

e-Protection Review

(incorporating HealthCare Insurance Report)
from Peter Le Beau MBE, Andy Couchman, Kevin Carr

The clock is ticking—conference delegates warned of need for speed

The Coalition Government is still in its honeymoon period, but the health and protection insurance industry has just a few months to get its messages across if it wants to be taken seriously by the new Government, speakers told delegates at the fourth annual **Protection Review** conference in London on 15 July.

In the opening presentation of the day, Richard Hobbs, director, regulatory consulting at **Lansons**, outlined the background to the present political situation and advised the health and protection insurance industry that this was “an opportunity to be influential”.

The theme was continued by the following panel discussion, which included **Cicero's** Mark Twigg, the **ABI's** Nick Kirwan and leading freelance journalist (and past *Money Marketing* editor) John Lappin, as well as IFA Alan Lakey, **Grant Thornton's** Nigel Cooke and **PartnerRe's** John O'Neill. Later panels and speakers also referred to the opportunities for the industry to influence Government policy, as it sought to cut costs.

The industry already offers products that help protect people against events such as illness, disability, unemployment and death and in recent years has started providing more practical help and advice as well as giving financial benefits. As such, its solutions help take some of the burden off the State, which otherwise has to provide welfare benefits. The State is also, arguably, less well placed to provide the help and advice people need—often to help them rebuild their lives.

However, the industry's main products only appeal to a proportion of the population. Only around half of all people have protection cover, with the main focus being on life assurance, even though long term illness or disability is a higher risk and likely to have greater financial implications for most families. ABI stats show that at the end of 2008, 12.6m individual term policies were held, along with 9.9m whole life and 10.4m endowment policies (a figure likely to have fallen since then). This compares to just 411,000 standalone critical illness cover policies (although most CI cover is a rider benefit, usually on a term assurance policy), and 1.9m individual income protection plans.

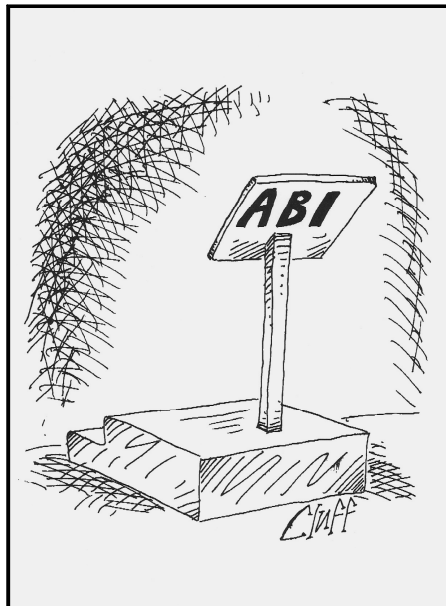
That compares to a working population of just under 30m, indicating that many people have little or no personal protection insurance. (Continued on Page 2).

Quotes of the month:

“With more people living longer, we urgently need to find a fair and sustainable way to pay for the care which many of us will need.” Commission for the Funding of Care and Support chairman Andrew Dilnot, 20 July.

“Younger people see the hot weather as a cause for celebration, tanning and barbecues – but for older people and those with long term health problems, it can be very serious and cause unnecessary deaths.” Yvonne Doyle, Regional Director of Public Health, and heatwave advisor to the Government, 9 July 2010.

‘The Government's ambition is for health outcomes—and quality services—that are among the best in the world.’ DH press release 12 July.



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It's our publication summer break now—next issue on 28 September.

Key statistics:

- NHS waiting lists England to 31 March 2010: 614,121.
- e-Protection Review Long Term Protection Sales Index: 104.3 (Quarter 1, 2010, compared to base 100 in Quarter 1, 2000).
- e-Protection Review Employment Index: 106.590 (To end May 2010, compared to January 2000, see Page 11).

(Continued from Page 1) With many—albeit with notable exceptions—IFAs (independent financial advisers) increasingly focusing on high net worth and high income clients in recent years, the risk is that personal financial advice effectively becomes unavailable to the vast majority of working people, especially as the old large direct salesforces have now largely disappeared.

Outside the protection arena, many advisers now charge fees rather than take commission and this is the route the **FSA (Financial Services Authority)** has advocated in its Retail Distribution Review. As too few consumers express much interest in paying even a minimal fee for protection advice—necessary, as neither schools nor workplaces provide significant training or information on the subject—it is hard to see how protection sales can break through the industry's self-imposed glass ceiling without a fundamental reappraisal of how to access the mass market in future.

Unique opportunity beckons

The theme of working to influence Government policy was echoed by the conference's closing speaker, Professor Sir Mansel Aylward. Changing the opening of his planned presentation, he described in passionate and very effective terms how the industry had a unique opportunity to influence policy but also how important it was for it to speak with one voice.

