INSTITUTE AND FACULTY OF ACTUARIES

EXAMINERS' REPORT

September 2011 examinations

Subject ST1 — Health & Care Specialist Technical

Purpose of Examiners' Reports

The Examiners' Report is written by the Principal Examiner with the aim of helping candidates, both those who are sitting the examination for the first time and who are using past papers as a revision aid, and also those who have previously failed the subject. The Examiners are charged by Council with examining the published syllabus. Although Examiners have access to the Core Reading, which is designed to interpret the syllabus, the Examiners are not required to examine the content of Core Reading. Notwithstanding that, the questions set, and the following comments, will generally be based on Core Reading.

For numerical questions the Examiners' preferred approach to the solution is reproduced in this report. Other valid approaches are always given appropriate credit; where there is a commonly used alternative approach, this is also noted in the report. For essay-style questions, and particularly the open-ended questions in the later subjects, this report contains all the points for which the Examiners awarded marks. This is much more than a model solution – it would be impossible to write down all the points in the report in the time allowed for the question.

T J Birse
Chairman of the Board of Examiners

December 2011

General comments on Subject ST1

Candidates who approach the questions, especially the more substantial elements of each question, in a methodical and detailed manner are far more likely to pass the subject. Candidates will gain few marks if they do not address the question asked but merely write around the topic of the question. The mark allocation for each question part gives an indication of the relative length of answer or number of points to be made to gain full marks. In general each valid point in the answer would normally attract 0.5 marks with the more basic elements e.g. details in a pricing basis such as age and sex, attracting 0.25 marks, and key points gaining 1 mark.

It is often helpful to use subheadings when answering long part questions.

Comments on the September 2011 paper

Although the paper was towards the more difficult end of the range, the general performance was better than in April 2011 with well-prepared candidates scoring well across most of the paper. As in previous diets, questions that required an element of explanation or analysis were less well answered than those that just involved calculation. In particular, many candidates found it difficult to gain many marks on questions 3 and 4. The comments that follow the questions concentrate on areas where candidates could have improved their performance. Candidates approaching the subject for the first time are advised to concentrate their revision in these areas.

1 (i) Principles of setting statutory reserves:

The amount of the reserves should be such as to ensure that all liabilities arising out of insurance contracts can be met by the insurance company. The amount of the reserves should be calculated by a suitably prudent valuation of all future liabilities for all existing policies including guaranteed benefits, options available to the policyholder, expenses, including commission, and taking credit for the premiums which are due to be paid under the terms of each policy in the future.

A prudent valuation is not a "best estimate" valuation, i.e. neither too much nor too little, but should include an appropriate margin for adverse deviation of the relevant factors.

The valuation should take account of the nature, term and method of valuation of the corresponding assets, depending on the type of policy.

The use of appropriate approximations or generalisations should be allowed.

The rate of interest (where appropriate) used in the calculation of the reserves should be chosen prudently, taking into account the currency in which the policy is denominated, having regard to the yields on the corresponding existing assets and to the yield which it is expected will be obtained on sums to be invested in the future.

The statistical elements of the basis, that is the demographic and persistency assumptions, should be chosen prudently, having regard to the type of insurance, as should the allowance for expenses used in the calculation, the territory of the persons insured, and the administrative costs and commission expected to be incurred.

If a valuation method defines in advance the amount of expenses to be used in the valuation, the amount so defined should be not less than a prudent estimate of the relevant future expenses.

The method of calculation of the reserves from year to year should be such as to recognise profit in an appropriate way over the duration of each policy and should not be subject to discontinuities arising from arbitrary changes to the valuation basis.

Each insurance company should disclose the methods and bases used in the valuation.

Some actuaries would prefer to strengthen these principles to say that the allowance for expenses should allow for the possibility of the company ceasing to write new business, if that would increase the reserve.

The setting and calculation of statutory reserves must comply with local statutory requirements.

(ii) Checks to ensure statutory reserves are accurate:

Cross-check carefully a printout of the model input parameters against a list of the required assumptions, by product.

Break down the results, as this makes it easier to find mistakes. Valuation class or product level would be appropriate.

Compare the values with those from the last exercise and investigate any very large changes. Check for any areas where business has "vanished", as this probably indicates an error.

Check some summary statistics, such as total sum assured, between those implied by the data and those output by the reserving programming, to ensure no data points have been lost.

