general statistics, provided contradictory data. CEOOR also requested more detailed statistics from the Banking, Finance and Insurance Commission, but this could not be provided because CEOOR is not mentioned in the relevant law applicable to the

<sup>165</sup> Section 5 (2) (d) of the Equal Status Acts 2000 creates an exception as long as differences in treatment “is effected by reference to I) actuarial or statistical data obtained from a source on which it is reasonable to rely or II) other relevant underwriting or commercial factors and is reasonable having regard to the data or other relevant factors”.

<sup>166</sup> Equality Tribunal, complaint IE-3 (see Part III, Annex 3).

<sup>167</sup> Equality Tribunal, complaint IE-2 (see Part III, Annex 3).

<sup>168</sup> Ombudsman for Equal Treatment, complaint AT-1 (see Part III, Annex 3).

exchange of statistical information.<sup>169</sup> Questions of expertise and legal status of the inquiring body can therefore be important obstacles in establishing issues of fact and evidence. This can even affect the willingness of relevant bodies to investigate, as the Swedish Equality Ombudsman (SEO) pointed out:

*“Just a few cases are brought forward by the SEO. This is related to the fact that cases are quite difficult to investigate, they take a lot of time and effort. For instance, when investigating complicated issues, banking companies or insurance companies are very restrictive in the kind of data or information they provide, or they provide a lot of irrelevant information. Therefore the issue is not so much if a case is justified or not, but rather that it might be too difficult to try. This is an important reason why the SEO has not brought more cases forward so far”.*

This leads to the following conclusion:

**18. Evidence provided by financial services providers to justify differential treatment of customers has been challenged in complaints filed to equality bodies and courts.** Investigations conducted by these bodies have led to different conclusions depending on the circumstances of the case, reaching from the conclusion that evidence for the risk assessment was insufficient or, in other cases, was found to be sound. Key obstacles to investigate evidence provided by insurers and banks to justify differential treatment are the required level of actuarial expertise and limitations of the data that is provided by the defendant or available from other sources.

#### **4.5.2 Proportionality of the behaviour of the provider**

In section 3.4 of this study we have already mentioned that the requirement of the exception for financial services in Article 5 (2) of the Gender Directive (which is complemented by a broadly similar provision in the Draft Directive), namely that differences in premiums have to be ‘proportionate’, has generally not been further clarified at the Member State level when transposing the Directive, and that this, together with the lack of guidance provided at EU level, leads to uncertainty among stakeholders. Stakeholders therefore often point to the need to clarify whether ‘proportionate differences’ are to be interpreted as meaning ‘mathematical proportionality between risk and premium’, or rather that differences in premiums (or differential treatment in general) directly related to sex, age and disability should be justified in a proportionality test, as it is well-known from EU non-discrimination legislation.

In EU non-discrimination law, certain forms of unequal treatment which are justified by a legitimate aim do not amount to discrimination if the means of achieving that aim are appropriate and necessary. This is reflected in the definition of indirect discrimination,

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<sup>169</sup> Centre for Equal Opportunities and Opposition to Racism (CEOR), complaint BE-1 (see Part III, Annex 3).

and also, for example, in Article 4 (5) of the Gender Directive. As a commentary on this principle points out, the existence of a legitimate aim is not sufficient in and of itself:

*“There needs to be proof that the unequal treatment is the only way to achieve this goal. The application of such a justification is tempered by the requirement of proportionality. From the perspective of the broader interest of society the benefits have to outweigh the disadvantages of the unequal treatment”.*<sup>170</sup>

The justification test to deal with alleged discriminatory character of unequal treatment has been developed in case law of the European Court of Justice, the European Court of Human Rights and national constitutional courts, and comprises several accumulatively applicable criteria:

- Legitimacy test: *Is the distinction, classification or differentiation made in pursuit of a legitimate aim?*
- Objectivity test: *Is the distinction or classification based on an objective element?*
- Pertinency test: *Is the distinction relevant in relation to the aim pursued? The unequal treatment has to constitute an effective means to achieve the aim pursued.*
- Less restrictive alternative test: *Can the distinction be generally regarded as a necessary or indispensable means to attain the aim pursued? This implies an investigation as to the availability of less burdensome alternatives to the distinction made.*
- Proportionality test: *Is the distinction proportionate? It has to be ascertained whether the defendant has reasonably balanced the interests that are served by the distinction against the interests that are impaired by the distinction. This balancing should not be arbitrary.*<sup>171</sup>

This justification test derives from case law and its application depends on whether it is applied in a vertical relationship (i.e. the relation between the state and its citizens) or in a horizontal relationship (i.e. the relation between private parties, such as a private employer and employee, or service provider and consumer). The difference is that in a vertical state–citizen situation, the courts are being asked to balance individual rights (which are often fundamental rights in the context of non-discrimination/equality) against the state’s interest in defending wider public interest goals. Whereas in a horizontal consumer–insurance provider situation, the interests at stake are different. The consumer is claiming a fundamental right but the private party, the provider, will be arguing that reasonable commercial interests are at stake. An additional aspect is that if complaints bodies such as ombudsmen conduct investigations and decide on a complaint, they often do not base their decisions only on the law and case law, but

<sup>170</sup> Research Group on the Existing EC Private Law 2009.

<sup>171</sup> Slightly edited from Thiery, Y. and Van Schoubroeck, C. 2006.

they focus on the practical solution of the dispute.<sup>172</sup> Still, the influence of this justification test is clearly notable in documented decisions of courts, equality bodies and ombudsman collected by Civic Consulting in the framework of this study. Although there are exceptions, and the number of documented complaints that has been subject to a court case or other inquiry is too limited to reach a definitive conclusion, the reasoning of the bodies deciding on the complaints appears to draw on a relatively common understanding of the concept of proportionality that is applied to the individual cases.

Documented decisions that address the issue of proportionality mainly concern three different problem areas that are subject to complaints:

- Differences in premiums / surcharges
- Additional requirements / exclusions and restrictions
- Refusal to provide a service / age limits

The following sub-sections describe relevant decisions and criteria applied for each area.

### **Proportionality of differences in premiums / surcharges**

Several of the documented complaints that have been subject to an inquiry – all of them relating to insurance products – concern the proportionality of differences in premiums or surcharges.

Two very similar complaints concerned differences in premiums, one referring to differences depending on age in motor insurance (reported from Ireland),<sup>173</sup> and another one referring to differences because of sex in life insurance (reported from the Netherlands).<sup>174</sup> In both cases, the behaviour of the insurer was considered appropriate by the investigating body, i.e. the difference in premiums was accepted as being a proportionate reflection of differences in risk and life expectancy, respectively. In a similar way, the *Instituto de Seguros de Portugal* turned down a complaint brought by a cured cancer patient who applied for life insurance and had to pay a surcharge, because it considered the justification provided by the insurer to be sufficient to justify the premium differentiation. According to the *Instituto de Seguros*, the insurer's position was based on a specific medical evaluation, and the contractual consequence of such evidence reflected specifically the terms of the Reinsurance Underwriting Manual.<sup>175</sup>

In other cases, however, the behaviour of the insurer was found to be not appropriate by the investigating body. In a previously mentioned complaint from Cyprus, it was alleged that insurance companies classified persons with disabilities in the category of high-risk drivers, requiring them to pay premiums 25% higher than premiums

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<sup>172</sup> See Civic Consulting 2009.

<sup>173</sup> Equality Tribunal, complaints IE-2 and IE-3 (see Part III, Annex 3).

<sup>174</sup> Dutch Equal Treatment Commission, complaint NL-2 (see Part III, Annex 3).

<sup>175</sup> *Instituto de Seguros de Portugal*, complaint PT-1 (see Part III, Annex 3).

demanded from people without disabilities. The responsible Office of the Commissioner for Administration (Ombudsman) expressed the view that the existence of a disability alone cannot justify an increased risk of causing an accident. The Commissioner argued that special vehicles for drivers with disabilities which counterbalance various forms of physical disability are available today, and expressed the view that every decision on the determination of a premium should be specifically justified by comparative statistical data or any other data documenting and justifying any deviation from the principle of equal treatment. The Commissioner suggested that the insurance companies re-examine their policy vis-à-vis the persons with disabilities.<sup>176</sup> A prominent case in this category is also the DKV case from Belgium, which relates to premium increases in health insurance. The box below presents details of the case, for which appeal is still pending. It is notable that the President of the Commercial Court applies in detail the above-mentioned criteria of the justification test.

**Proportionality in the case of *Test-Achats vs. DKV*<sup>177</sup>**

A private health insurance company had unilaterally imposed a premium increase that was higher for older insured than for younger ones. Because substantial premium increases were imposed to older insured, without applying the same conditions to younger members, *Test-Achats* asked the president of the Brussels Commercial Court to recognise that the implemented premium increase was discriminatory within the meaning of Belgian anti-discrimination legislation of 2003.

In assessing the discriminatory nature of the premium increases, the President of the Commercial Court makes a fairly rigorous application of the criteria used by the Belgian Constitutional Court and the European Court of Human Rights to assess potential forms of discrimination in state legislation. The ruling of the President particularly focused on the so-called legitimacy criterion, the pertinence criterion, and the criterion of comparative effectiveness. The President ruled that the differential way in which the insurance premiums had been increased was not pertinent to the objective pursued.<sup>178</sup> Statistics had been presented by the insurance company showing, according to the President, the relation between the number of claims and age, but not the way age was related to increases in the cost of hospitalisation. Under the necessity criterion, the President argued that the insurance company could also have chosen less burdensome measures.<sup>179</sup>

<sup>176</sup> Office of the Commissioner for Administration (Ombudsman), complaint CY-2 (see Annex 3, Part III).

<sup>177</sup> President of the Brussels Commercial Court 7 March 2005, *Revue du Droit Commercial Belge* 2005, 678. See country report Belgium, section 2.2.1, for further information and footnotes.

<sup>178</sup> According to the president, DKV was deemed to know that the risk of hospitalization, at the time of the conclusion of the contract, increases with age and that older population increases in size. Moreover, it was argued, the increase in health costs is experienced the same way for all patients, regardless of their age.

<sup>179</sup> In particular a linear increase could have been applied, which does not distinguish according to the age of the insured, as this distinction should already have been taken into account at the time of the assessment of risk and the original calculation of premiums.

### **Proportionality of additional requirements / exclusions and restrictions**

A small number of documented complaints that have been subject to an inquiry of a relevant body concerned the proportionality of additional requirements or exclusions and restrictions imposed by the service provider.

One complaint focusing mainly on an exclusion in an insurance contract which originates from Germany. The complaint led to a court case and concerned a pregnant woman that applied for private health insurance. The insurer wanted to accept a contract only if all costs for pregnancy and related to pregnancy were excluded, a practice that according to the court was justified, because the 'insured event' (pregnancy) already happened.<sup>180</sup> In none of the documented decisions was an exclusion judged to be not proportionate by the investigating body.

Several complaints concerned additional requirements of the service provider, mainly for foreign nationals applying for insurance or banking services. These were in some cases judged to constitute discrimination. For example, in the case of the German resident in Austria who applied for a car loan and was asked to provide an Austrian guarantor or additional collaterals in spite of a high degree of creditworthiness, the bank paid a compensation to the applicant and spoke of a 'misunderstanding' after the intervention of the Austrian Ombudsman for Equal Treatment.<sup>181</sup> In a case with some similarities from Denmark, the complainant had become a Danish citizen several years ago. When he applied for a car loan, his Danish driver's licence and his national health insurance card were considered to be not sufficient by the service provider, and he was asked to provide an additional copy of the Danish passport or permanent residence permit. The Board of Equal Treatment found this requirement not proportionate. Although it was considered a legitimate aim that the provider was interested in ensuring that the loan would be paid back, the means of achieving the aim were judged to be not appropriate and necessary, because the loan taker already had provided proof of his legal stay in Denmark (information that was subsequently verified through check with the Central Office for Civil Registration), and no additional guarantee would be given by asking for additional information about citizenship and legal residence in Denmark.<sup>182</sup> In contrast, in a case from Ireland concerning a free bank account, where the complainant of Nigerian nationality had to provide documentation not mentioned in a promotional document, the Equality Officer accepted that any applicant would have been subjected to the same documentary requirements as the complainant. The bank had imposed extra requirements internally at branch level for opening new accounts after experiencing a very high level of fraudulent activity. Accordingly, the Equality Officer found that the complainant failed to establish a prima facie case of discrimination on the race ground.<sup>183</sup>

<sup>180</sup> See also footnote 161.

<sup>181</sup> Austrian Ombudsman for Equal Treatment, complaint AT-2 (see Part III, Annex 3).

<sup>182</sup> Board of Equal Treatment, complaint DK-1 (see Part III, Annex 3).

<sup>183</sup> Equality Tribunal, complaint IE-6 (see Part III, Annex 3).

### **Proportionality of refusal to provide a service / age limits**

Most of the 43 documented complaints that were subject to an inquiry by a relevant complaints body or court concern the refusal to provide a requested service (including because of age limits). Decisions of equality bodies, ombudsmen and courts that came to the conclusion that a refusal to provide a requested service is *not proportionate* in the particular case, are reported from Austria, Belgium, Cyprus, France, Greece, Hungary, Ireland, the Netherlands and Sweden. Decisions that found refusals to provide services to be *proportionate* in the cases investigated are reported from Germany, Poland and Portugal.

In a number of the documented complaints, the dispute centred around the use of age as a 'blanket' reason for denial of a service (insurance or credit). For example, two complaints from Hungary concerned consumers aged 73 and 77 who were denied consumer credit.<sup>184</sup> The Equal Treatment Authority in both cases established that the bank had breached the principle of equal treatment. As the Authority argues in one of the cases, "it is not lawful to follow a practice where conclusion of contract with a client having a proper financial background and otherwise not representing special risk is refused merely due to their age" (see also box below). A similar argument was made by the Belgian Centre for Equal Opportunities and Opposition to Racism which found that age as such is not determining for the customer's financial standing and creditworthiness and therefore "the use of a standard age limit is - in principle - arbitrary and not objectively justified".<sup>185</sup>

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<sup>184</sup> Equal Treatment Authority Hungary, complaints HU-1, HU-2 (see Part III, Annex 3).

<sup>185</sup> Centre for Equal Opportunities and Opposition to Racism, complaint BE-1. A similar line of argument can be found in a case concerning motor insurance, BE-2 (see Part III, Annex 3).

**Age limits not considered being proportionate  
Two cases from Ireland and Hungary**

In *Ireland*, the Equality Authority investigated the case of a woman aged 70 who was refused a loan by her bank to buy a car. The complainant had a good credit record and substantial sums on deposit and an adequate pension income. It was established that the bank had a de facto practice of imposing age limits although this was not transparent.<sup>186</sup> According to the Equality Authority, the refusal of a service based on the age of the customer was in contravention of the Equal Status Acts, 2000-2008. It was established that the bank did not consider the risk or ability to repay the loan but made a decision based solely on the age of the applicant. A prima facie case of discrimination was found, and compensation for the upset and humiliation awarded.

In a similar case, the Equality Treatment Authority of *Hungary* reported the case of a 77-year-old complainant who applied for a consumer credit seeking to buy a washing machine for the sum of 260 Euro. According to the reporting organisation, after having completed and presented all the necessary documents and having sent them electronically, the employee of the credit institution refused his credit application without specifying the reason for refusal. The complainant's financial standing provided sufficient security for the repayment of the loan and he had no other credit contracts or debts. The Equal Treatment Authority of Hungary found that the bank could have used several other ways of securing the payback of the loan and that refusal based on age was unlawful.<sup>187</sup>

We only could document one decision that found the use of age as reason for refusal to provide a requested service to be proportionate. It concerned a man older than 70 who was refused a life insurance contract in Poland. The provider argued that there was a very high possibility of occurrence of one of the risks defined in the insurance agreement. In this case, the Polish Financial Supervision Authority found that the refusal was appropriate to the risk assessment.<sup>188</sup>

Refusal to provide requested services that were not based on a proper risk assessment were often considered to be not proportionate by the investigating body, or led to settlements to avoid a decision. However, criteria for what can be considered to be a proper risk assessment vary. This can be illustrated with the following decisions: A complaint reported from Sweden concerned a child that was denied access to private health insurance due to a hearing loss with undiagnosed cause. The provider argued that the overall risk was too high and that it could not exclude the hearing loss from the insurance, since the reason for the hearing loss had not been ascertained. The Swedish Equality Ombudsman, however, judged the denial to be not proportionate as the insurer could have granted cover with exclusions relating to the hearing loss.<sup>189</sup> In contrast, a German court found the denial of contracting to be compatible with non-

<sup>186</sup> Equality Authority, complaint IE-1 (see Part III, Annex 3).

