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Non-medical implications of malignant melanoma

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SUMMARY. **Insurance and mortgage companies continue to regard melanoma in a rigid and perhaps flawed way, with detrimental effect to patients' financial standing.**

We questioned 100 consecutive patients coming to our clinic between the ages of 20 and 50, and asked if they had had problems obtaining life insurance, mortgages *etc*, since they were diagnosed. A substantial proportion of patients in the younger age groups had problems with mortgage and insurance applications.

In our dealings with patients suffering from malignant melanoma we are all too aware of the physical and psychological effects on the patient. As doctors, we are trained in diagnosis and treatment, and are thus able to cope to a greater or lesser degree with these problems. However, the patient can often run into much more materialistic problems following his or her diagnosis. Obtaining a mortgage, loans and life insurance can be difficult, if not impossible.

We performed a simple outpatient survey of our patients to assess the size of the problem. We also approached several of the larger insurance companies and asked them their policies.

Materials and methods

A simple anonymous questionnaire was given to our patients when they attended the clinic. These were filled in whilst waiting. We asked for age, sex, whether they had encountered problems, and if so, what they were.

Results

One hundred questionnaires were given out, to which we had 85 replies, 63 female and 22 male, which fits with the roughly 2:1 female:male ratios of melanoma incidence.

Of those who replied, 49 said that problems of mortgage/insurance did not apply as they had obtained their mortgages *etc* before their diagnosis, or had never applied.

The sex ratio in this group was 6.5 female:1 male, and the average age was 50.1 years.

At least one patient admitted to not applying for a mortgage or life insurance, as he/she assumed automatic rejection. One accountant anticipated his diagnosis and its possible consequences, so took out full cover before consulting his doctor. This ensured his and his family's financial security, but delayed his diagnosis and treatment.

In the group that admitted to some applications, 36 in all, the sex ratio was 1:4 female:male with an average age of 38.0 years, which was thus a younger group with a more even sex distribution. Fifteen had had their applications accepted (although most of the mortgage and life insurance policies required no medical). One obtained a health insurance policy with increased premiums. Seventeen patients had had their applications rejected outright. Eleven of these were for mortgages or life insurances, one for a pension plan, and one for inheritance tax. Two were awaiting the outcome of life insurance applications. One patient had been refused emigration, and three refused entrance into the armed forces on the grounds of their disease.

Discussion

From our results it would seem that a significant proportion of our patients do have some financial problems arising from their diagnosis. Obviously this applies less to the older age groups as they have usually already arranged their mortgages, life insurances and pensions. Most of the females in this group were married and their husbands had the policies.

The problem affects mainly the younger age groups, as one would expect, where they have still to arrange their policies. More of the females in this age group are single and financially independent, so that the sex distribution is more evenly spread. Although we would not expect insurance companies to give policies on poor prognosis tumours unless highly weighted, we would hope that good prognosis tumours might be treated better.

When we approached the companies we found that they had very strict guidelines depending on the histological features.[1,2,3] From this, policies were either granted at normal rates, weighted or deferred for a variable period before being granted (but weighted). However, there was no set rule for all the companies, although they generally fell into two groups—either allowing up to 0.5 mm depth at stan-

dard rates, or up to 0.6 mm. Above these levels, a similar arrangement of weighting or deferral operates. It is interesting to note that in most papers, 1.0 mm thickness is taken as being a thin, good prognosis melanoma, and certainly 0.75 mm.[4] Often the histologist may only give the thickness as less than one of these levels. If no histology at all is available to the company, the patient falls into an intermediate group which may be worse than necessary.

Of the three patients refused entry into the armed forces, two are known to have had thin (0.75 mm) tumours, treated by simple excision and suture. Their prognosis is excellent, with a 5-year survival over 95 % (probably as good as a healthy soldier). Yet they were refused entry, despite being eligible in every other way.

The reasoning behind the armed forces' refusal remains a mystery. The idea that the patient may be posted too far away from medical aid in case of an emergency in this age of technology and transport is not justified. In any case very few problems of the disease require emergency treatment. We suspect the reason is financial, as they may be liable to a large pension if the patient had to retire on grounds of ill health.

We have shown that a significant proportion of our younger patients do run into a variety of financial problems following the diagnosis of malignant melanoma. (Some have got round this by using their spouse's name on their policies.) Whilst we do not expect companies to issue policies without some form of screening, perhaps their protocols could be brought more into line with medical thinking. The thickness of tumours at which normal rate policies are given should certainly be increased.

The armed forces and emigration bureaux could also be brought up to date.

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