Compare the size of the reserves with the number of policies, for both this time and last time, to give a rough check.
Consider the direction of the changes – should reserves have gone up (if new business is being written) or down (if the business is running off and the reserves are unwinding). Need to estimate/adjust for the effect of basis changes.
Are there seasonal variations in the reserves – e.g. IBNR reserves may be higher in winter months for some classes of business. Look back at previous levels of reserves.
Look at the reserve for one sample policy (or several if time). Estimate the value of the reserve manually, and compare with the value the program has produced.
Explain movements between current and previous reserves or perform an analysis of surplus.
Compare results against other investigations the company is carrying out.
Making use of benchmarking publications, if available.
Check against regulatory or other relevant guidance.

In general this question was well answered. Part (i) of this question is straight bookwork, well answered by those who were familiar with the Core Reading. Part (ii) was more difficult but was also generally well answered - the Core Reading points in the direction of several of the points which might be made.

2 (i) It could be similar but not identical to that used on income protection business, if such an investigation has already been performed by the CMIBA.
A survey of data kept by existing CI insurers will be needed.
There may already be a consensus of opinion or consistency of approach.
The classification may be weighted by size of CI claims for each insurer.
Data collected should be sufficient to give credible experience.
Advice and information may also be needed from reinsurers or consultants.
The CMIBA could consider similar classifications used by experience investigation bureaux in other countries.
There may be a regulatory standard or guidance that should be followed.
Occupations would need to be grouped into classes so that there is relatively homogenous experience in each class. Need to generate an appropriate number of classes. The draft occupation classification can then be developed and circulated for discussion and approval.
It will be necessary to create a 1-to-1 conversion table from each contributing office's data to the CMIBA classification.

(ii) Recording of sex in the data and investigations should be straightforward.
Marital status should be broken down into:
- Single
- Married/civil partnership
- Divorced/separated
- Widow/ered
- Living together but not married.

Need to decide if required at inception or at status of claim.

The data may be incomplete on marital status, for example for joint life policies.
There may be a lack of data in some cells, therefore not credible.
Changes in classification (predominantly of marital status) may lead to compromises on what can be used.

(iii) Would provide useful information for other insurance companies writing small amounts of this business. However, the CMIBA will need to obtain the permission of each office to publish. The main issue is that the two offices will be able to estimate their competitor's experience knowing the complete experience and their own data.
The data may not be homogenous, e.g. the two companies may have different definitions, and difficult for other users to make the appropriate adjustments.
Should seek the views of the regulator and other interested parties (e.g. other smaller insurers).

(iv) Easier for customers and distributors to understand and compare products and less hassle in the sales process, particularly as there will will be limited medical underwriting. Overall market new business levels might therefore increase.
The insurers' expenses will reduce, e.g. no medical underwriting costs, no pricing calculations to perform.
There is less scope for anti-selection as can't go to insurer with least underwriting and for disputes at claim stage.
However, insurers are no longer able to apply premium loadings based on medical underwriting. They may still be able to decline business based on proposal form answers but overall the scope for underwriting appears to be considerably limited. Insurers may decide to decline a high proportion of business based on proposal form answers, in order to be prudent and to manage the average claim experience. This will result in those in less good health becoming uninsurable; whereas if full underwriting had been permitted then they may have been provided with cover, albeit restricted.
Since the proposal is applicable to all insurers, this reduces the potential for anti-selection between companies based on differing strictness of underwriting but it is still possible that the overall claim rates will increase because those who previously would have been rated may now be more inclined to take out insurance.
It will be difficult for the insurer to anticipate the average standard of health within its portfolio in order to determine whether it will be profitable to offer this business.
Need to consider whether reinsurers will be prepared to accept this business.
May need to hold higher reserves, at least initially, due to increased uncertainty regarding likely claim rates.
Competitive advantage would have to be based on something else now rather than on policy design or price, for example service levels or it may be commission driven.
There also does not appear to be any scope to amend the medical conditions covered, so products may fall behind customers' requirements (depending on how frequently the standard terms are updated).
May need a one-off change to systems with related cost.

The main way to obtain higher profit per policy will now be through low costs, therefore it may be difficult for smaller companies / new entrants.
Harder to differentiate product and stifles innovation.
CI business in the market may not be attractive to insurers so capacity in the market may be reduced.