<sup>187</sup> Equal Treatment Authority of Hungary, complaint HU-2 (see Part III, Annex 3).

<sup>188</sup> Polish Financial Supervision Authority, PL-8 (see Part III, Annex 3).

<sup>189</sup> Swedish Equality Ombudsman, complaint SE-1 (see Part III, Annex 3).

discrimination law in the case of a child that was denied access to complementary private health insurance because it suffered from a rare disease. The insurer had argued that there was only insufficient data on rare diseases and that therefore the risk was not insurable.<sup>190</sup> Two other complaints concerned banking services and again have similarities, but were decided differently. The first complaint concerned a Lithuanian woman living in Northern Ireland who was denied a debit card by her bank. A counter assistant had told her that the denial might be due to the fact that she was from another country, whereas the branch manager stated that she was refused a debit card due to her credit score following a credit reference check. The case was settled before court, and the bank took further steps to make sure in the future it will act in compliance with equality law and relevant codes of practice.<sup>191</sup> A similar complaint from Germany led to a different conclusion. A current account was denied to a woman of foreign origin married to a German and living in Germany for a year by several banks. They solely offered the opening of an account in conjunction with her husband. The banks pointed to the fact that no credit assessment was possible and that the woman had no bankable collateral either. The Federal Anti-Discrimination Agency concluded the banks did not make distinctions on the grounds of racial or ethnic origin, age, gender or alike, as they denied indiscriminately applications for current accounts to all persons who might have an incalculable credit risk. No discrimination within the meaning of the General Act on Equal Treatment was found.<sup>192</sup>

This leads to the following conclusions:

**19. A majority of documented decisions of courts, ombudsmen and equality bodies concerning discrimination complaints in the area of insurance and banking focus on the issue of proportionality of provider behaviour.**

Reasoning of the bodies deciding on the complaints appears to draw on a relatively common understanding of the concept of proportionality which is rooted in the justification test to deal with alleged discriminatory character of unequal treatment, developed in case law of the European Court of Justice, the European Court of Human Rights and national constitutional courts.

**20. More than half of the documented decisions of courts, ombudsmen and equality bodies concern the refusal to provide a service.**

Decisions that came to the conclusion that under national non-discrimination law a refusal to provide a requested insurance or banking service is *not proportionate* in the particular case are reported from Austria, Belgium, Cyprus, France, Greece, Hungary, Ireland, the Netherlands and Sweden. Decisions that found refusals to provide services to be *proportionate* in the cases investigated are reported from Germany, Poland and Portugal. Denial of access to a service not based on a proper risk assessment was often considered to be not proportionate by the investigating body, or led to settlements to avoid a decision. However, criteria for what can be considered to be a proper risk assessment vary.

<sup>190</sup> Complaint DE-6 (see Part III, Annex 3).

<sup>191</sup> Equality Commission for Northern Ireland, complaint UK-3 (see Part III, Annex 3).

<sup>192</sup> Federal Anti-Discrimination Agency, complaint DE-1 (see Part III, Annex 3).

## 4.6 Conclusions

From the discussion presented in this chapter it is clear that the significant differences in stakeholder views with regard to what constitutes discrimination in financial services on the grounds of sex, age and disability has a direct impact on identifying, and consequently addressing, actual or potential problems of discrimination. We therefore adopted a dual and comprehensive methodology, first to identify numbers and nature of consumer complaints to relevant organisations across the EU regarding alleged discrimination, and second to document and analyse decisions of equality bodies, ombudsmen and courts regarding these complaints.

The analysis in this chapter led to the following key conclusions:

- ⇒ *The overall number of complaints about alleged discrimination in financial services appears to be low compared to other types of consumer complaints.* Organisations from 17 Member States reported detailed statistics concerning relevant complaints, in total 375 complaints were received on average per year for the period 2007-2009. This figure does not include data from a small number of organisations that could only provide an estimate regarding the total figure of relevant complaints. Taking these estimates into account, the average figure of complaints concerning alleged discrimination in financial services reported by participating organisations is approximately 1,075 to 1,675 per year. This is roughly equal to 0.6% to 1.0% of cases reported by major alternative dispute resolution schemes in the Member States specialised in financial services.
- ⇒ *Because of likely underreporting of complaints, it is not possible to come to a firm conclusion about the scale of the problems of perceived discrimination in financial services.* Reasons for underreporting of complaints include the lack of civil society organisations which work on issues of discrimination in financial services in many Member States and the relatively recent setting up or restructuring of several national equality bodies. Furthermore, it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations. Quantitative consumer research is needed, e.g. in the framework of a Eurobarometer survey, before a conclusion can be drawn about the scale of the problem.
- ⇒ *Insurance products are more likely to be subject to complaints concerning alleged discrimination than credit and banking products.* Within the insurance area, product categories most often subject to complaints are private health insurance, life insurance, motor insurance and travel insurance. Within the banking area, consumer credit and mortgage loans are the two product categories most often subject to complaints (with complaints concerning deposit accounts also being relatively frequent).
- ⇒ *Denial of access to financial services is the main reason for complaints.* This was consistent across all types of respondents (industry, national authorities, equality bodies, ombudsmen, civil society organisations). It was also reflected in the

complaints documented in detail. Exclusions or restrictions and expensive premiums were also common areas of complaint in both our survey and the documented complaints.

- ⇒ *Age and disability were most frequently mentioned as discrimination grounds or factors to which complaints mainly relate by respondents to our survey. Racial/ethnic origin ranked as third most important factor according to survey results. According to the survey results, sex is also a relevant factor in terms of complaints, whereas sexual orientation was marked by few organisations as a factor to which complaints mainly relate, which is also reflected in a lower number of documented complaints regarding this issue. The factor religion/belief was not mentioned by any organisation and only one complaint regarding this factor was documented.*
- ⇒ *A majority of documented decisions of courts, ombudsmen and equality bodies concerning discrimination complaints in the area of insurance and banking focus on the issue of proportionality of provider behaviour. Reasoning of the bodies deciding on the complaints appears to draw on a relatively common understanding of the concept of proportionality which is rooted in the justification test to deal with alleged discriminatory character of unequal treatment, developed in case law of the European Court of Justice, the European Court of Human Rights and national constitutional courts.*
- ⇒ *More than half of the documented decisions of courts, ombudsmen and equality bodies concern the refusal to provide a service (including because of age limits). Decisions that came to the conclusion that under national non-discrimination law a refusal to provide a requested insurance or banking service is *not proportionate* in the particular case, are reported from Austria, Belgium, Cyprus, France, Greece, Hungary, Ireland, the Netherlands and Sweden. Decisions that found refusals to provide services to be *proportionate* in the cases investigated are reported from Germany, Poland and Portugal. Denial of access to a service not based on a proper risk assessment was often considered to be not proportionate by the investigating body, or led to settlements to avoid a decision. However, criteria for what can be considered to be a proper risk assessment vary.*

## 5 Existing measures to prevent discriminatory practices

This chapter is focused on the implementation of EU legislation and other national and international rules in force which have specific provisions to prevent or restrict discrimination of people based on their sex, age, disabilities and other protected grounds such as religion, sexual orientation or racial/ethnic origin, in terms of access to, and supply of, financial goods and services. The findings are based on surveys, interviews and desk research carried out for this study by Civic Consulting, as well as complementary research carried out by the European Commission<sup>193</sup> and by the actuarial profession.<sup>194</sup>

### 5.1 Implementation of the Gender Directive

In December 2004 the EU adopted the Gender Directive, which outlaws discrimination between women and men in the provision of goods and services. The Directive is a minimum standards Directive, and Member States were obliged to comply with its requirements through adoption of national laws, regulations and procedures by 21 December 2007.

Article 5(1) of the Directive states that Member States “shall ensure that in all new contracts concluded after 21 December 2007 at the latest, the use of sex as a factor in the calculation of premiums and benefits for the purposes of insurance and related financial services *shall not result in differences in individuals’ premiums and benefits*” (our emphasis). However, as has been discussed before in section 3.4 Article 5(2) of the Directive also allows Member States to opt out of this rule and treat men and women differently in terms of premiums and benefits, if ‘sex is a determining factor in the assessment of risk’, providing this assessment is based on ‘relevant and accurate actuarial and statistical data’. The Article also requires that any differences (in premiums and benefits) must be ‘proportionate’.

The opt-out clause comes with certain provisos and conditions. Member States that make use of this exception to the rules of non-discrimination are required to compile, publish and update regularly accurate data which is “relevant to the use of sex as a determining actuarial factor”. A further condition is that Member States must also review their decision five years after the deadline for implementation,<sup>195</sup> taking into account research and reports by the European Commission. The Commission is required to draw up and submit to the European Parliament and to the Council a summary report including a review of the current practices of Member States with

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<sup>193</sup> Survey conducted by the European Commission, Forum on the Implementation of Article 5 of Directive 2004/113/EC. Because of the comprehensive character of the Commission survey, it was decided in the inception phase of this study to base the assessment of the implementation of the Gender Directive mainly on this source, to avoid a duplication of data collection efforts.

<sup>194</sup> Groupe Consultatif Actuariel Européen 2009.

<sup>195</sup> 21 December 2012, Art 5.2.

regard to the use of sex as a factor in the calculation of premiums and benefits, and accompany this report with proposals to modify the Directive where appropriate.<sup>196</sup>

The opt-out rule does not apply to costs related to pregnancy and maternity,<sup>197</sup> but Member States were allowed to defer the implementation of the pregnancy/maternity rule by a further two years, to 21 December 2009.

At the time of finalising this report, all Member States had transposed the requirements of Article 5 of the Gender Directive into their national laws, with the exception of Poland where it is not yet fully implemented.<sup>198</sup> Some of the Member States were as late as two years after the transitional period had expired in implementing,<sup>199</sup> which naturally will have an impact on their ability to review and report to the required deadlines.

A majority of Member States have chosen not to delay the implementation of the measure related to non-discrimination in premiums and benefits related to maternity and pregnancy costs.<sup>200</sup> All of the Member States that have implemented the Directive have chosen to make use of the Article 5(2) opt-out clause and so allow gender differentiation in premiums and benefits for at least one type of insurance, in some cases limiting this to contracts that involve life insurance and annuities. Over half, however, have chosen to apply the exception in their national legislation to all types of voluntary insurance products (this is further discussed in section 5.1.3 below).

All this leads to the following conclusions:

**21. Article 5 of the Gender Directive has now been implemented in all the EU Member States except one.** At the time of finalising this report, only Poland had not yet fully transposed the requirements of this Article into its national laws. All countries that implemented the provision have made use of the opt-out clause in order to differentiate insurance premiums and benefits between men and women for at least one type of insurance, most often related to life insurance contracts.

### **5.1.1 Interpretation of key terms of Article 5(2) of the Directive**

Article 5(2) of the Gender Directive that allows Member States to opt-out of the equal treatment requirement for insurance products contains a number of key terms: sex as ‘determining factor’; premiums based on ‘relevant and accurate actuarial and statistical

<sup>196</sup> Art. 16.

<sup>197</sup> Art. 5.3.

<sup>198</sup> The Office of the Government Plenipotentiary for Equal Treatment is in charge is drafting a horizontal law that will implement Directive 2004/113/EC and other European directives on equal treatment. This law is likely to be implemented in the latter half of 2010.

<sup>199</sup> Czech Republic, Latvia and Greece passed this legislation in 2009.

<sup>200</sup> According to the Groupe Consultatif Survey (see footnote 194 above), only 5 countries of those responding to the survey have chosen to defer implementation of Article 5.3: Cyprus, Ireland, Lithuania, Luxembourg and the UK.

data'; and the differences in premiums have to be 'proportionate'. In section 3.4 above we have already discussed that these terms are far from being unambiguous and raise a number of important questions for financial services providers and regulators.

Therefore individual Member States' interpretations of these terms are important, as the majority of Member States have followed closely the wording of Article 5(2) of the Directive in their national legislation. These terms are generally not defined in the legislation or through accompanying procedures or guidelines, leaving it either to the regulatory authorities, the industry itself or equality bodies and courts to apply these terms in practice. This fact is confirmed by the in-depth analysis carried out by Civic Consulting in selected Member States (see Part II). There is no universally common understanding of the key terms used in legislation – they are subject to a variety of interpretations and views, as is illustrated with the examples of Belgium and Germany:

#### **Interpretation of key terms in Belgium<sup>201</sup> and Germany<sup>202</sup>**

In *Belgium*, there is so far no general and uniform understanding as to the meaning and content of the separate terms 'proportionate differences', 'relevant and accurate actuarial and statistical data', and 'determining factor'. The Belgian financial supervisor (CBFA) states that the proportionality of differences in premiums is interpreted as a requirement imposing that 'differences in premium levels reflect the difference in the assumed risk'. Consumer organisations state that the notion of 'proportionate' is open to diverging ways of interpretation and could still lead to vast differences in treatment. Insurance companies rather consider the exception as a general and explicit permission to make continued use of different survival and mortality tables for men and women in life insurance. The insurance association (Assuralia) explains that under Belgian legislation, insurance companies are still allowed to set up mortality tables on the basis of their own experiences within their own insurance portfolio. Insurance companies only have to take into account certain minimum survival and mortality rates, based on the figures of the Belgian National Institute for Statistics (NIS), imposed by the Royal Decree of 14 November 2003.

In *Germany*, the principles of all European Union directives concerning equal treatment are reflected in the AGG (*Allgemeines Gleichbehandlungsgesetz*). According to Section 19 (1) No. 2 AGG, "any discrimination on the grounds of racial or ethnic origin, sex, religion, disability, age or sexual orientation shall be illegal when founding, executing, or terminating civil-law obligations which (...) have as their object a private-law insurance". Exceptionally, in accordance with section 20 (2) 1 "differences of treatment on the ground of sex shall only be permitted in case of the application of Section 19 (1) No. 2 with reference to premiums and benefits where the use of sex is a determining factor in the assessment of risk based on relevant and accurate actuarial and statistical data".

Accordingly, an implementation of the term 'proportionate differences' cannot be found in the German non-discrimination law. The lack of the term 'proportionate' might be attributed to the assumption that in a proper risk assessment risk features are always proportionate to the calculated premiums.

<sup>201</sup> See country report Belgium, see Part II for full details.

<sup>202</sup> See country report Germany, see Part II for full details.

### **Sex as a determining factor in risk assessment**

A number of Member States explained ‘determining factor’ in terms of statistical data, clear differences in claim sizes and frequency and actuarial estimation of differences in risk covered. So if statistics shows that women live significantly longer and are less prone to accidents and fatal illnesses, then they pay less in life insurance premiums, but also receive less than men in monthly pensions when they retire for the same money invested. There was only one country, Estonia, which indicated that more in-depth research and analysis of the impact of other factors should be carried out before deciding whether sex is a determining factor in risk assessment. In Estonia, research has been carried out to assess whether sex has a significant impact on longevity and mortality risks. Various other factors were taken into account, such as education, family circumstances, income and employment. The research indicated that “of all measurable background data sex is the factor influencing life span the most in Estonia”.<sup>203</sup> Finland in its response also indicates that: “It is important to show that it actually is gender and not some other underlying factor that explains the difference”.<sup>204</sup>

Two Member States – Latvia and Sweden – state that sex in itself is not a determining factor in risk assessment, but that the determining factor is the difference in behaviour between the sexes. A Swedish answer indicated:

*“Sex is not a determining factor. Difference in behaviour between sexes is a determining factor that statistical data in certain environment and under certain period is showing”.*<sup>205</sup>

Some of the equality bodies also emphasise the need to consider behaviour and lifestyle of individuals in preference to using general data for a whole population.<sup>206</sup>

### **Premiums based on relevant and accurate actuarial and statistical data**

Methods of collection, source of the data, representativeness of the sample, data types and the time periods covered were all mentioned by Member States as factors influencing the relevance and accuracy of the data. Judging from the responses, Lithuania is the only country that specifies in detail in its legislation both the methodology for collecting statistics, and its sources.