This was a difficult question. In part (i) many candidates did not appear to understand the practical aspects, with most apparently answering a slightly different question (e.g. why would you do it).
Candidates generally scored reasonably well on parts (ii) and (iii).
In part (iv) some students made comments about setting premiums, but these are not valid, as the question states that rates will also be defined.

3 Check whether staff have any existing health insurance benefits as part of their benefit package.

Doctors and nurses:
Will probably receive standard health treatment from within the clinic as part of their employment contract, although doctors may be entitled to more than nurses.
PMI may be needed but only with quite a high excess.
Health cash plans are unlikely to be needed.
Income protection will be desirable, particularly for younger members of staff, (to cover, for example, monthly mortgage payment or salary replacement) but only to such an age as to not provide an overlapping benefit with the ill health early retirement. Again, this may vary between doctors and nurses.
The precise details of the cover will need to be investigated so that someone is not materially disadvantaged by falling ill just before or just after a significant birthday.
Critical illness would be a useful benefit, to cover, for example, a mortgage. This is unlikely to be covered by any other benefits available from working at the clinic.
The ready access to health care will affect the propensity to claim – this should be reflected in the price offered.

Clerical staff:
Most relevant points are similar to those for doctors and nurses, however income protection would need to be a more comprehensive cover and the insurer should check whether the clerical staff have the same access to health care as the medical staff.

General
Possible benefits to employer include attracting/retaining good staff. Also, staff may return to work quicker.
The staff may value/see the need for these products more than the general population.
Moral hazard/anti-selection – the staff may be in a better position to exploit the insurance eg expensive treatment, friendly doctor to sign off IP, earlier knowledge of impending pre-existing illness.
The degree to which State provides benefits and potential overlap should be considered.
Consider the affordability of the benefits if staff are required to contribute; doctors are more likely to be able to afford them. May need to offer different options to different

staff and different levels of excess and there may be different incapacity definitions used.
Compare with what is offered at other practices.

This was a challenging question and candidates struggled to come up with many of the points available. Many candidates described product features rather than why or how the product may be appropriate for this group of individuals. Few candidates considered how potential benefits should complement existing benefits or the specific needs of this group. Very few candidates considered the differing needs of doctors, nurses and support staff.

4 Improve the efficiency of the IT systems.
Integrate the IT platforms and database.
Use model points instead of policy by policy approach.
Consider using data from an earlier period and using roll forward techniques wherever possible.
Reduce the level of manual calculations/valuation procedure.
Produce robust revenue account forecasts at the same level of detail as accounting information is held; actuarial balance sheet liabilities at the same level as accounting information.
Integrate models. e.g. tax models.
Ensure timely production of internal data/information. Negotiate timely supply of information from third party providers and reinsurers.
Reduce the number of stochastic runs to a level that is appropriate to the size, nature and complexity of the business.
Reduce the projection frequency period (e.g. monthly to annual) if it doesn't compromise accuracy.
Simplify the expense allocation processes.
Use appropriate simplifications based on materiality.
Streamline the production process of disclosures and other non financial data not supported by systems.
Identify and remove duplicated effort created by separate teams doing similar work.
Streamline the data checking process such that many of the potential errors could be identified and corrected at an early stage of the valuation process. Build automated checks into the projection system, which would flag up inconsistencies automatically in output results and so can more quickly be fixed.
Clarify accountability and roles and responsibilities (poor accountability is often a cause of delay).
Streamline the population of end user applications.
Reduce the number of reports, streamline to one version for all interested stakeholders.
Build key analytics ahead of time.
Gain a thorough understanding of what management needs. Improve the quality and relevance of the management information to help speed the management review and quality processes.
Review governance structures and timetables – inefficiencies in this area can cause unnecessary lags and re-work.
Identify whether outputs can be used for more than one reporting purpose.
Make use of internal/external programme management specialists to spot inefficiencies.

Have good quality process documentation.
Assign project manager to manage the reporting process.
Regular meetings and updates between those producing the results, to encourage full knowledge sharing.
Hold a review (e.g. just after a recent reporting exercise) in order to identify the key inefficiencies, so that know where to focus improvement efforts.
Engage auditors/reviewers early on in the process.
Have ongoing staff training.
Outsource if more efficient, with deadlines enforced by SLA.
Keep up-to-date with regulatory changes as they are announced.

This was often found to be a challenging question. It should be noted that the command word is "Suggest" rather than "Describe"/"Discuss" etc – a detailed discussion of the ways efficiency could be improved was not required. Several candidates went completely down the wrong track, by describing the actual tasks involved in the reporting process rather than how to improve it, as the question asked.

5 (i) Pricing factors

The number of employees recruited would be needed, to "size" each policy in relation to number of claims. This may need to be estimated in advance, and therefore a "true-up" premium may be required at the end of the year.
Depending on the product structure, this might alternatively be proxied using number of employees (which would eliminate the need to "true up" but would bring in additional risks).
Another factor would be needed to "size" the policy in relation to the benefit size. This is likely to be related to salary level, so salary of employees recruited might be used. However, if the product is sold based on number of employees, this would be related to total annual salary.
Some adjustment would be needed in the pricing to allow for the fact that one might expect a company to have a salary distribution of a large number of relatively lowly paid staff and a smaller number of more highly paid staff.
Need to take into account the method of recruitment used by the company, as the product also covers recruitment costs.
The type of work undertaken would be relevant to the pricing of the policy. For an annual policy, the relevant rating factor might be the industry the company operates in and the split of blue and white collar workers. For a "per-employment" policy, the pricing could be based on the occupation of the role concerned.
The age of the individual would affect the likelihood of a claim – again the rating factor here would depend on the type of policy taken out. The sex of the individual employed would also affect the likelihood of a claim, and so this may be used as a rating factor. Location would be likely to affect the number of claims – it is less likely, however, that this would be used as a rating factor.
Distribution channel - closeness to/cooperation with employer.
The intention is to use the suggested factors as a proxy for health related questions not being asked.
It is possible that there may be a profit-sharing arrangement. This would only be the case for large employers.

(ii) Volume risk: risk of low take up – so that development costs are not recouped. This could be because there is no interest in the product (i.e. employers do not view this as a risk that warrants insurance, little recruitment due to a recession) or because the price is set too high or action of competitors. Alternatively, if the product is extremely successful, then the admin teams may be unable to cope and there may be excessive strain on capital resources.
Mitigation: thorough market research before too much development costs are incurred to gauge uptake, and to assess what a reasonable price would be, including liaison with distribution channel, which is likely to be specialised brokers.
The risk of renewal rates being lower than expected.
Mitigation: through appropriate remuneration structure / incentives to distributors or market / advertise the product well.
Risk of pricing too low, so that losses are incurred. This is exacerbated through not having experience data for this specific type of business.
Morbidity risk: there could be more claims than expected. Claim amounts may be higher than expected, e.g. due to longer periods of sickness than expected or, for the annual policy, due to higher than expected salaries or higher recruitment costs than the average allowed for or due to a higher number of recruitments than expected.
Mitigation: tight claims controls. Thorough research, data collection and careful pricing including margins. Reinsurance may be available to share the risk. However, it may not be available, or only at a prohibitive price so the company should engage early with reinsurers and if no reinsurer can be enticed in, consider co-insurance with another direct writer.
Change product design, for example, place a cap on the amount that may be paid out, increase the deferred period, reduce coverage period, cover salary or recruitment costs but not both.
Ensure no guarantees are in place on the price, so that the price can be increased in the light of poor experience.
The pricing risk is increased due to the guaranteed acceptance, as the insurer may be constrained in the extent to which it can increase the price.
Mitigation: remove this feature or stop selling the product.
The pricing/claims risk is increased due to aggregation by industry/location.
Mitigation: try to sell across wider range of employers/locations.
Expenses may be higher than those assumed in the pricing basis, leading to losses on the business.
Mitigation: thorough bottom-up analysis of the expense model. Outsource the administration of the product, if a fixed price contract can be negotiated.
Moral hazard and anti-selection: Employers with this contract may take less care to ensure they employ individuals they believe will be able to attend and contribute. More extremely, they may employ friends or relatives they know to be unable to work.
Mitigation: profit sharing and other experience rating mechanisms will limit the impact. Place a cap on benefits so that the product does not provide full indemnity. Ensure the employer is motivated to retain staff, for example by not indemnifying training costs. Require the employer to cover all recruits for all roles.
Regulation – there may be difficulties in getting such an innovative product agreed by the regulator and future regulatory changes might cause problems.