Of course insurance companies use their own statistics in addition to the officially published ones, and some countries did mention that such own market data is not always easy to assess. Such data has to be evaluated independently taking into account how representative is the sample in relation to the insured portfolio, as well as the number of years covered (Estonia, Finland).<sup>207</sup>

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<sup>203</sup> Ministry of Finance of the Republic of Estonia, response to EC Survey and Civic Consulting Questionnaire.

<sup>204</sup> Ministry of Social Affairs and Health, Finland, response to EC Survey.

<sup>205</sup> Financial Supervisory Authority, Sweden, CEIOPS joint answer to EC Questionnaire.

<sup>206</sup> Dutch Equal Treatment Commission, Austrian Ombudsman.

<sup>207</sup> Ministry of Social Affairs and Health, Finland; Ministry of Finance, Estonia.

The situation of Cyprus highlights the importance of having the data available in the local market, especially when the total business is small or not many years of experience are available. Malta puts forward another important challenge peculiar to small markets, but with implications generally for cross-border provision of financial services: how accurate and relevant is the data for the territory in which the product is offered if the company operates in another Member State and relies on the statistical evidence from that country, for example an Italian company selling health insurance in Malta, based on the Italian situation.<sup>208</sup>

According to the Preamble of the Gender Directive, data has to be reliable.<sup>209</sup> There were a variety of interpretations for how this term can be defined, though an opinion from Belgium summarises aptly a predominant thread in responses:

*“The reliability of the data: [the term] implies the reliability of the sources, notably if the data are collected, produced and/or certified by any relevant independent public body”.*<sup>210</sup>

The independence of the source is considered of crucial importance by many respondents to the Commission survey, and many mention the need for independent oversight and control/auditing mechanisms, particularly in view that internal data used by individual companies may not be published.<sup>211</sup> Civil society stakeholders<sup>212</sup> believe that insurers not only should be requested by law to use data certified by relevant public institutions, but also that the reliability of such data should be confirmed by further independent research as for e.g. past mortality rates currently used do not reflect future probabilities due to impacts of change in lifestyles and working conditions.

### **Proportionality of the premiums**

In the Commission survey, the question related to how Member States interpret proportionality elicited the least clear responses, so no firm conclusions can be drawn from these. Some Member States stated that there should be a mathematical relationship between the premiums charged and the difference in risk – for example if a man is 50% more likely to cause an accident than a woman, then a 50% difference in premium is justified. In countries such as Estonia, the responsible actuary has to issue an annual actuarial report with his/her opinion of the adequate premium differences, which acts as a benchmark system. In contrast, in Germany the term ‘proportionate differences’ is not even mentioned in the legislation (see country report Germany, Part II). Civil society representatives consequently fear that different interpretations in different Member States could lead to large differences in treatment and are asking the Commission to achieve a harmonised interpretation.

<sup>208</sup> National Commission for the Promotion of Equality (NCPE), response to EC Survey.

<sup>209</sup> Recital 19.

<sup>210</sup> Institute for Gender Equality, Belgium, response to EC Survey.

<sup>211</sup> E.g. Estonia, Greece, Italy, Lithuania, Luxembourg, Spain.

<sup>212</sup> *Test-Achats*, European Women’s Lobby (EWL) and AGE.

Implications of the varying definitions of ‘proportionality’ have already been discussed in previous sections of this report, see sections 3.4 and 4.5.

The research into Member States interpretations of the key terms in the Gender Directive leads to the following conclusions:

**22. Overall there is no consistent interpretation of any of the key terms of Article 5(2) of the Gender Directive across the Member States, though some elicit more agreement than others.** For example, the methods needed to ensure accurate data, or the need to have independent oversight. Surprisingly few Member States mention the need for further evaluation and research, particularly in the light of the potential impact on Internal Market cross-border trade. Some of the Member States mention the important challenges faced by smaller countries with smaller markets where sufficient historical and commercial data may not be available.

### **5.1.2 Implementation of the publication requirement**

The requirements for compilation and publication of statistical and actuarial data vary greatly among Member States.<sup>213</sup> There are detailed requirements in Finland, Sweden and the UK, whereas in other Member States there is little or no prescription as to the process or nature of the data to be published. Sweden, in particular, is unique among all the Member States, in that it has an independent consumer body (Swedish Consumers Insurance Bureau) that both gives advice to consumers and publishes the data, which is compiled by the Research Council for Actuarial Science.

Some Member States require individual insurers to compile and publish data; others compile and publish at national level. National authorities and equality bodies’ responses to the Civic Consulting survey indicate that most frequently a central body or other public body publishes the data, whereas the option that financial services providers or associations of financial services providers publish the data is less frequently chosen. In several countries more than one type of organisation publishes data. In some countries information is published by the financial supervisor (e.g. in Belgium), in others by the ministry of finance (e.g. in France), national banks (e.g. in Slovakia), or industry associations (e.g. in the UK).

As prescribed by the opt-out option in Article 5(2) of the Gender Directive in the EU legislation, the requirement for publication only applies to insurance products where differences in premiums and benefits based on sex are allowed. For example, in Belgium only data related to life insurance must be published, as it is the only type of insurance where differentiation exists (see box below). In other Member States where no opt-out restrictions exist, data nevertheless is published only for those products where sex differentiation in premiums exists de facto.

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<sup>213</sup> Groupe Consultatif Actuariel Européen 2009.

In terms of the type and nature of data published, regardless of whether the process is prescriptive or not, this is generally public aggregated high-level statistical data, sometimes accompanied by summary statements. In Finland, the Supervisor publishes on its website the names of insurance companies that use gender as a determining factor and the products in which it is used, while companies must do a highly specified risk analysis which includes a summary part that must be published on their websites.

Insurers are not generally required to publish company-specific data, due to market and competition considerations. Only a handful of Member States report that company specific data is used.<sup>214</sup> In some Member States there is prescription on how often data should be reviewed, but in most cases it is not prescribed. When asked how frequently the data should be updated, Member States' reports varied between 1 and 10 years, in one case as much as 20.

#### **Implementation of the publication requirement in Belgium<sup>215</sup>**

The Belgian financial supervisor (CBFA) has a legal obligation to publish the data relevant for risk calculation in life insurance contracts. The CBFA has indeed published this data on its website. The available data represent the aggregate results of the figures resulting from the periodic reporting by the insurance companies supervised by the CBFA. The figures show the amount of male and female insured in the year 2006 per age and the number of these males and females that died in that year. On the basis of these results, a different mortality can be deduced for men and women.

#### **Published data and pricing of products**

An interesting question raised by the actuarial profession (*Groupe Consultatif Actuariel Européen*) is the extent to which Member States require that the differences in premium rates and benefits must be supported by the published data, and consequently to what extent insurers have the flexibility and freedom in pricing their products. This is in fact another aspect of the debate of the meaning of proportionality. It seems that the situation varies between countries, with some stating that the pricing of products must be supported to some extent or other by the published data, while others were quite clear that the purpose of the data is only to justify the use of gender as a rating factor. Several countries were still undecided. For example, in Austria the published data is not binding, but if different data are used, these have to be published by the company. In Finland, the differences in premiums must be consistent with the statistical difference in the published data, while in Hungary, insurers have to publish the data that has been actually used for rating purposes.<sup>216</sup> Consequently, the relationship between the published data and its impact on pricing freedom is one of the greater concerns expressed by the industry regarding the publication requirement, as there are differing views on whether the published data is required only to justify

<sup>214</sup> Germany, Slovakia, Austria, Romania, Denmark and Cyprus, according to the responding national authorities.

<sup>215</sup> Country report Belgium, see Part II.

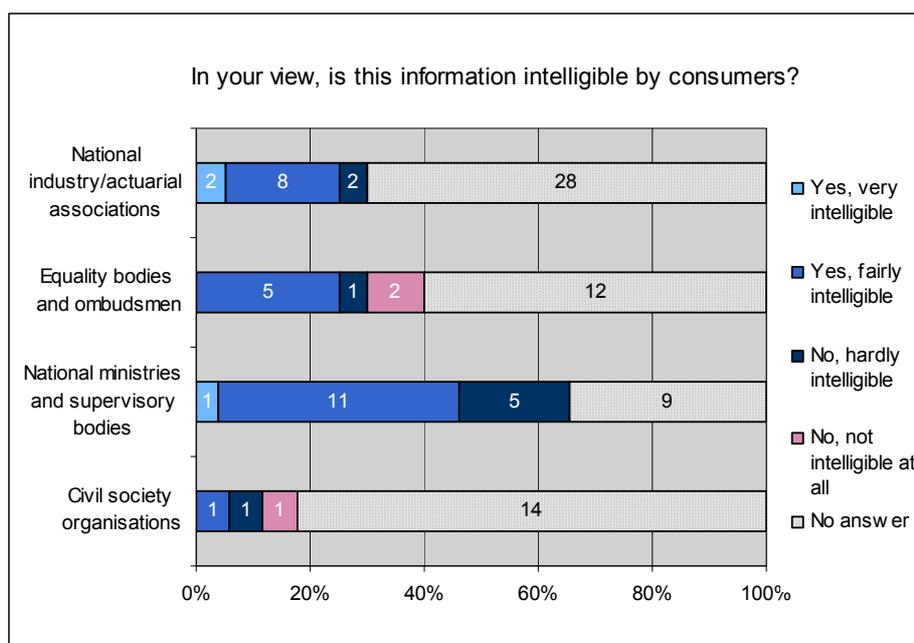
<sup>216</sup> Groupe Consultatif Actuariel Européen 2009, p.20 and its response to the EC Survey.

decisions to allow gender as a rating factor, or whether insurers are also required to base their pricing on the published data. In reality, companies use different data when calculating their premiums and reasons may include the need to use companies' own (unpublished) claims experience, future mortality trends or reflecting current rather than historical conditions (see a more detailed discussion in section 3.3 above).

**Publication requirement, transparency and consumer awareness**

The other side of the coin is that the publication requirement in Article 5(2) of the Gender Directive was intended as the main consumer protection policy measure against gender discrimination, through increasing transparency and raising awareness. Member States' governments and other interested parties' views differ on whether the publication of data is actually fulfilling this purpose. Judging from the responses received to the Commission survey, many Member States believe that the simple act of publishing relevant statistics, predominantly on the internet, has increased consumer awareness and transparency and therefore it is a good measure, but others are more reserved stating either that awareness has not increased or that the nature and way of presenting the information would be difficult for consumers to understand or would downright confuse them. Judging from responses received, no research or evaluation has been carried out by individual countries to verify any of these theories. The more pessimistic views regarding how easy the published data is to understand are backed up by our own survey for this study; the more significant figure in Figure 27 below is the large proportion of respondents who did not provide an answer when asked whether the information was intelligible to consumers.

**Figure 27: Stakeholder assessment of intelligibility of published information concerning the use of sex, age and disability**



Source: Civic Consulting surveys of national industry/actuarial associations (N=40), national ministries and supervisory bodies (N=26), equality bodies and ombudsmen (N=20), and civil society organisations (N=17).

From further comments by respondents, combined with the more detailed interviews, there seems to be general agreement that this information is of limited use to consumers. It may help to explain, for example, differences between mortality rates for men and women in relation to life insurance, but cannot be used by consumers to help understand their specific case, as individual premiums are determined by a multiplicity of factors.

The limited research that has been carried out in other areas of regulated information to ensure consumer protection and awareness confirms that often provision of information required by law is not useful to consumers and it is not fulfilling its goals in terms of enhancing individuals' awareness.<sup>217</sup>

In addition such information would not be of help to the many consumers in the EU who still do not have access to the internet. This concerns especially vulnerable groups of consumers, such as elderly people.

**Is the published data helpful? The UK perspective<sup>218</sup>**

In the UK the HM Treasury is responsible for the publication of data and has issued guidance on the requirement. The data is aggregated and published by the Association of British Insurers. Although aggregate data is published and obligations under the publication requirement are fulfilled, we have no reports that the data has been helpful to consumers in understanding how insurance decisions are made. The Association of British Insurers stress that information published may not allow consumers to work out how their individual policies are priced. This is because the information published is aggregated rather than company specific, and because gender or age is only one of many interrelated risk factors when pricing insurance.

Age Concern and EHRC (the equality body) expressed concern that currently the data which is published is too general. EHRC also pointed out that there is no process of challenging the data, and the data is not presented in a consumer-friendly way.

Age Concern would like to see an independent third party publish aggregate data. They propose that the regulator (Financial Services Authority, or FSA) collect data as companies already have to report other data annually to them. The FSA has enforcement powers should the data not be accurate.

The UK Treasury who are responsible for publishing the data do not collect information on how often the data is accessed, who uses it and how useful it is.

However, as civil society groups point out, the publication requirement and greater transparency is an essential tool in ensuring protection of consumers as it can enable them to advise consumers or challenge insurance company practices when necessary,

<sup>217</sup> See for e.g. "Warning: Too Much Information can Harm", A final report by the UK Better Regulation Executive and National Consumer Council on maximising the positive impact of regulated information for consumers and markets, November 2007, <http://www.berr.gov.uk/files/file44588.pdf>, accessed 24 March 2010.

<sup>218</sup> Country report UK, see Part II.

provided the underlying data is understandable and can be interpreted. Sweden provides a consumer-friendly example in this respect, as the publication of data is entrusted to a specialist independent Consumers Insurance Bureau which provides free advice and pre-purchase information to consumers, as well as publishing the statistics and drawing up intelligible overviews of most types of consumer insurance products. The Bureau has had 14,200 enquiries in 2008 (email and telephone), which is a large number for a relatively small population.

This overview and analysis of the publication requirement in Article 5(2) of the Gender Directive leads to the following conclusions:

**23. Member States have implemented the publication requirement in a variety of ways and by a variety of bodies, the most common being aggregated statistics for relevant insurance products published on the internet.** Opinions (as there is little evidence) on whether these statistics are helpful to consumers and enhance their protection and awareness vary, but on the whole industry, NGOs and some of the governments agree that they are not that helpful for individuals, though can be important as a transparency and general evidence measure. Sweden provides a useful example of how the publication requirement can be combined with consumer advice functions. Industry's greatest concern regarding the publication requirement is its possible impact on pricing freedom, particularly in countries which require that the pricing be supported by the published data in some form or another.

### **5.1.3 Unisex premiums in the MS**

In order to understand the situation regarding unisex insurance products in EU Member States in relation to the implementation of the Gender Directive, there are three considerations that have to be taken into account:

First, which are the insurance and related financial products for which sex is/can be used as a determining factor, so potentially covered by the Directive? In addition to motor insurance, health insurance and life insurance, Member States quoted a variety of other products that fall in this category including annuities, critical illness, income protection, long term care, travel insurance, disability/income protection insurance and, most frequently, accident insurance.

Second, which of these products are offered on an equal basis to both men and women as prescribed by the legislation implementing the Gender Directive, i.e. the way the exception in Art. 5(2) has been applied by individual countries? This question is particularly important, as resulting changes in policies from a previous situation would be the best way to measure any impacts that unisex premiums may have had on the insurance market.

According to the survey carried out by the European actuaries' organisation which included 24 Member States, 11 of them do not permit the use of gender as a rating factor for at least one type of insurance, which means they have compulsory unisex

premiums and benefits for some types of insurance.<sup>219</sup> These types vary from country to country: for example, unisex rates are required for motor insurance in 9 of the countries surveyed,<sup>220</sup> while accident insurance is obligatory on a unisex basis in 4 of the countries surveyed. Other unisex insurance variously required is critical illness, health, private health and long-term care. Even countries that permit the exception for all products apply unisex premiums for insurance types linked to social welfare policies, for example Germany has unisex products for complementary private pensions subsidised by the state.<sup>221</sup> In Ireland and the Netherlands premiums payable under health insurance contracts may not be varied with reference to sex (in both countries 'community rating' applies, see section 3.3.4 above). Among the Member States not covered by the survey of *Groupe Consultatif*, Greece confirmed that no law imposes to offer specific financial products on unisex basis.<sup>222</sup> Overall there has been a change in policy on use of gender as a rating factor in seven of the countries surveyed after the implementation of the Gender Directive. The biggest changes have taken place in Belgium and Cyprus, which had no restrictions prior to implementation. Both have now chosen to limit the opt-out from equal treatment only to contracts that involve life insurance. This means that all non-life insurance contracts such as private health insurance, motor insurance, travel insurance, etc. have now become compulsorily unisex.<sup>223</sup> The same range of products are offered on a unisex basis in the Netherlands, and this has been the case for some years, since the introduction of the Equal Treatment Act in 1994 (see box below), so not as a result of the Gender Directive.