Mitigation: early engagement with the regulator and ongoing lobbying.
Legislation change – the ban could be reversed when a new government takes over, or if employers lobby hard and are successful. In that case, the insurer would lose their investment in developing this product.
Mitigation: delay product development until the legislation is embedded.

In general, part (i) was well answered although some candidates did not explain the factors, as required. Not all candidates appreciated that this is a product sold to the employer and thus it is effectively the employer that is rated - some of the suggestions provided were more appropriate for rating an individual, and would not be information to which the employer is likely to have access (for example, dangerous hobbies).
In part (ii), candidates who applied their knowledge to the particular scenario scored well. However, suggestions about generic risks such as operational risks, flood/fire etc that the company would face anyway, irrespective of writing this product, did not answer the specific question asked and gained no marks.

6 (i)

Generally only covers acute conditions
Indemnity basis, possibly subject to limits
Annually renewable

Hospital costs or day care operations
For in-patient treatment:
- Accommodation
- Nursing care
- Operating theatre
- Diagnostic procedures
- Surgical dressings
- Drugs

Specialist consultations and physiotherapy received as an inpatient.
Accommodation for one parent to stay in hospital with an insured dependant under 12 years old.

Specialist Fees
Surgeons' and anaesthetists' fees for in-patient and day care operations and physicians' fees for in-patient treatment
Out-patient treatment
Specialist consultations
Diagnostic procedures such as radiology and pathology
Physiotherapy
Radiotherapy, chemotherapy and scanning

Other Features
Private Ambulance
Recuperative care, to include nursing and domestic services
Overseas cover
Cash payments for treatment received as an inpatient on a State healthcare funded basis

(ii) Drug abuse
Alcohol abuse
Self-inflicted injuries/suicide
Out-patient drugs and dressings
HIV/AIDS
Normal pregnancy
Cosmetic surgery
Gender reassignment (also known as sex change)
Preventative treatment
Kidney dialysis
Mobility aids
Experimental treatment/drugs
Organ transplant
War risks
Injuries arising from dangerous hobbies (often called hazardous pursuits).
Chronic conditions
Pre-existing conditions
Failure to follow medical advice
Illegal acts

(iii) Better risk control.
Prevent anti-selection, particularly of pre-existing conditions.
Reduce moral hazard e.g. injuries arising from participation in reckless activities, self-inflicted injuries, cosmetic surgery.
Protect the company against extreme and unpredictable events, e.g. arising from war or terrorism.
Excludes risks that are difficult to price.
Excludes risks that might have too high a cost if loaded into the premium.
Protective effect throughout lifetime of policy.
Provide a deterrent at the outset.
Define benefit limitations and increase customer certainty.
Align pricing assumptions with risk exposure.
Reduce underwriting expenses and effort.
Speed up the application process.
Avoid bad publicity in specific areas, e.g. experimental medical treatment that goes wrong.
Some benefits are covered elsewhere, e.g. by the State.
Keep in line with competitors.
Some exclusions may be mandatory or required by the regulator e.g. it may be unlawful to provide a benefit if injured as a result of committing an illegal act (e.g. terrorism).

(iv) Risk of being perceived as hiding behind the small print/risk of being perceived as not treating customers fairly.
Doesn't meet customers' needs.
Not always noticed or well understood.
Exclusions are not popular with policyholders and leave gaps in cover.
Insurer can be in an uncomfortable position when declining claims. This could lead to potential complaints, even legal actions. If legal ruling is in

favour of policyholder, this could set a precedent of expected additional future claims.
Reputational risk, which can reduce future sales and renewals.
Low volumes insufficient to recoup expenses.
Increased underwriting cost/more cost and work at claim management stage.
May lose business if other competitors don't use these exclusions.

This question was generally well answered. In part (iv) some students mentioned that the exclusions might not be allowed by the regulator – however, this is not a disadvantage of using such exclusions since in that case they would not be allowed to use them in the first place.

7 (i) This would normally be a defined-benefit defined-premium insurance product.
For low premiums, the subscriber and family would be entitled to a cash payment when having treatment or a consultation. Schedules of benefits are bought in "units" with equivalent levels of contribution increase.
Limits may apply to ensure that the payout is no more than, say, 50% of the medical bill or there may be a maximum payment per treatment. There will usually also be an annual limit on the total payment.
Short-term, annually reviewable.