A third consideration is the extent to which products are offered on a unisex basis by the industry voluntarily. Legal situation notwithstanding, all Member States have situations where insurance products are offered on equal gender basis and these existed before the gender equality legislation was implemented. These vary between countries, and include a variety of generally non-life products, with motor insurance being the most frequently quoted as offered on a unisex basis (see section 3.3.1 above).<sup>224</sup>

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<sup>219</sup> *Groupe Consultatif Actuariel Européen 2009* and its response to the EC Survey. *Groupe Consultatif* surveyed 26 countries, 24 EU member states plus Norway and Croatia. The omitted Member States are Greece, Malta and Romania. The countries that said the use of gender is forbidden for at least 1 type of insurance are BE, BG, CY, EE, FR, IR, LV, LT, NL, SI, NO, CZ, therefore 11 Member States (excluding Norway).

<sup>220</sup> BE, BG, CY, EE, LV, LT, NL, SI say unisex is used for motor insurance.

<sup>221</sup> The so-called *Riester-Rente*.

<sup>222</sup> In Norway, the only non-EU EEA country covered by the Survey of Group Consultative, gender as a rating factor is allowed for life insurance and annuities.

<sup>223</sup> See also country report Belgium, Part II.

<sup>224</sup> Responses to EC Survey, in particular by CEIOPS (Committee of European Insurance and Occupational Pensions Supervisors).

### **Unisex premiums and their impact in the Netherlands**

According to the stakeholders interviewed for the present study, the Gender Directive has not had an impact on the insurance industry in the Netherlands. The Equal Treatment Act of 1994 already banned discrimination on the grounds of religion, belief, political opinion, race, sex, nationality, sexual orientation or civil status, both in employment and in the provision of goods and services, including insurance. Article 2 includes a general exception to the rights contained in the Equal Treatment Act: differentiation on the basis of sex is allowed when sex is a determining factor. The cases in which sex is a determining factor are limited and listed in two Regulations: the Equal Treatment Regulation and the Regulation determining occupations for which sex is a determining factor. Art. 1, paragraph h of the Equal Treatment Regulation contains an exception for life insurance. No exception is established for other financial products.

In addition, Article 12 of the Equal Treatment of Men and Women Act (a separate act) specifically refers to pensions and mentions that sex can be used as a factor in actuarial statistics and calculations, but that this may not lead to differences in pension benefits and premiums. Insurance companies are allowed to use actuarial statistics that include sex as a determining factor in order to calculate how much money needs to be reserved to pay out the pensions, but they cannot charge different premiums for pensions to men and women, nor grant different amounts of money depending on gender.

According to the insurance association, all insurance products except life insurance are offered unisex in the Netherlands. Insurance companies use the factor sex to determine the total risk for other insurance products. For example, if there are more male customers in the portfolio, claim costs in motor insurance are expected to increase. However, insurers cannot use these calculations to offer different premiums for men and women. For motor insurance, the practice to avoid differentiating prices between men and women was in place even before the Equal Treatment Act came into force. The Code of Conduct of 1992 recommended insurance companies to avoid discrimination on the basis of gender. Therefore, the implementation of the Equality Act did not cause a sudden change in insurance practices.

The Dutch Equality Treatment Commission reported that some insurance companies, while offering disability (income protection) insurance on equal premiums, used sex and sex related data to calculate the benefits that customers were entitled to receive for loss of income after having become disabled/unable to work. Since women leave their job for maternity leave, work less time after children are born and usually retire earlier than men, this practice leads to lower payments for women. The Dutch Equal Treatment Commission took three decisions on the matter (in 1999, 2004 and 2007). In all three cases, discrimination on the ground of sex was established. The Equal Treatment Commission is not aware whether this practice is still common among insurers.

### **Impacts of providing unisex products**

One important finding from all the available research for this study, including our own surveys and interviews, is that there is very little evidence or evaluation to draw on for assessing impacts of providing unisex premiums in terms of discrimination complaints, general acceptance or consequences for costs and product development. There is more than one reason for this:

- In many Member States, unisex premiums for relevant products were available before the implementation of the new gender equality legislation;
- In many countries, the exception applies to all types of products, so there has been no real change from the situation that existed prior to the implementation of the Gender Directive;
- As the exception applies in one form or another in all Member States, few authorities have considered it necessary to evaluate this field;
- As the legislation is relatively new, and implemented late in some of the countries, there has been little time for consumers to become aware of any substantive changes, therefore there is very little evidence of complaints in this field. In several countries suitable complaint and redress mechanisms are not available to consumers.

Therefore most of the information provided in responses to the Commission survey by Member States is anecdotal, focusing mainly on costs of premiums. Several authorities acknowledge they have no information on the impacts of the EU legislation; others report that there has been no impact; and some say that there has been an increase in premiums. The actuarial profession also acknowledges that there is as yet no evidence base to answer this question.

As shown above, the biggest changes in policies in terms of unisex products have taken place in Belgium and Cyprus. The Belgian financial supervisor affirms that following the introduction of unisex rates for non-life insurance products “in a number of cases, there are indications that the premiums have increased and that there is a shift in the composition of insurance undertakings' portfolios”.<sup>225</sup> The consumer organisation *Test-Achats* observed that premiums for car insurance rose in some cases by up to 20% between 2008/2009 and 2009/2010 but also state that tariffs generally lie in the middle of the formerly differentiated premiums. Young women appear to have suffered most from the increase.<sup>226</sup> The Belgian Insurance Ombudsman reports some complaints related to increased premiums. Regarding the situation in Cyprus, neither the association nor the national authorities collected systematic evidence on impacts; the latter report that the impact has not been significant, the former that there has been some impact (see box below).

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<sup>225</sup> CEIOPS Members and Observers Replies to the EC-forum questionnaire on the implementation of article 5 of Directive 2004/113/EC, 23 September 2009.

<sup>226</sup> Test-Achats 2010 and survey response.

### **Impact of the Gender Directive in Cyprus**

Cyprus applied the exception in Art. 5 of the Gender Directive only for life insurance products. The use of sex in the design and provision of insurance products is therefore allowed only for life insurance, annuity products and loan insurance/payment protection insurance for the part of insurance covering the contingency of death, while it is banned for all other financial products. This decision was based on the results of a study carried out by the Cyprus Association of Actuaries on mortality rates based on data collected between 2003 and 2006 from 10 out of the 11 life insurance companies operating in the country for each of the major categories of the individual life insurance business. At the time the Gender Directive was implemented into national law in 2007, the insurance association claimed that there was neither the time nor the infrastructure in a small country like Cyprus to extract all relevant information for all classes of insurance products. They asked the supervisory authority for the possibility to use data from other countries in order to prove the influence of gender also on non-life insurance products. The authority declined the request and applied the exception only for those products where the influence of gender had been proved, namely life insurance products. In view of the review of the law foreseen in 2012, a dialogue between the supervisory authority and the insurance association is ongoing. The insurance association asks the authority for a less strict approach on the data collection, i.e. the possibility to use also EU level statistics and not only national data to prove the relevance of gender in risk assessment. The authority holds its position that, in principle, national sources should be used because data collected in other countries does not always reflect the actual situation in Cyprus. Should the Cyprus national data be not statistically relevant, statistics based on experiences in other countries could be accepted. The authority, however, states that it is not clear whether the review should concern all classes of products or only those for which Cyprus has prohibited the use of gender and asks the European Commission for direction on the issue.

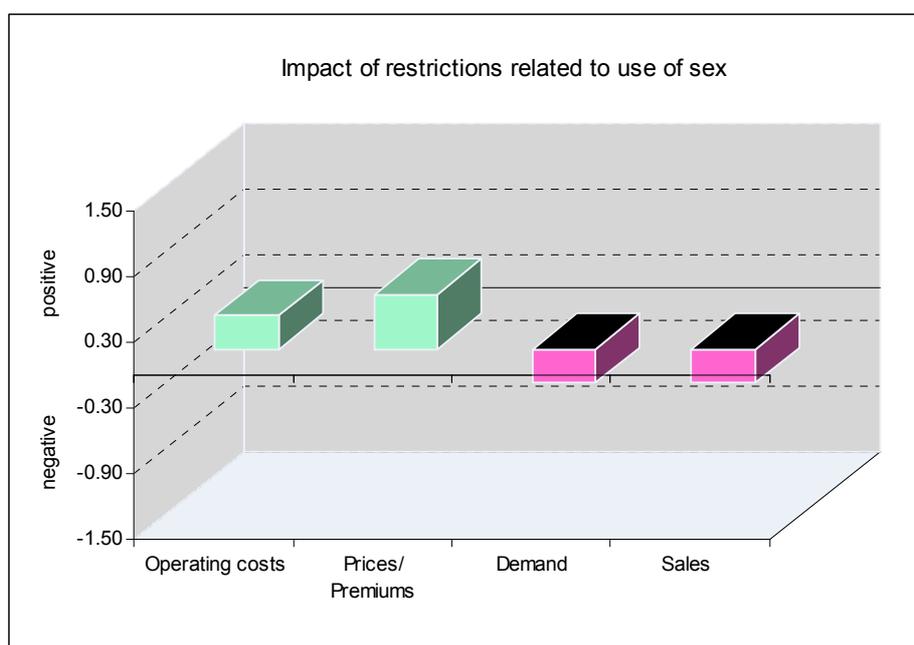
No systematic information on the impact of the gender ban has been collected to date. The authority reported that they have checked informally with a number of companies whether the new provision imposed relevant costs on insurers' business, but the costs were not reported to be significant. The costs mainly consisted of changing software and training the agents/brokers about the new rules. This view is confirmed by the insurance association, which states that insurance companies had to adapt their pricing policies to the new system, publish documentation for customers, and communicate new premiums to clients and train agents. However, these costs have not been quantified, nor are there any data available on the impact of the gender ban on single insurance products. According to the insurance association, the impact is unlikely to be relevant for products such as home insurance and motor insurance, which were offered on unisex basis even before the legal ban.

Finally, our own survey of insurance companies may point to some of the possible impacts. From the responses received it seems that the assessment by the industry itself is quite moderate, indicating on average insignificant increases in operating costs and product prices, and insignificant decreases in demand and sales.<sup>227</sup> Several banks, actuarial associations and industry associations report that restrictions related

<sup>227</sup> The following scale was used for the assessment: Increased significantly (5% or more); Increased insignificantly (less than 5%); Remained the same, Reduced insignificantly (less than 5%); Reduced significantly (5% or more).

to use of sex had no impact. It has, however, to be noted that only a very limited number of responses were received to this particular question. Most insurers and most industry associations participating in the survey did not provide an opinion. For example, from Belgium, where the change to unisex premiums affected most insurance products, we received responses of a total of 19 insurers, from which only two provided an assessment of impacts of restrictions related to the use of sex, 17 did not provide an opinion. Assuralia, the Belgian insurance association, indicated “don’t know”.<sup>228</sup>

**Figure 28: Assessment of insurance companies concerning the impact of restrictions related to the use of sex (weighted average)**



Source: Civic Consulting survey of insurance companies. Weighted average rating, where values represent the assessment of impacts on a scale from ‘reduced significantly’ (-2) to ‘increased significantly’ (+2) (N=13 to 14, depending on item; “Don’t know” and “No answer” not considered).

### Impacts of unisex costs relating to pregnancy and maternity

As stated in section 5.1 above, the opt-out rule does not apply to costs related to pregnancy and maternity,<sup>229</sup> but Member States were allowed to defer the implementation of the pregnancy/maternity rule by a further two years, to 21 December

<sup>228</sup> Assuralia explained this reluctance to provide an assessment on impacts as follows: “There are no official data available on this matter. Therefore, Assuralia cannot respond in one way or another for the entire Belgian insurance sector. Besides, insurance companies all have their own commercial strategy. Consequently, the impact of the existing national legislation on the price of insurance products (e.g. third party liability motor insurance) can differ from insurance company to insurance company”. See also country report Belgium, Part II.

<sup>229</sup> Directive 113/2004/EC, Art. 5(3).

2009. Most have implemented this rule earlier. However, just as is the case with other unisex insurance, evidence of impacts in this area is also only anecdotal. Many Member States respondents to the European Commission's survey, as well as the industry body, expect increases in premiums, while the actuarial profession points out that a potential impact could be that certain types of covers might not be available in the future.

One of the consumer organisations in Germany points out that there is some evidence of health insurance companies avoiding the unisex maternity costs provisions by deferring cover for one year if the woman discloses she is pregnant at the time of signing the contract. The Dutch Equal Treatment Commission reports a similar situation in the Netherlands, where many insurance companies which offer loss of income insurance for self-employed women require women to be insured for at least two years in order to receive benefits if they get pregnant.<sup>230</sup>

Our analysis of unisex product policies and their impacts lead to the following conclusions:

**24. *Unisex non-life insurance products are available in many Member States.***

Availability varies between countries and can range from motor insurance to private health, accident to long term care insurances. Many of them were available before the EU legislation was implemented at national levels. The biggest changes in policy have taken place in Belgium and Cyprus, which had no restrictions prior to implementation of the Gender Directive. Both have now chosen to limit the opt-out from equal treatment only to contracts that involve life insurance. Little national research has been done on the impact of the legislation and evidence is generally anecdotal, from which no firm conclusions can be drawn. Most insurers and insurance associations surveyed did not provide an assessment of impacts. Those who did indicated on average insignificant impacts.

**5.2 Implementation of other legislative measures at national level to prevent discriminatory practices**

Apart from gender, the other protected grounds under Art. 19 of the Treaty<sup>231</sup> are age, disability, racial or ethnic origin, religion or belief and sexual orientation. Measures to combat discrimination on these grounds in the access to good and services are not as

<sup>230</sup> According to the Equal Treatment Commission, this practice violates the Equal Treatment legislation. However, the higher courts have established that, since pregnancy is not a risk, it falls outside of the scope of the legislation. According to the courts, pregnancy is not a risk, it's a calculated event; even though women do not exactly know when they'll get pregnant, it is something that they can foresee coming in most cases, so it is fair that insurers are not tied to the rules of risk management when it comes to pregnancy. See also footnote 161.

<sup>231</sup> Consolidated Version of the Treaty on the Functioning of the European Union, Official Journal 2010/C 83/01.

yet in force at the EU level (except concerning racial/ethnic origin),<sup>232</sup> though at the time of writing this study a Draft Directive is being discussed within the Council of the European Union to rectify this situation.<sup>233</sup> Similar to the Gender Directive, the latest draft of the Directive includes an opt-out clause in Art. 2(7) regarding the provision of financial services, which concerns the grounds age and disability and echoes the text of the exception of the Gender Directive (see box below).

**Proposal for a Council Directive on Implementing the Principle of Equal Treatment Between Persons Irrespective of Religion or Belief, Disability, Age, Sexual Orientation**

Article 2(7) of the Draft Directive allows Member States to permit ‘proportionate differences in treatment’ in financial services, “where, for the product in question, the use of age or disability is a key factor in the assessment of risk based on relevant and accurate actuarial or statistical data”. This is explained by the European Commission in that the “use of age or disability by insurers and banks to assess the risk profile of customers does not necessarily represent discrimination: it depends on the product”.<sup>234</sup> The opt-out rule has been subject to change in various proposals discussed in the Council (e.g. concerning the replacement of ‘key factor’ with ‘determining factor’ to safeguard consistency with the Gender Directive and with regard to the evidence that can be used to justify differential treatment), and the final wording was not known at the time of writing this report. Significantly, and unlike the Gender Directive, the opt-out clause in the Draft Directive does not include a publication of statistical data requirement.

The Preamble<sup>235</sup> to the Draft Directive states that beyond the area of employment (which is covered by EU legislation), the degree and form of protection against discrimination on the grounds listed above varies between the different Member States. This is particularly true with regard to financial services, as confirmed by our research. We examine the national measures, legislative and voluntary, in the sections below using, where relevant, examples from countries we examined in more detail, including two third countries outside of the EU, Canada and New Zealand.

<sup>232</sup> Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin also covers access to and supply of goods and services which are available to the public, including housing (the Directive does not cover difference of treatment based on nationality).

<sup>233</sup> Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation, COM(2008) 426 final.

<sup>234</sup> Explanatory Memorandum, p. 5.

<sup>235</sup> Preamble, Recital 8.

### 5.2.1 National legislation that prevents or restricts use of age, disability, religion/belief and sexual orientation in the provision of financial services

There is a patchwork of legislative and regulatory measures across the Member States that deal with discrimination, including in financial services. The majority of countries prohibit any form of discrimination, with no exceptions, on the grounds of racial/ethnic origin, religion/belief and sexual orientation, including through the Constitutions of several of the countries (e.g. Czech Republic, Finland, Malta, Poland, Portugal, and Spain). Germany has a specific exception similar to the one used for gender, age and disability in the case of religion and sexual orientation, as does Belgium where, under certain conditions and providing the objective is legitimate and justified, differentiation is potentially allowed on a number of factors, including sexual orientation, physical or genetic characteristic and religion.<sup>236</sup> In (rare) cases when some of these grounds are not covered by law, they may be not used de facto by the insurance industry on ethical grounds, as is the case, for example, for the sexual orientation factor in the UK.

With a few exceptions, *age* and/or *disability* are the two most relevant grounds alongside gender, which Member States may allow to be used in the provision of financial services, either because they have no regulation in this respect or, in a number of countries, by means of an opt-out clause (or exception) in the relevant non-discrimination legislation related to goods and services. For instance, the Austrian Disability Act of 2005 allows for risk differentiation according to risk assessment. In Luxembourg, the Law of 28 November 2006 provides possible exceptions for age and disability when objectively and reasonably justified.

13 out of the 28 countries which responded to our survey restrict by law the use of both age and disability in the design, supply or pricing of financial products. Seven additional countries restrict use of disability only. Some of the countries have included such exceptions for age and disability alongside sex, during the transposition of the Gender Directive, in legislation dealing with insurance contracts, using similar wording. This is the case for example in the Czech Republic, Germany and Slovakia.

A country-by-country overview table of restrictions on use of sex, age and disability is provided below. A detailed table listing relevant legislation by Member State is provided in Part III (Annex 2).

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<sup>236</sup> See country report Belgium, Part II.

**Table 9: Restrictions concerning the use of sex, age and disability in the design, supply or pricing of financial products by Member State**

Country	Sex	Age	Disability
Austria	Restrictions	No Restrictions	Restrictions
Belgium	Restrictions	Restrictions	Restrictions
Bulgaria	Restrictions	Restrictions	Restrictions
Cyprus	Restrictions	No Restrictions	Restrictions
Czech Republic	Restrictions	Restrictions	Restrictions
Denmark	Restrictions	No Restrictions	No Restrictions
Estonia	Restrictions	No Restrictions	No Restrictions
Finland	Restrictions	Restrictions	Restrictions
France	Restrictions	Restrictions	Restrictions
Germany	Restrictions	Restrictions	Restrictions
Greece	Restrictions	No Restrictions	No Restrictions
Hungary	Restrictions	Restrictions	Restrictions
Iceland	Restrictions	Restrictions	Restrictions
Ireland	Restrictions	Restrictions	Restrictions
Italy	Restrictions	Restrictions <sup>(a)</sup>	No Restrictions
Latvia	Restrictions	No Restrictions	No Restrictions
Lithuania	Restrictions	No Restrictions	No Restrictions
Luxembourg	Restrictions	Restrictions	Restrictions
Malta	Restrictions	No Restrictions	Restrictions
Netherlands	Restrictions	No Restrictions	Restrictions
Poland	Restrictions <sup>(b)</sup>	No Restrictions	No Restrictions
Portugal	Restrictions	No Restrictions	Restrictions
Romania	Restrictions	No Restrictions	No Restrictions
Slovakia	Restrictions	Restrictions	Restrictions
Slovenia	Restrictions	Restrictions	Restrictions
Spain	Restrictions	Restrictions	Restrictions
Sweden	Restrictions	No Restrictions	Restrictions
United Kingdom	Restrictions	No Restrictions <sup>(c)</sup>	Restrictions

Source: Civic Consulting survey and communication with national authorities/ equality bodies.

Notes:

- (a) In Italy, the use of age in motor insurance is partially restricted by the possibility of young drivers to enter an insurance contract with the same bonus class of a cohabitant parent.
- (b) Poland has not yet fully implemented the Gender Directive. However, the Act on Insurance Activities of 22 May 2003 (as amended) allows for the use of gender to determine premiums and benefits when gender constitutes a decisive factor in risk assessment based on relevant and detailed actuarial and statistical data.
- (c) Restrictions will apply starting from October 2010.

### Restrictions on use of age

According to national authorities and equality bodies, there are currently no restrictions concerning the use of sex, age and disability in the design, supply or pricing of financial products in Austria, Cyprus, Denmark, Estonia, Greece, Italy, Latvia, Lithuania, Malta, Netherlands, Poland, Portugal, Romania and Sweden. In contrast, the use of age in financial services is restricted in Belgium, Bulgaria, Czech Republic, Finland, France, Germany, Hungary, Iceland, Ireland, Italy, Luxembourg, Slovakia, Slovenia and Spain.

In the UK, the use of age will be restricted from October 2010. It seems from our research that the restrictions are not specific to categories of financial products (as is the case for gender in several countries), but refer more generally to products where age (young as well as old) would be a factor in risk assessment and its use can be justified by some kind of evidence. This would include products where age is a proxy for mortality, such as term life insurance, or where age is a (statistical) indicator for health conditions, such as critical illness or the health element of travel insurance, or where age may be a proxy for accident risks, for example motor insurance. Other legal provisions regarding age limits would also be a factor, for example credit and loans for minors. However, age limits applied by insurance companies are not generally prescribed by the law.

In contrast to the EU experience, the use of age is banned for specific products such as motor insurance in several Canadian provinces. This is described in the following box. More details are provided in the country report on Canada (see Part II).

#### **Use of age criteria – the Canadian experience**

In Canada, distinctions on the basis of age are made routinely in respect of life insurance and financial products like annuities. In Canada, this is uncontroversial and considered to be reasonable and bona fide. For other classes of insurance (including other sub-classes of insurance of the person, such as disability insurance or sickness insurance), courts and tribunals require cogent evidence demonstrating the relation between the age of the person insured or seeking insurance and the risk covered and that there is no reasonable alternative. Uncertainty about the relation between age and the insured risk because of the absence of statistics is not sufficient.

As regards motor insurance, where this issue attracts the most discussion, age is becoming less relevant. Of the ten provinces of Canada, only two (as well as the three territories) continue to permit the use of age as a rating factor. It should also be noted that one of these provinces is Quebec. For personal injury and death caused in automobile accidents, Quebec has a government-run insurance scheme the costs of which are covered by vehicle and driver licensing fees. In this scheme, personal characteristics, such as age, play no part. Age is only relevant to coverage for property damage (first and third party) which is sold by private insurers. It should be noted that, in those jurisdictions where age is not permitted, years of driving experience is retained as a rating factor, but this does not violate human rights legislation.

#### **Restrictions on use of disability**

According to national authorities and equality bodies, the use of disability in financial services is not restricted in 8 Member States: Denmark, Estonia, Greece, Italy, Latvia, Lithuania, Poland and Romania. Legal restrictions are reported from 18 Member States and Iceland: Austria, Belgium, Bulgaria, Czech Republic, Finland, France, Germany, Hungary, Iceland, Ireland, Luxembourg, Malta, Netherlands, Portugal, Slovakia, Slovenia, Spain, Sweden, and UK. In several countries general restrictions on the use of disability are included in the constitutions (Iceland, Finland), laws on equality

treatment (Hungary, Sweden) or laws that prohibit the use of the factor disability in the provisions of goods and services (for example, disability acts in Austria and Cyprus). In some countries, the law provides for specific exceptions on the use of disability in financial services, when objectively justified (Luxembourg, Portugal, Slovakia).

### **Impacts of restrictions on use of age and disability in national legislation**

As described in the sections above, the exceptions in national legislations that allow for the use of age and disability in the provision of financial services in specific circumstances tend to be ‘horizontal’, i.e. applicable to all products. We have not seen evidence of any specific prohibitions on the use of age and disability for particular financial products available on a voluntary basis, as is the case for gender. Therefore the survey of all stakeholder groups indicates no significant impact of restrictions with regards to prices, access or demand. However, impact with regards to the accountability of companies for their decisions is reported, for example, from Germany and Belgium (see box below).

#### **Belgium – impacts of restrictions on use of age and disability**

Current anti-discrimination legislation is reported by an industry association to have had no impact on operating costs, prices, demand and sales in the field of banking and credit products.

As for insurance in general, the Insurance Ombudsman notes that the 2007 anti-discrimination legislation did not significantly modify the previous anti-discrimination law of 2003. Nonetheless, the Ombudsman stressed the impact of the 2003 Anti-Discrimination Act, in particular because it imposed insurers to justify their decisions (objective and reasonable justification). Insurers felt obliged to explain to consumers the reasons underlying their premium setting and this enhanced a more open dialogue between the Ombudsman, insurers and consumers.

## **5.2.2 Implementation of the UN Convention on Rights of Persons with Disabilities**

The UN Convention on Rights of Persons with Disabilities came into force in May 2008 and has been signed by all EU Member States. Persons with a disability are defined in the Convention as including “those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others”.<sup>237</sup> Article 12(5) specifies that persons with disabilities should have equal access to bank loans, mortgages and other forms of financial credit. States are required to take “appropriate

<sup>237</sup> Article 1 Convention on the Rights of Persons with Disabilities, United Nations. In comparison, the definition of disability provided by the European Court of Justice in the context of employment is as follows: “... the concept of ‘disability’ within the meaning of Directive 2000/78 must be understood as referring to a limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life ...”. ECJ, Case C-13/05 (Chacón Navas), full judgment available under <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:62005J0013:EN:HTML>.

and effective measures” to ensure that access. Article 25e requires States to “prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner”.

There is as yet no comprehensive analysis on the implementation of the Convention in full by signatory countries. Most countries did an analysis to see whether they complied with the Convention before they ratified it. This is, for example, true of Sweden, which considers that its existing legislation already fulfils the requirements of the Convention.<sup>238</sup> In Belgium, the Centre for Equal Opportunities considers that the relevant articles of the Convention have only been partially implemented, though an analysis of the existing legislation concludes that this goes a fair way towards implementation. Germany is in the course of taking action to implement the Convention (see box below), while France is in the process of ratification.

**Germany – Implementation of the UN Convention on the Rights of Persons with Disabilities**

The UN Convention on the Rights of Persons with Disabilities remains to be fully implemented. There is the intention to prepare an action plan to implement the aims of the Convention in the present legislative period (2009-2012). It will be developed in cooperation with disabled people and the main association of persons with disabilities. Within the campaign “All inclusive! - The new UN Convention”, initiated by the Federal Government’s Commissioner for the Disabled, several expert conferences have already taken place. With the help of the associations, these conferences aimed at substantiating the purposes of the Convention, assessing the current situation, defining the need for action, and to support the public relations efforts concerning the Convention. The results of these conferences now have to be implemented in the political process. The campaign stresses that special attention should be given to the ongoing support and extension of accessibility measures and the promotion of awareness of a culture of non-discrimination. Independent of the Convention, a number of regulations in social security law stipulate the rehabilitation and integration of disabled people.

Overall, according to the responses received to our survey, only a minority of countries have actually implemented the Convention in full; the use of disability as a rating factor in financial services is nevertheless restricted in 18 Member States, as reported in the section 5.2.1 above. Signatories to the UN Convention are required to submit a comprehensive report on measures taken and on progress made within two years of its entry into force, which means the first reports are due in May 2010.

<sup>238</sup> See country report Sweden, Part II.

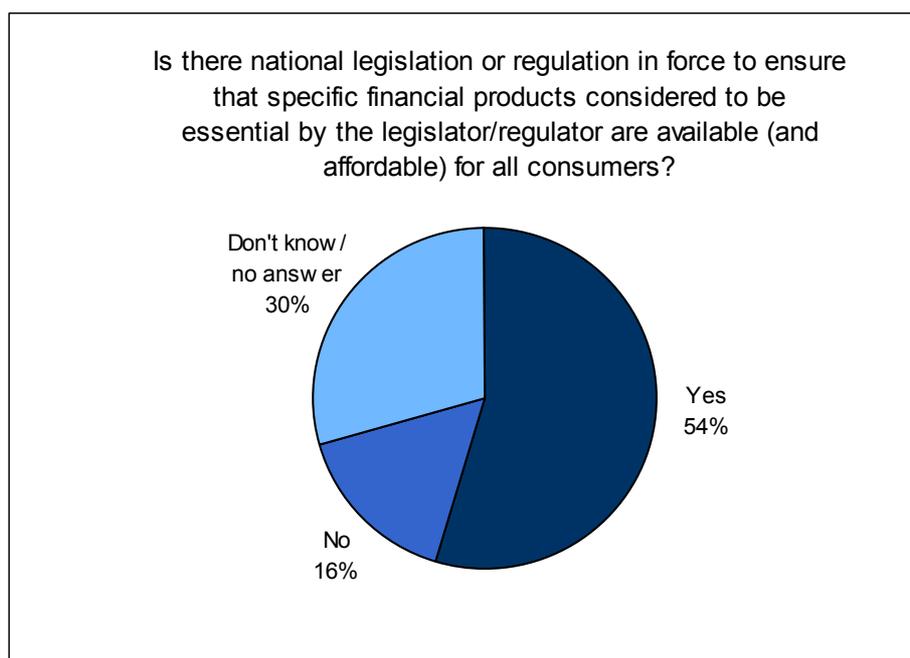
Our analysis in the preceding sections leads to the following conclusion:

25. **The majority of countries prohibit any form of discrimination, with no exceptions, on the grounds of racial/ethnic origin, religion/belief and sexual orientation.** Differentiation on the grounds of age and disability in the design, supply or pricing of financial products is restricted in roughly over half of the countries, usually by means of an opt-out clause that allows the use of the grounds in the provision of financial services under certain conditions. There seems to be no total prohibition on the use of age or disability for certain financial products, as is the case for gender. The UN Convention on Rights of Persons with Disabilities has been signed by all EU Member States, but so far only a small minority appear to have implemented it in full, including as regards its provisions on financial services.

### 5.2.3 Legislation to ensure that essential financial products are available

Our survey asked authorities and equality bodies whether national legislation or regulation is in force to ensure that specific financial products considered to be essential by the legislator are available and affordable for all consumers.

**Figure 29: National legislation in force regarding essential products**



Source: Civic Consulting survey of national authorities and equality bodies (N=44).

54% of those responding to the survey (24 organisations) answered that there was legislation in force regarding essential products (see Figure 29 above). This usually referred to third party motor insurance. Some respondents commented that although the insurance is obligatory, there's nothing to ensure that it's *affordable*. However many respondents did not address the issue of affordability.

### **Motor insurance**

As motor third party liability cover is compulsory throughout the EU (see section 3.3.1) it is unsurprising that some countries have adopted schemes to ensure accessibility. Examples provided by respondents to the survey include: Slovakia, where there is an arrangement to oblige an insurer to take on a contract; Estonia, where the law stipulates that an insurer shall enter into a liability insurance contract if the policyholder meets the requirements prescribed in the standard terms and this applies to all obligatory liability insurance; France, where the law stipulates that, for all types of insurance that are compulsory, if a person is refused insurance, the Central Bureau of Tarification (consisting of representatives of relevant stakeholders) has the right to impose on the insurer to offer insurance at a tariff determined by the Bureau. Italy also provides an interesting example through its so-called *Bersani* law, which tries to address problem of high premiums for young drivers by offering them the possibility of being assigned the same bonus class as a cohabiting parent. Other countries that reported regulation covering obligatory motor insurance are Lithuania, Poland, Greece, Portugal and Belgium. These schemes usually involve obliging an insurer to take on a risk. According to the Irish Declined Cases Agreement, to which all motor insurers doing business in Ireland are parties, an individual unable to secure motor insurance after approaching three companies will be able to secure cover. A committee of representatives of the insurers that are party to the Agreement decide which firm should make a quote. If the individual held a policy within the last three years, the company that most recently insured the individual must provide a quote. If the individual has not had a policy in the last three years, then the first company approached has to provide a quote.<sup>239</sup>

### **Health insurance**

As already stated before (see section 3.3.4) the role of private health insurance differs significantly between Member States and so do schemes to ensure accessibility. In Ireland and the Netherlands, insurers are obliged to accept all applicants and charge the same premiums for them, regardless of their individual characteristics ('community rating'). In some other Member States, where insurers are able to reject applicants and determine differential prices depending on individuals' characteristics, there are schemes to improve accessibility. Examples include Germany, where private health insurers have to offer (in addition to their other products) a uniform base rate (*Basistarif*), intended to ensure that everyone can afford cover;<sup>240</sup> Other examples are Slovenia, where insurers offering supplementary health insurance have to accept a customer with obligatory health insurance and Belgium (see box below).