(ii) **Capitation basis**
This is the practice of charging for cover by forecasting the likely claims on an individual basis and charging this, adjusted for expenses and profit, as the premium. In effect, the insurance company "carves out" the cost of all dental claims and passes this risk on to the provider by giving a proportion of the insurance premium for each person managed to the provider up-front rather than an amount per claim. The insurer and provider agree an amount per annum per person insured

Indemnity basis
This is where the insurer covers pound for pound of treatment delivered subject to any excess or policy limits. Insurers work closely with providers to ensure that applicants are screened initially for pre-existing conditions or imminent treatment, and to ensure that treatment thereafter is in accordance with risk expectation.

(iii) Under the capitation method the provider takes on the main risks:
They may not offer all of the required treatments, so would have to arrange to subcontract to other providers.
The insurer may not be able to find enough physiotherapy practices large enough to be willing to take on these risks.
There may not be sufficient local coverage.
Costs of negotiating with many providers.

Under the indemnity method the insurer retains the main risks:
That the number of patients requiring treatment may be higher than expected and the cost of treatment increases faster than expected.
Pricing risk is more of an issue since a small company.

Pricing will need to be more accurate, with higher margins to allow for the greater uncertainty and don't want to have to increase premiums too much at each annual review date. There are likely to be inadequate data available for pricing purposes. National data may not reflect insured population.
Data will need to be tabulated by age/age group and sex (even if not used).
Systems/admin/staff costs.
Patients will be likely to have more routine physiotherapy appointments than dental. Regular appointments and treatment are at the policyholder's option (doctor referral not required). The cost of routine physiotherapy appointments will be relatively low compared with other types of health treatment:

if reimbursement is 50% of cost there will be many claims for small amounts

if reimbursement is subjected to an excess (unlikely) it will not meet policyholder need and lead to trivial payments.

Need to allow in pricing for moral hazard - physiotherapists may inflate bills (or number of appointments in course of treatment) if insured.
Some claims may be large.
Cost will vary significantly by area; as area is unlikely to be used as a rating factor the claim amount will depend on the location mix of the business sold.
Profitability for the insurer is dependent on long-term policyholder loyalty, cost-efficient claims admission procedures and volumes in force.
Likely to be a low number of policyholders so more difficult to establish suitable average cost per treatment and inception rate to calculate premiums.
More variability in expenses.
There is no previous experience on which to base estimates. Even if an existing plan covers physiotherapy the experience is unlikely to be relevant – policyholders of general plans may forget that it covers physiotherapy treatment; this is unlikely under a physiotherapy plan.
Products are typically community-rated. More difficult to establish a suitable age (range) estimate on which to determine a flat rate premium.
Plan may be particularly attractive to certain segments e.g. sports players, manual workers.
Risk of accumulation of certain lives due to marketing method.
Particular risks due to some illnesses e.g. back problems which may become more prevalent in the population or extend to younger or older ages than at present.
Standard long waiting periods may not meet customer need and reduce sales.
Standard risk reduction procedures e.g. screening for pre-existing conditions or imminent treatment will involve more providers and hence be costly.
Anti-selection risk – may actively target certain groups which recognise their greater need for cover particularly since there would be limited underwriting as low cost.
Competitor price comparison difficult if limited market.
Will be more difficult to identify imminent treatment.
More option of elective treatment which would need to be excluded.
Need to allow for potential changes in the level of State provision of physiotherapy services.

(iv) Contact existing policyholders to advise of the new product
Offer a discount/guaranteed acceptance/no waiting period if add on this plan
Leaflets/posters in suitable locations e.g. doctors' surgeries, hospitals, sports clubs, gyms
Direct marketing
Mailshots, perhaps offering a free gift to encourage enquiries
Telephone selling
Press advertising e.g. advertise in fitness magazines
Internet
Affinity clubs
Unions
Worksite marketing
Organisations aimed at people with specific diseases/injuries

Parts (i) and (ii) were bookwork and generally reasonably well answered.
The question is about pricing the new plan, not all the factors to consider when launching the new plan. In part (iii) points that wandered away from specific pricing considerations into more general product launch/design considerations did not receive many marks. Also the question asks about issues and not about how the pricing should be done; again some candidates provided a description of how the product would be priced rather than thinking about related issues and hence gained few marks.
In part (iv) the command word is "Suggest", so explanations, descriptions and discussions of the methods were not required.

END OF EXAMINERS' REPORT