<sup>239</sup> Europe Economics 2003.

<sup>240</sup> Country report Germany, Part II.

### Private health insurance in Belgium

In Belgium there are specific arrangements for private health insurance. This follows a law from 2007, which made it obligatory for insurers to offer private health insurance to all people up to the age of 65. A Conciliation Board has been established which in case of dispute conciliates on the proportionality and technical soundness of the exclusion of costs related to the pre-existing conditions of the insurance candidate. Insurance companies are also restricted in modifying the conditions of coverage and premiums during the term of the contract. Insurance contract law provides that from 1 July 2009 on, it is prohibited to modify the technical bases of the tariff or the conditions of coverage in existing contracts. After that date, premium increases can only take place commensurate with the regular economic price index, after authorisation by the financial supervisor (the Banking, Finance and Insurance Commission, CBFA), or commensurate with a medical index per age group and for different kinds of guarantees (to be calculated by the public authorities competent for economic matters on the bases of criteria set out by Royal Decree). This index has been published on the website of the Federal Public Service Economy, on the basis of the Royal Decree of 1 February 2010.<sup>241</sup>

Belgian insurance law also gives people with work-related public health insurance the right to continue this cover on an individual level without additional examinations or questionnaires should they lose the work-related cover.<sup>242</sup>

### Banking

A number of respondents reported on initiatives to ensure availability of bank accounts to all. A number of countries have introduced obligatory basic bank accounts to make it easier for those with impaired or restricted credit histories to open an account. Examples are Belgium and the UK.<sup>243</sup>

This leads to the following conclusion:

**26. Several Member States have national legislation in place to ensure that specific financial products considered to be essential are available.** Insurance products that are covered by this legislation are often reported to be motor third party liability insurance and private health insurance. On the banking side, a number of countries have introduced obligatory basic bank accounts to make it easier for those with impaired or restricted credit histories to open an account.

#### 5.2.4 Legislation planned

Respondents (national authorities and equality bodies) were asked about new legislation or regulation planned to prevent or restrict the use of sex, age, disability and

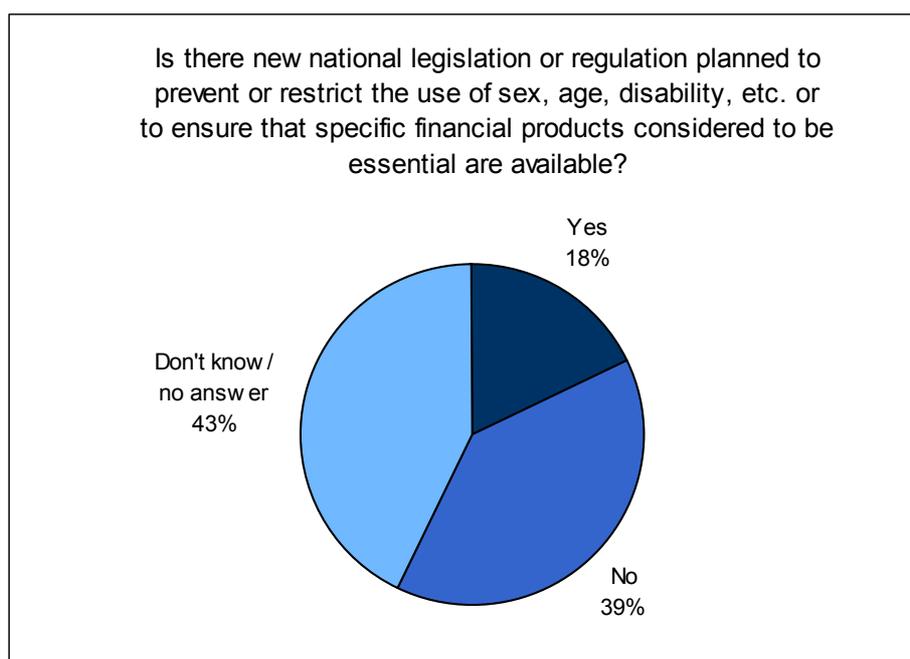
<sup>241</sup> Country report Belgium, Part II.

<sup>242</sup> Country report Belgium, Part II.

<sup>243</sup> Country reports Belgium and UK, Part II.

other protected grounds, or to ensure that financial products considered to be essential are available and affordable to all. 18% (8) answered that new legislation was planned,<sup>244</sup> with 39% (17) saying no. A number of Member States referred to forthcoming legislation to restrict the use of gender and other grounds of differentiation. Three reporting organisations mentioned new legislation planned on use of age as a factor (Lithuania, Sweden, UK).

**Figure 30: New national legislation planned**



Source: Civic Consulting survey of national authorities and equality bodies (N=44).

Two new pieces of legislation, which already have been adopted but are not yet in force, are reported from Belgium and the UK (see following box).

<sup>244</sup> Belgium (both an equality body and the supervisory authority), Finland, Lithuania, Poland, Spain, Sweden, UK.

**New legislation in Member States – examples from Belgium and the UK**

In *Belgium*, a recent Act of January 2010 aims at the improvement of access to certain loan insurance contracts for people with increased health risk in view of the renovation or acquisition of the proper and only residence of the insured.<sup>245</sup> Insurers will be under an obligation to justify their decisions and premiums. The Act creates a “*Bureau de suivi de tarification*” which has the legal authority to inquire whether surcharges are objectively and reasonably justifiable from a medical and actuarial-technical point of view. If an insured person does not agree with the insurer’s offer or refusal, the insurance company is obliged to obtain the advice of its reinsurer and must follow its decision to grant a better offer to the insurance candidate. Insured persons obtaining an offer to pay a surcharge of more than 200% have a right to a standardized form of loan insurance. A compensation mechanism (*Caisse de compensation*) funded by insurance companies will pay the amount of the surcharge that exceeds the surcharge of 200%. This Act will enter into force upon publication of a Royal Decree.<sup>246</sup>

In the *United Kingdom*, the new Equality Act, which comes into force in October 2010, will bring in measures to prevent all forms of discrimination in goods, facilities and services. It allows for an exemption for differential treatment on grounds of age as long as the difference can be justified. The Equality Act envisages greater transparency on the use of age information, along the lines of gender information, and improved signposting (or referrals to available insurers) for consumers particularly in motor and travel insurance.

This leads to the following conclusion:

**27. Access to financial products is an area of debate and change in some Member States.** The Belgian case of a new law to facilitate access to home loan insurance for people with health risks indicates that some Member States address problems related to access to financial services by direct legislative measures. In contrast, the UK approach in the context of age legislation is to improve access via the non-statutory solution of improved signposting (or referrals to available insurers) for consumers particularly in motor and travel insurance.

**5.3 Non-regulatory measures**

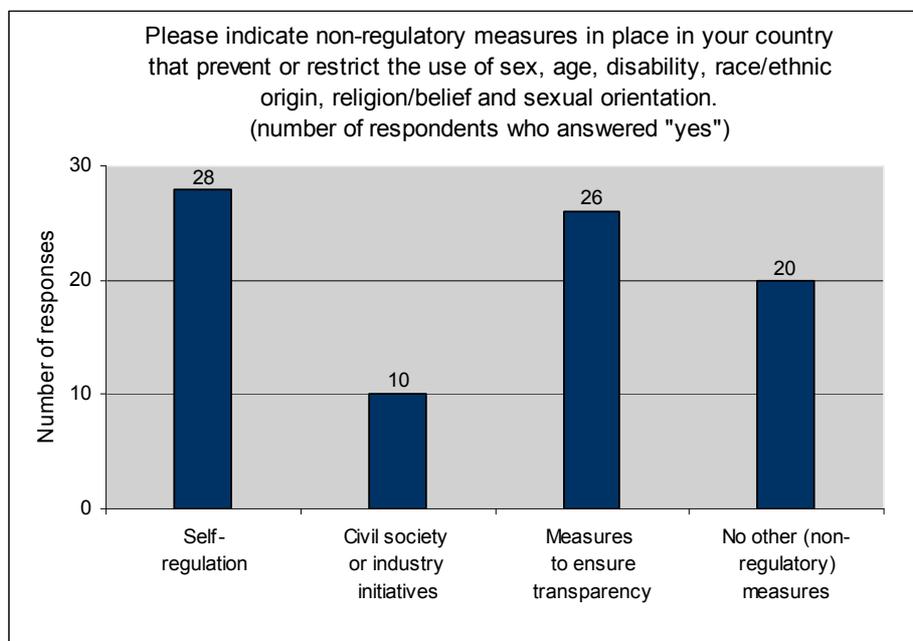
The survey carried out for the present study asked about non-regulatory measures to prevent or restrict the use of sex, age, disability, etc., or to ensure that financial products considered to be essential are available and affordable to all customers. Overall results from the survey (see Figure 31 below) indicate that self-regulatory initiatives are the most common, followed by measures to ensure transparency. Civil society initiatives (such as specialised providers) were less common. These findings

<sup>245</sup> This means that, on the basis of this act, insurance cannot be granted for a loan on a second house or on the house of someone else.

<sup>246</sup> See country report Belgium, Part II.

may over-represent measures that are specific to the issue of this study as many industry associations that answered that non-regulatory measures existed actually reported on general codes of practice or general information on company websites.

**Figure 31: Non-regulatory measures**



Source: Civic Consulting surveys of national industry/actuarial associations, national authorities and equality bodies and civil society organisations (N=103, multiple answers possible, "Don't know" and "No answer" not included in figure).

Furthermore, on the issue of transparency, most of the answers and examples received refer to the publication requirement in relation to the Gender Directive addressed in detail in the section 5.1.2 above, since there doesn't seem to be such a requirement for other forms of differentiation in the vast majority of national legislations. More comprehensive approaches are, however, reported from several Member States: In Belgium, the annual reports of the Insurance Ombudsman are considered to have the benefit also of enhancing transparency as to the motives that are invoked for denials of access, higher premiums, and the use of exclusions and these reports can also improve the dialogue between the Ombudsman, companies and consumers.<sup>247</sup> In Sweden, transparency is also considered good in the sense that information is easily accessible through the websites of the Swedish Insurance Federation, National Board for Consumer Complaints, Consumers Insurance Bureau and the individual companies. However the Equality Ombudsman considers that it would be helpful if the Swedish Consumers Insurance Bureau published information not just about gender, but also how the other factors enter the calculations.<sup>248</sup> An interesting example also

<sup>247</sup> Country report Belgium, Part II.

<sup>248</sup> Country report Sweden, Part II.

comes from Canada where information, including that relating to rating criteria, is provided by provincial regulatory agencies through for e.g. online tutorials.<sup>249</sup>

### **Voluntary initiatives to ensure access to financial products**

In several Member States, voluntary agreements or schemes provide interesting examples of ways to improve access to financial services through non-legislative measures. Predictive genetic test information<sup>250</sup> can be a potential obstacle to access to specific insurance products (such as health and life insurance) for those consumers that are diagnosed with an increased risk for a specific condition. Germany and the UK both report on agreements by insurance companies concerning predictive genetic test information.<sup>251</sup> In Germany, a voluntary formal commitment of member companies of the German Insurance Association (*Gesamtverband der Deutschen Versicherungswirtschaft*) concerning predictive genetic testing is effective until the end of 2011. Member companies having signed the declaration commit themselves to not make the conduct of predictive genetic tests a prerequisite for the conclusion of a contract.<sup>252</sup> In the UK, a policy agreement between the ABI and the Government (the 'Concordat and Moratorium on Genetics and Insurance') concerns the use of genetic test results in insurance underwriting practices. The Concordat and Moratorium set out the policy on how predictive genetic tests may be used and the insurers' agreement not to use specified genetic tests. According to the document, insurers agree that customers will not be asked to nor be put under any pressure to undergo a predictive genetic test in order to obtain insurance. Customers will not be required to disclose the results of predictive genetic tests for policies up to £500,000 of life insurance, or £300,000 for critical illness insurance, or paying annual benefits of £30,000 for income protection insurance.<sup>253</sup>

Also, the Association of British Insurers has published a statement of good practice on HIV and insurance. This document makes it clear that insurers do not ask questions about an applicant's sexual orientation or request an HIV test to be taken solely because of perceived sexual orientation. The UK, with its large insurance market, also provides useful examples of specialist providers and use of 'signposting' to direct people who are refused insurance from standard providers to these specialist companies. There are providers who specialize in insurance for older people or people

<sup>249</sup> See "Educational Auto Rate Tutorial" at [www.fsco.ca/english/auto/edurateguide.asp](http://www.fsco.ca/english/auto/edurateguide.asp).

<sup>250</sup> Predictive genetic testing refers to testing a person who currently does not have symptoms or signs of disease, but may be at increased risk due to family history or other factors.

<sup>251</sup> See country reports Germany and UK, Part II.

<sup>252</sup> Voluntary formal commitment of member companies of the German Insurance Association (*Gesamtverband der Deutschen Versicherungswirtschaft e. V. – GDV*), dated 18.07.03.

<sup>253</sup> Concordat and Moratorium on Genetics and Insurance, March 2005. It is complemented by an ABI Code of Practice for Genetic Tests (June 2008).

with pre-existing medical conditions, such as cancer. The industry argues that this sort of niche marketing is good for innovation and benefits groups of consumers.<sup>254</sup>

Codes of practice can provide guidance for insurance companies, and this can also help to address the complex issues related to proportionality that have been discussed in previous sections of this report. An example for guidance provided from an actuarial association comes from New Zealand. The Society of Actuaries has issued two set of specific guidance notes to help its members not only to respect existing human rights legislation, but also to make the right decisions when considering allowed exceptions for individual cases (see country report New Zealand, Part II, and box below).

**New Zealand Society of Actuaries Guidance Notes<sup>255</sup>**

The New Zealand Society of Actuaries is a professional body for actuaries practising in New Zealand. It has produced two sets of guidance notes for actuaries which relate to the Human Rights Act (HRA). One covers the exceptions in the law regarding financial products, and the other, to be read in conjunction with the first, covers health insurance premiums (Guidance Note No.3A). The former is a predictable set of notes, reflecting the legislation. Guidance Note No.3A, on the other hand, is of interest.

Guidance Note No.3A, effective from 1 March 2002, sets out the considerations that an actuary should take into account when providing advice regarding health insurance premiums, in accordance with the HRA. It was pointed out that the wide variation in age band premiums throughout the industry raised concerns regarding whether all such diverse practices complied with the HRA (variations included premiums related to each year of age, premiums with 5 years age bands, and premiums with broader age bands). The Guidance Note points out that there is evidence that health costs vary with age, among other factors, and so premiums that vary with age comply with the HRA. It goes further, however, to point out that the volatility in health insurance claim costs can cause difficulties. Such volatility derives from variation in the incidence and propensity to claim, changes in public health provision, and changes in medical techniques and technology. The Guidance Note sets out some considerations that an actuary must take into account, including that the groupings (i.e. subsets or bands) do not introduce any bias, and that the actuary should ensure that the deviation from the central estimate is reasonable at each age. When finalising premium rates, actuaries are directed to bear in mind the intention of the Act.

In some cases, non-regulatory initiatives can directly address accessibility issues. One example concerning the banking sector comes from Germany, where a voluntary scheme since 1995 aims at ensuring universal access to basic banking, further recommended by the Parliament in 2004. However there is no agreement on how effectively this scheme has been implemented by the banking sector, and consumer

<sup>254</sup> See country report UK, Part II.

<sup>255</sup> See country report New Zealand, Part II.

representatives would like this to become law, rather than recommendation.<sup>256</sup> Another example is reported from France. In this country, a formal agreement between stakeholders aims at ensuring access to loan insurance for consumers with aggravated health conditions, an issue that recently has been addressed in Belgium by a new law. The Convention AERAS in France is described in the following box and (in more detail) in Part III, Annex 5.

**Voluntary agreements: The Convention AERAS in France<sup>257</sup>**

In France, in order to facilitate the access of persons with aggravated health risks to home and consumer loans, the government, the banking and insurance associations and the associations representing patients and consumers have signed the Convention AERAS (*S'Assurer et Emprunter avec un Risque Aggravé de Santé*). The Convention establishes three levels of evaluation that a case must go through before loan insurance is denied to consumers. In addition, for home and business loans, the agreement establishes a mechanism of resource sharing between insurance companies and credit institutions, to limit the additional cost resulting from aggravated health risks. There is a legal control of the application of this agreement by banks and insurers. Potential disputes are solved by the *Commission de la Médiation AERAS*.

In 2008, approximately 400,000 people were eligible to benefit from the Convention (estimated to be about 10% of the total market). Thanks to the Convention and its three-level evaluation, 93% of the people who applied for loan insurance were able to obtain it. However, the number of people with extremely severe health conditions who benefited from reductions in premiums is not as high as expected at only 1,345. The reasons for this maybe that consumers do not fully understand the benefits of the scheme, or that they do not want to go through complicated procedures to prove their financial status.<sup>258</sup>

Another interesting outcome of the Convention as reported by HALDE (the equality body) is that training on the Convention has improved awareness of bank staff in branches so that they are aware that people with increased health risks can be insured. HALDE also commented that despite the Convention some consumers with increased health risks still are refused insurance or cannot afford the premiums.

<sup>256</sup> Country report Germany, Part II.

<sup>257</sup> For a detailed account of the Convention AERAS, see Part III.

<sup>258</sup> Report of the Convention Aeras, "*Bilan de l'application de la convention AERAS-s'assurer et emprunter avec un risqué aggravé de santé*", 2009.

This leads to the following conclusion:

28. ***Voluntary initiatives of industry associations can play an important role to provide better access to financial products and to guide insurers and banks when applying non-discrimination legislation in practice.*** Examples reported from Member States and third countries include codes of good practice, statements and commitments regarding HIV, and insurance or predictive genetic testing and guidance notes from actuarial associations. Voluntary initiatives in some countries directly address issues of accessibility that are subject to legislation in other countries. Examples are a voluntary scheme in Germany to ensure universal access to basic banking, and a formal agreement in France between stakeholders that aims at ensuring access to loan insurance for consumers with aggravated health conditions.

#### 5.4 Conclusions

Article 5 of the Gender Directive has now been implemented in nearly all EU Member States. At the time of finalising this report, only Poland had not yet fully transposed the requirements of this Article into its national laws. All countries that implemented the provision have made use of the opt-out clause in order to differentiate insurance premiums and benefits between men and women for at least one type of insurance, most often related to life insurance contracts. A key issue remains that there is no consistent interpretation of any of the key terms of Article 5(2) of the Gender Directive across the Member States.

Partly as a consequence of the Gender Directive, unisex non-life insurance products are available in many Member States. Availability varies between countries and can range from motor insurance to private health, accident to long term care insurances. Many of them were available before the EU legislation was implemented at national levels. The biggest changes in policy have taken place in Belgium and Cyprus, which had no restrictions prior to implementation of the Gender Directive. Both have now chosen to limit the opt-out from equal treatment only to contracts that involve life insurance. Little national research has been done on the impact of the legislation and evidence is generally anecdotal. Most insurers and insurance associations surveyed did not provide an assessment of impacts. Those who did indicated on average insignificant impacts.

Our analysis of other national measures in place (both legal and non-legal) leads to the following conclusions:

⇒ *The majority of countries prohibit any form of discrimination, with no exceptions, on the grounds of racial/ethnic origin, religion/belief and sexual orientation. Differentiation on the grounds of age and disability in the design, supply or pricing of financial products is restricted in roughly over half of the countries, usually by means of an opt-out clause that allows the use of the grounds in the provision of financial services under certain conditions. There seems to be no total prohibition on the use of age or disability for certain financial products, as is the case for gender.*

- ⇒ *The UN Convention on Rights of Persons with Disabilities has been signed by all EU Member States, but so far only a small minority appear to have implemented it in full.*
- ⇒ *Voluntary initiatives of industry associations can play an important role to provide better access to financial products and to guide insurers and banks when applying non-discrimination legislation in practice. Examples reported from Member States and third countries include codes of good practice, statements and commitments regarding HIV, and insurance or predictive genetic testing and guidance notes from actuarial associations. Voluntary initiatives in some countries directly address issues of accessibility that are subject to legislation in other countries. Examples are a voluntary scheme in Germany to ensure universal access to basic banking, and a formal agreement in France between stakeholders that aims at ensuring access to loan insurance for consumers with aggravated health conditions.*

## 6 Recommendations for possible action at EU, national and industry level

### 6.1 Key conclusions of the study

In this study we have analysed the current use of the factors sex, age, disability, racial/ethnic origin, religion/belief and sexual orientation in the provision of financial services. We have scrutinised complaints of alleged discrimination and decisions of relevant bodies on these complaints. Finally, we have assessed legislative and other measures in place across the EU to prevent discrimination in the provision of financial services.

Conclusions of the study include:

- ⇒ *The factors age, sex and disability (or rather the underlying health condition) are widely used in the design and supply of financial products.* Pricing of consumer insurance and credit products is generally based on segmenting the population of covered risks and placing them into groups or classes having similar characteristics (and hence similar levels of risk). The criteria used to sub-divide the population of risks are those which are believed to reflect the probability of loss, including age, sex or disability. Many of the underwriting factors used by providers are not so much causes of loss as proxies for other things that may cause loss. The use of proxies is commonly justified by reference to the costs that would be incurred if a detailed examination had to be carried out for each consumer.
- ⇒ *There is very little direct use of racial/ethnic origin, religion, belief or sexual orientation as factors in the supply of financial products.* Some providers have affiliations with religious bodies and some products have been developed specifically for certain religious groups (e.g. Islamic banking products), but the study found no strong evidence of the use of these factors by suppliers on any of these grounds. However, the factor racial/ethnic origin may be used indirectly, e.g. through requirements concerning nationality and residence.
- ⇒ *In a highly competitive market, private insurers have a natural incentive to distinguish between risks as precisely as possible and charge premiums which are as accurate as they can be in actuarial terms.* An insurer that is able to assess the risk of loss more accurately than its competitors will be able to identify and attract lower-risk customers who are being overcharged by the rest of the market, while avoiding higher-risk customers who are being undercharged. However, the incentive to do so will be reduced if the market is not competitive, especially if the product in question is mandatory by law (e.g. third party motor insurance) or is one which is essential in practice. Fine-tuned differential pricing of insurance can also lead to very high-risk consumers being priced out of the market or even refused insurance altogether.
- ⇒ *The overall number of complaints about alleged discrimination in financial services appears to be low compared to other types of consumer complaints.* The total number of complaints was (taking into account estimates provided by some

organisations) roughly equal to 0.6% to 1.0% of cases reported by major alternative dispute resolution schemes in the Member States specialised in financial services. However, because of likely underreporting of complaints, it is not possible to come to a firm conclusion about the scale of the problems of perceived discrimination in financial services without conducting quantitative consumer research. Reasons for underreporting of complaints include the lack of civil society organisations which work on issues of discrimination in financial services in many Member States and the relatively recent setting up or restructuring of several national equality bodies. Furthermore, it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations.

- ⇒ *Insurance products are more likely to be subject to complaints concerning alleged discrimination than credit and banking products.* Within the insurance area, product categories most often subject to complaints are private health insurance, life insurance, motor insurance and travel insurance. Within the banking area, consumer credit and mortgage loans are the two product categories most often subject to complaints. Denial of access to financial services is the main reason for complaints. Age and disability were most frequently mentioned as discrimination grounds. Racial/ethnic origin ranked as third most important factor according to survey results, before the factors sex and sexual orientation. The use of exclusions and restrictions related to pregnancy and maternity by insurers indicates a need to clarify whether these are in line with the general rule of non-discrimination for reasons of pregnancy and maternity in the Gender Directive.
- ⇒ *A majority of documented decisions of courts, ombudsmen and equality bodies concerning discrimination complaints in the area of insurance and banking focus on the issue of proportionality of provider behaviour.* Reasoning of the bodies deciding on the complaints appears to draw on a relatively common understanding of the concept of proportionality which is rooted in the justification test to deal with alleged discriminatory character of unequal treatment, developed in case law of the European Court of Justice, the European Court of Human Rights and national constitutional courts.
- ⇒ *More than half of the documented decisions of courts, ombudsmen and equality bodies concern the refusal to provide a service (including because of age limits).* Decisions that came to the conclusion that under national non-discrimination law a refusal to provide a requested insurance or banking service is *not proportionate* in the particular case, are reported from Austria, Belgium, Cyprus, France, Greece, Hungary, Ireland, the Netherlands and Sweden. Decisions that found refusals to provide services to be *proportionate* in the cases investigated are reported from Germany, Poland and Portugal. Denial of access to a service not based on a proper risk assessment was often considered to be not proportionate by the investigating body, or led to settlements to avoid a decision. However, criteria for what can be considered to be a proper risk assessment vary.

- ⇒ *Article 5 of the Gender Directive has now been implemented in all the EU Member States except one. All countries that implemented the provision have made use of the opt-out clause in order to differentiate insurance premiums and benefits between men and women for at least one type of insurance, most often related to life insurance contracts.*
- ⇒ *There is a patchwork of legislative and regulatory measures across the Member States that deal with discrimination caused by the use of other factors than sex. The majority of countries prohibit any form of discrimination, with no exceptions, on the grounds of racial/ethnic origin, religion/belief and sexual orientation, including through the Constitutions of several of the countries. Thirteen Member States restrict by law the use of both age and disability in the design, supply or pricing of financial products. Seven additional Member States restrict use of disability only.*
- ⇒ *Voluntary initiatives of industry associations can play an important role to provide better access to financial products and to guide insurers and banks when applying non-discrimination legislation in practice. Examples reported include codes of good practice prepared by insurance associations and guidance notes from actuarial associations. Voluntary initiatives in some countries directly address issues of accessibility that are subject to legislation in other countries.*

## 6.2 Recommendations

Study results confirm the existence of problems of discrimination in the provision of financial services that need to be addressed through adequate measures. Nearly half of the Member States already have various legislative provisions in place that prohibit the use of racial/ethnic origin, religion/belief and sexual orientation, and permit the use of sex, age and disability in the provision of financial services under certain circumstances, and thereby broadly anticipate the legal framework proposed by the European Commission.<sup>259</sup> In addition to legislative measures the study recommends to take immediate action in seven areas:

1. EU-wide consumer research concerning the scale of the problem;
2. Coordinating reporting of market impacts for the review process according to Article 5(2) of the Gender Directive;
3. Commission guidance for interpretation of key terms;
4. Developing consumer complaints infrastructure and reporting;
5. Codes of good practice;
6. Sectoral agreements;
7. Signposting systems.

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<sup>259</sup> Once the Draft Directive is adopted, the EU legislative framework would prohibit the use of racial/ethnic origin, religion/belief and sexual orientation, and permit the use of sex, age and disability in the provision of financial services under certain circumstances.

These options for action at EU, national and industry level are not listed in order of priority, but rather follow a logical order of action. They are described in detail in the following sections.

### **6.2.1 Conducting a representative consumer survey in all EU Member States**

Although this study has confirmed the existence of problems of discrimination in the provision of financial services, it is not possible to establish the scale of the problems because of likely underreporting of complaints. It would therefore be useful if the European Commission would conduct a representative consumer survey in all EU Member States to provide evidence regarding the extent to which consumers have experienced denial of access to specified financial products (the main cause of complaints) and regarding the extent to which consumers perceive they have experienced discrimination in the provision of financial services. The research could also explore the impact of denial of services or perceived discrimination had on them – for example, did the consumer find another provider for the product in question (i.e. by shopping around), or was the consumer excluded from this service and what implications did this have. We recommend that this research focuses on private health insurance, life insurance, motor insurance, travel insurance, consumer credit and mortgages (including underlying loan insurance) as these are the areas where this study has revealed the greatest number of complaints reported by various stakeholders. It is possible to complement the research with questions regarding affordability of specific products.

More detailed questions could be included in a special Eurobarometer survey. In previous Eurobarometer surveys, questions asked regarding the provision of financial services were not focused on collecting data for assessing the scale of the problems for the products scrutinised in this study. Because perceptions concerning what constitutes a discrimination problem vary among stakeholders, a two-step approach is recommended for drafting relevant questions:

- In a first step, initial survey questions could be discussed with stakeholder organisations, e.g. in the framework of the Dialogue on the use of age and disability in financial services;
- In a second step, it would be possible to test the questions with a small group of target consumers to validate understanding.

For the practical implementation it would be important to safeguard through adequate sampling strategies that subgroups that appear (based on the collected complaints data) to be potentially subject to discrimination are adequately represented. These subgroups would likely include:

- Elderly people and the oldest (≥ 80 years old);
- Disabled persons;
- Persons with a cured or not-cured pre-existing condition (such as cancer or other serious disease);
- Women that are pregnant or were pregnant during the last 2 years;

- Persons that are non-nationals and/or self-assess that they belong to an ethnic minority;
- Persons that self-assess that they belong to a minority based on sexual orientation or gender re-assignment;

To obtain representative results for these subgroups, it is likely that oversampling is required to achieve the desired numbers of interviews for each sub-group.<sup>260</sup>

This leads to the following conclusion:

**29. It would be useful if the European Commission would conduct a representative consumer survey in all EU Member States to establish the scale of the problems, which is currently unclear because of likely underreporting of complaints.** This would provide evidence regarding the extent to which consumers have experienced denial of access to specified financial products (the main cause of complaints) and regarding the extent to which consumers perceive they have experienced discrimination in the provision of financial services. More detailed questions could be included in a special Eurobarometer survey. To safeguard acceptance of results across all stakeholder groups, survey questions could be discussed in the framework of the Dialogue on the use of age and disability in financial services.

### 6.2.2 **Review process according Article 5(2) of the Gender Directive**

The Gender Directive requires Member States to review their decision to opt out according to Article 5(2) after the end of 2012.<sup>261</sup> If this review is done in a coordinated way, this process could lead to additional evidence concerning the impacts of measures taken so far on the market. During the course of the study we found there was very little evidence available to assess the impact of the introduction of unisex premiums for certain products in some Member States. Most industry associations and providers surveyed for this study in those countries that prohibit the use of sex as rating factor did not provide an assessment in this respect. In the review process, the relevant authorities of the Member States could invite service providers and their organisations to evaluate their data on operating costs, product prices, volume of sales

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<sup>260</sup> Specific subgroups may only be a small percentage of the population and with a typical sample of 1,000 consumers per Member State for a Eurobarometer, would not be included in a general population sample in a sufficient number to allow reliable conclusions. For this reason, these subgroups have to be oversampled (e.g. by defining a minimum number of 100 consumers that need to be interviewed from each sub-group) and the result has in a second step to be weighted according to the population characteristics to eliminate the potential for bias. This will likely increase the costs of such a survey, but is indispensable.

<sup>261</sup> Article 5(2) provides that: "Member States may decide ... to permit proportionate differences in individuals' premiums and benefits where the use of sex is a determining factor in the assessment of risk based on relevant and accurate actuarial and statistical data. (...) These Member States shall review their decision five years after 21 December 2007, taking into account the Commission report referred to in Article 16, and shall forward the results of this review to the Commission."

and number of providers after the introduction of unisex rates (in those countries that have require them for certain products). This data could be combined with the above mentioned consumer research to complement the assessment of impacts.

To safeguard a coordinated review process, the European Commission could elaborate a template which would outline key criteria to be addressed in the review process. Appropriate sources for data could be specified including insurers, their associations and regulators.

This leads to the following conclusion:

**30. *The review process for Member States that have used the opt-out provision according to Article 5(2) of the Gender Directive could be used to provide additional evidence concerning the impacts of the introduction of unisex premiums.*** In the review process, the relevant authorities of the Member States could invite service providers and their organisations to evaluate their data on operating costs, product prices, volume of sales and number of providers after the introduction of unisex rates (in those countries that have require them for certain products).

### **6.2.3 Guidance for interpretation of key terms**

A key finding of this study is that there is a lack of clarity of terms used in the opt-out provision of Article 5(2) of the Gender Directive. As discussed in detail before, terms such as ‘determining factor’; ‘relevant and accurate actuarial and statistical data’; and ‘proportionate differences in ... premiums and benefits’ are generally not defined at EU or national level, neither through legislation nor through accompanying guidelines, leaving it either to the industry, the regulatory authorities, equality bodies and courts to apply them in practice. Consequently, the terms are being interpreted differently throughout the EU, although courts, equality bodies and ombudsmen appear to base their decisions concerning discrimination complaints on a relatively common understanding of the concept of proportionality in the context of non-discrimination legislation. Additional and more specific guidance would reduce uncertainty for industry and provide a better basis for decisions of redress bodies that are often not sufficiently prepared to deal with complex actuarial issues.

The European Commission, after consulting stakeholder, could therefore issue a binding or non-binding guidance document, which would provide general principles and harmonised definitions of key terms. The guidance could also clarify if exclusions, restrictions and waiting periods for pregnant women that wish to conclude an insurance contract e.g. for health insurance, are in line with the provisions of the Gender Directive which prohibits “less favourable treatment of women for reasons of pregnancy and maternity”.<sup>262</sup> In addition, a “gray list” or “blacklist” of specific practices of financial services providers related to evidence and proportionality could be developed. The

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<sup>262</sup> See footnote 161.

grey list would describe practices which are *prima facie* considered to be not proportionate, although they can be acceptable under certain circumstances. The blacklist would describe practices that are not considered to be proportionate in all circumstances. This would create clarity for insurers and courts. A blacklist of commercial practices is e.g. contained in the Unfair Commercial Practices Directive (Directive 2005/29/EC).

This leads to the following conclusion:

**31. After consultation with stakeholders, the European Commission could issue a binding or non-binding guidance document, which would provide general principles and harmonised definitions of key terms.** It could also clarify if exclusions, restrictions and waiting periods for pregnant women that wish to conclude an insurance contract e.g. for health insurance, are in line with the provisions of the Gender Directive which prohibits “less favourable treatment of women for reasons of pregnancy and maternity”. This guidance could be accompanied by a ‘gray list’ or ‘blacklist’ of specific practices of financial services providers related to evidence and proportionality. The grey list would describe practices which are *prima facie* considered to be not proportionate, although they can be acceptable under certain circumstances. The blacklist would describe practices that are not considered to be proportionate in all circumstances. This would create clarity for insurers and courts.

#### **6.2.4 Consumer complaints infrastructure and reporting**

Better monitoring of markets from a consumer perspective and better redress for consumers are ongoing initiatives of the European Commission. For example, since 2010 the Consumer Markets Scoreboard is published twice a year to benchmark national consumer environments and regularly screen consumer markets to identify which one is not delivering the outcomes expected by European consumers.<sup>263</sup> In a related development, the Commission has published recently a Recommendation on the use of a harmonised methodology for classifying and reporting consumer complaints and enquiries.<sup>264</sup>

The value of these initiatives is clearly confirmed by this study: In some countries there was no information about consumer complaints concerning discrimination available; in others some anecdotal information was available but no quantitative information about the level of complaints. There are large differences between EU Member States in the degree of interest and information in this area. This points to problems with a lack of adequate mechanisms for consumer complaints concerning discrimination, a lack of

<sup>263</sup> See [http://ec.europa.eu/consumers/strategy/facts\\_en.htm#CMS](http://ec.europa.eu/consumers/strategy/facts_en.htm#CMS).

<sup>264</sup> See Commission Recommendation on the use of a harmonised methodology for classifying and reporting consumer complaints and enquiries, C(2010)3021 final; also relevant is a previously published documents that specifically addresses discrimination complaints: European handbook on equality data, European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities - 2006

awareness on the part of consumers about their rights, and deficiencies in the way complaints data is collected and recorded.

Within each Member State, there needs to be a clear process for consumers to follow if they want to make a complaint about alleged discrimination. In general redress bodies do exist (such as equality bodies or ombudsmen). However consumers may be unaware of their rights or the existence of a relevant body, and it may not be clear which body takes responsibility for discrimination complaints. Consumers need to be made aware of how to pursue a complaint about alleged discrimination at the point that they experience difficulties. Equality bodies need to have appropriate training and support to enable them to pursue a case if necessary. A number of bodies reported during the survey that taking up cases in the area of financial services is complex and time-consuming and this could be a barrier to redress. Greater sharing of experience and cooperation between equality bodies and specialised alternative dispute resolution schemes in the area of financial services (especially insurance and banking ombudsman schemes), combined with clarification of key terms through guidelines (and possible codes of good conduct, see below) could help to assist these bodies in settling disputes. Good coordination and signposting of consumers to relevant redress mechanisms for discrimination complaints is especially relevant, because it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations.

In addition to a complaints mechanism, there also needs to be a system for data on such complaints to be recorded in a consistent way and in sufficient detail, by all bodies who receive complaints from consumers, to facilitate future analysis across Member States. The ongoing Commission initiative for introducing a harmonised methodology for classifying and reporting consumer complaints could therefore be used as a point of reference for equality bodies and other bodies accepting discrimination complaints to improve data collection. It would also be important to include categories for discrimination complaints (separately by ground of discrimination) into the harmonised methodology.

This leads to the following conclusion:

**32. *The European Commission and Member States could work together with relevant stakeholders to ensure that consumers have adequate access to redress mechanisms for discrimination claims in the area of financial services.*** Greater sharing of experience and cooperation between equality bodies and specialised alternative dispute resolution schemes in the area of financial services (especially insurance and banking ombudsman schemes), could help to assist these bodies in settling disputes. Good coordination and signposting of consumers to relevant redress mechanisms for discrimination complaints is especially relevant, because it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations.

### **6.2.5 Codes of good practice**

During the course of this study we have come across useful codes of good practice for insurers concerning HIV risks and implementation of non-discrimination legislation concerning disability. These could be used as a model for developing additional voluntary codes, preferably elaborated by EU industry associations in cooperation with stakeholders (e.g. relevant civil society organisations) to increase the credibility of the codes. Because of differences in national insurance markets it is needed to develop EU level codes that are complemented by national codes of good practice. The codes could provide direction both to insurers and consumers and be a flexible tool to complement Commission guidance for the interpretation of key terms (see above).

For example codes could include guidance on what consumers need to know if they are refused access to a product, thereby increasing transparency in this area, and how they could find alternative providers (see below, signposting). Education and training of staff is a key contributory factor to the success of such codes. Greater knowledge and understanding of non-discrimination principles, as well as guidance regarding proportionality (complementary to Commission guidance, including conditions for decisions to decline cover), illustrated by practical examples, could remedy this situation. Best practices for complaint management and for sectoral agreements concerning declined risks could also be included in the codes.

Additional areas highlighted in the report where such codes might offer guidance and prevent problems are:

- Age and motor insurance;
- Age and travel insurance;<sup>265</sup>
- Age and credit;
- Disability/health conditions and travel insurance;
- Disability/health conditions and private health insurance;
- Disability/health conditions and loan insurance;
- Limitations regarding exclusions, restrictions and waiting periods concerning pregnancy and maternity (to complement Commission guidance, see above);
- Nationality/residence – avoidance of practices which might lead to indirect discrimination on the ground of racial or ethnic origin, for example in access to banking services.

This leads to the following conclusion:

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<sup>265</sup> In the particular area of health related travel insurance, the code of conduct should include informing consumers about cover under the EHIC (European Health Insurance Card) agreement so that consumers are aware that to some degree they may be already covered.

33. **EU industry associations could, in cooperation with relevant stakeholders, develop voluntary codes** that would cover issues such as transparency, complementary guidance regarding proportionality, complaint management, signposting, education/training of staff, best practices for sectoral agreements concerning declined risks etc. Because of differences in national insurance markets, EU level codes would need to be complemented by national codes of good practice.

### 6.2.6 **Sectoral agreements**

At industry level, a flexible and effective approach for declined risks are sectoral agreements that can substitute legislative initiatives. An example for a sectoral agreement which addresses a country-specific problem of how to provide cover for declined risks is the AREAS Convention in France that aims at ensuring access to loan insurance for consumers with aggravated health conditions. Such agreements are particularly important where the financial product concerned is essential for the consumer. EU industry associations could exchange best practices concerning sectoral agreements concerning declined risks and encourage national associations to conclude such agreements.

This leads to the following conclusion:

34. **EU industry associations could exchange best practices concerning sectoral agreements on declined risks and encourage national associations to conclude such agreements.** Sectoral agreements are a flexible and effective approach for declined high-risk consumers that can substitute legislative initiatives. An example for a sectoral agreement which addresses a country-specific problem of how to provide cover for declined risks is the AREAS Convention in France that aims at ensuring access to loan insurance for consumers with aggravated health conditions. Such agreements are particularly important where the financial product concerned is essential for the consumer.

### 6.2.7 **Signposting systems**

Consumers who are insurable but have difficulties to find an appropriate provider can be helped through improved signposting/information systems. These ensure that consumers who are declined by one insurer are given advice on finding an alternative, which could be a specialist provider. The feasibility and method of practical implementation of this depends on each national market, the key requirement being maintenance of an up to date list of providers who specialise in or offer products to groups who may be rejected by insurers, and providing appropriate contact details to consumers. In Member States where there is a strong broker element to the market, a

broker association (such as BIBA in the UK<sup>266</sup>) can act as a route to find a specialist provider. Another model is the Swedish Consumers Insurance Bureau which publish different types of product overviews of many forms of consumer insurances.<sup>267</sup> Market overviews and tests prepared by independent consumer organisations or other independent agencies and funded by government or industry levies could contribute to more transparency for consumers, including for vulnerable subgroups such as elderly and disabled persons, concerning financial products and help them select the most appropriate provider.

A signposting system needs to be tailored to the requirements of those who need it most in terms of method of delivery, so telephone access in addition to the internet should be incorporated. The European Commission could encourage Member States to develop signposting systems and coordinate examples of good practice to enable Member States to develop a model that is suitable for their market.

This leads to the following conclusion:

**35. Member States could develop signposting systems tailored to the characteristics of each national market.** These ensure that consumers who are declined by one insurer are given advice on finding an alternative, which could be a specialist provider. The feasibility and method of practical implementation of this depends on each national market, the key requirement being maintenance of an up to date list of providers who specialise in or offer products to groups who may be rejected by insurers, and providing appropriate contact details to consumers. Market overviews and tests prepared by independent consumer organisations or other independent agencies and funded by government or industry levies could contribute to more transparency for consumers, including for vulnerable subgroups such as elderly and disabled persons, concerning financial products and help them select the most appropriate provider.

*The options described in this chapter are presented in the following overview table, which also provides a preliminary assessment of potential consequences.*

<sup>266</sup> See country report UK, Part II.

<sup>267</sup> The overviews compares the Swedish companies insurance terms, for example motor and travel insurance. In total, the Bureau has 33 overviews.

**Table 10: Overview of recommendations for possible action at EU, national and industry level and consequences**

Possible action	Level	Description	Potential benefits / positive consequences	Potential costs / negative consequences
<b>Conducting a representative consumer survey in all EU Member States</b>	EU	The European Commission would conduct a representative consumer survey in all EU Member States to establish the scale of the problems, which is currently unclear because of likely underreporting of complaints. This would provide evidence regarding the extent to which consumers have experienced denial of access to specified financial products (the main cause of complaints) and regarding the extent to which consumers perceive they have experienced discrimination in the provision of financial services. More detailed questions could be included in a special Eurobarometer survey. To safeguard acceptance of results across all stakeholder groups, survey questions could be discussed in the framework of the Dialogue on the use of age and disability in financial services.	More focused, evidence-based policy. It is also possible that a clearer evidence-base brings the diverging views of industry and civil society organisation closer together which would facilitate future cooperation.	If questions are incorporated into a planned Eurobarometer survey, the additional costs relate mainly in carrying out the analysis of the data on this specific area and the costs of oversampling specific subgroups such as disabled persons.
<b>Review process according Article 5(2) of the Gender Directive</b>	EU MS Industry	The review process for Member States that have used the opt-out provision according to Article 5(2) of the Gender Directive could be used to provide additional evidence concerning the impacts of the introduction of unisex premiums. In the review process, the relevant authorities of the Member States could invite service providers and their organisations to evaluate their data on operating costs, product prices, volume of sales and number of providers after the introduction of unisex rates (in those countries that have require them for certain products).	Evidence collected in a consistent format across Member States would underpin future policy-making. A harmonised template for the review process can reduce administrative efforts at Member State level.	As Member States are obliged to conduct a review, there are no additional cost involved.
<b>Guidance for interpretation of key terms</b>	EU	After consultation with stakeholders, the European Commission could issue a binding or non-binding guidance document, which would provide general principles and harmonised definitions of key terms. It could also clarify if exclusions, restrictions and waiting periods for pregnant women that wish to conclude an insurance contract e.g. for health insurance, are in line with the provisions of the Gender Directive which prohibits “less favourable treatment of women for reasons of pregnancy and maternity”. This guidance could be accompanied by a ‘gray list’ or ‘blacklist’ of specific practices of financial services providers related to evidence and proportionality could be developed. The grey list would describe practices which are prima facie considered to be not proportionate, although they can be acceptable under certain circumstances. The blacklist would describe practices that are not considered to be proportionate in all circumstances. This would create clarity for insurers and courts.	Benefits lie in greater clarity for stakeholders. For industry this helps to reduce uncertainty and facilitates cross-border competition. For advice and enforcement agencies clarity helps provide accurate guidance to consumers and more efficient use of resources in pursuing cases.	Costs of developing, publishing and promoting guidelines.
<b>Consumer complaints infrastructure</b>	EU MS	The European Commission and Member States could work together with relevant stakeholders to ensure that consumers have adequate access to redress mechanisms for discrimination claims in the area of financial services. Greater sharing of experience and	Consumers would benefit from better redress, policy makers would benefit from	As equality bodies currently exist in all countries and to varying extents collect and record complaints data

<b>and reporting</b>		cooperation between equality bodies and specialised alternative dispute resolution schemes in the area of financial services (especially insurance and banking ombudsman schemes), could help to assist these bodies in settling disputes. Good coordination and signposting of consumers to relevant redress mechanisms for discrimination complaints is especially relevant, because it is unclear how many of the existing consumer complaints bodies are dealing with complaints concerning problems that occur prior to the conclusion of a contract (e.g. denial of an insurance cover), as they generally focus on problems resulting from the performance of contractual obligations.	better data on complaints.	this recommendation is an enhancement on that system, a clarification of responsibilities and a coordination of the way data is recorded. Additional costs are limited and mainly related to training and coordination activities.
<b>Codes of good practice</b>	Industry (EU and national level)	EU industry associations could, in cooperation with relevant stakeholders, develop voluntary codes that would cover issues such as transparency, complementary guidance regarding proportionality, complaint management, signposting, education/training of staff, best practices for sectoral agreements concerning declined risks etc. Because of differences in national insurance markets, EU level codes would need to be complemented by national codes of good practice.	Benefits would include improved industry practices, greater clarity for staff training and consistency across Member States.	Limited costs for developing the codes of good conduct. Additional costs for publicising these within countries, depending on scale of publicising.
<b>Sectoral Agreements</b>	Industry (EU and national level)	EU industry associations could exchange best practices concerning sectoral agreements on declined risks and encourage national associations to conclude such agreements. Sectoral agreements are a flexible and effective approach for declined high-risk consumers that can substitute legislative initiatives. An example for a sectoral agreement which addresses a country-specific problem of how to provide cover for declined risks is the AREAS Convention in France that aims at ensuring access to loan insurance for consumers with aggravated health conditions. Such agreements are particularly important where the financial product concerned is essential for the consumer.	Increased access for consumers that are considered a high risk to products that are subject to the agreement.	Costs of setting up the agreement and possibly substantial costs, if coverage for high-risk consumers is subsidised by providers or the government. As the number of potentially covered consumers depends on the national market and the product, implementation costs will vary.
<b>Signposting</b>	EU MS	Member States could develop signposting systems tailored to the characteristics of each national market. These ensure that consumers who are declined by one insurer are given advice on finding an alternative, which could be a specialist provider. The feasibility and method of practical implementation of this depends on each national market, the key requirement being maintenance of an up to date list of providers who specialise in or offer products to groups who may be rejected by insurers, and providing appropriate contact details to consumers. Market overviews and tests prepared by independent consumer organisations or other independent agencies and funded by government or industry levies could contribute to more transparency for consumers, including for vulnerable subgroups such as elderly and disabled persons, concerning financial products and help them select the most appropriate provider.	Participation in the market of those who would otherwise be excluded from it.	As signposting systems depend on the national market, the costs will vary. Such a system will only work in a market where there are niche providers offering products to specialist groups. There is a cost in preparing market over-views or tests and maintaining an up to date list of insurers offering specialised products and in running a service which links consumers with these insurers.