However, the industry's track record in this area is poor. Senior civil servants talk of meetings where industry representatives have openly disagreed with each other on their preferred policy options, while the plethora of self-interest bodies in the industry means that it is hard for Government to know who to talk to or who can deliver any agreed solutions.

Arguably, the most important body in taking any discussions forward is the ABI. However, just a few minutes before she was due to address the Protection Review dinner at the Marriott, Grosvenor Square on 15 July, it was announced that director general Kerrie Kelly had left to return to Australia for 'personal reasons'.

In her place, the ABI's director of general insurance and health, Nick Starling, made the speech. In it he made the point that one of the challenges the industry faces is that we are an under-protected society. Echoing the theme from earlier in the day he said: "My message tonight is that there is a real opportunity now to take the next big steps."

In an assured and confident address he added: "Given the current financial challenges facing the Government and the increased pressures on an ageing population, it seems certain that in future people will be expected to accept

much more responsibility for their own financial security."

The ABI now has to urgently seek a replacement for Ms Kelly. In the short term, acting DG Maggie Craig is a safe pair of hands (she was acting DG before Ms Kelly took up her position too) and well understands both the industry and the political background. Her team too, including ex-industry product director Nick Kirwan, is experienced and, most recently, has driven through improvements to critical illness cover and private medical insurance policy wordings to give consumers greater confidence and trust in the industry's products.

But the ABI has challenges too apart from who should replace Ms Kelly. It has been criticised for supporting payment protection insurance, when many people believe that the product is fundamentally flawed. It also has to balance the conflicting interests of its larger and smaller member companies, many of whose interests are almost diametrically opposed.

Part of the ABI's vision going forward is for State benefits such as Employment and Support Allowance and Jobseeker's Allowance to be 'altered to interact with the private insurance market'. Doing so "makes sense for people who can afford it to make an active choice about whether to make a private arrangement or to continue to rely on State benefits which they would pay for through the tax system", Mr Starling told the dinner's 400 plus

guests. The ABI had already done some preliminary analysis and believes that there "is potential for this vision to become a reality and for significant savings to be achieved for the Government." he added.

The ABI's vision is however not for existing products to fulfil this role but "we need to design better products that people understand, can easily access, and that are affordable."

Such products are likely to be aimed at the mass market and that may mean radically different solutions in terms of risk assessment and distribution.

Risk sharing is one option to avoid insurer's 'cherry picking' risks. Under such arrangements, insurers who take on higher risks are effectively compensated by insurers who take on lighter risks. However, such systems can be complex to administer and may be deemed unfair by those providers who believe that such (often retrospective) adjustments are biased against them. In Ireland, for example, **Bupa** pulled out of offering health insurance partly for this reason.

The traditional commission-led broker/IFA model may also be deemed to be too costly and too small to advise the many millions of people who should be considering such products. Instead, workplace advice, along with greater public education and the use of technology to explain needs as well as features and benefits is likely to be needed if such a scheme is to prove viable.

Products of the future?

Jonathan Gunby, a director of **NMG Group** gave a presentation to the conference on products of the future. In doing so, he highlighted the fact that protection hadn't really grown in the UK in recent years. In fact, the number of individual policies held had fallen from 43m in 1999 to 29m in 2008—although part of that fall was due to the decimation of the mortgage endowment market since then.

In looking at other product possibilities he highlighted the fact that, so far, investment platforms did not include protection products, a situation that is likely to change soon.

Looking at international markets, he highlighted:

- Turkish insurer **Garanti Emeklilik** sells critical illness cover (£5,000) through bank ATMs and reports a 5-10% take-up rate.
- Many South African insurers offer **Zimele** (it means 'stand on your own two feet' in Zulu) branded products—simple, low cost cover for those earning less than R3,000 a month.
- **Insurance Shopper** has an iPhone insurance app in the USA.
- In New Zealand, **Intelligent Life** has a simple term platform.
- Colombian electricity supplier **Codensa** offers life and funeral cover plans to its consumers through **Mapfre**.

PMI market down in 2009

Two recent reports have highlighted how private medical insurance (PMI) has suffered during the recession.

Analysts **Laing & Buisson** reported in July that in 2009 the number of PMI policies held (including medical schemes self-insured by employers) fell by 4.8% to 4.112m. The total number of people insured under such schemes at the start of 2010 was 7.238m, representing 11.7% of the UK's population.

Company funded policies fell by 4.7% in 2009 to 3.050m, having increased by 0.7% in 2008. The fall was mainly due to widespread job losses and consequent policy lapses increasing.

In the individual market, policies held fell by 5.2% to a new low of 1.062m, following rises of 1.6% in 2008 and 0.7% in 2007. Laing & Buisson (L&B) says this was due to very low new business in 2009, as consumers tightened their belts and held back from new PMI purchases. Lapse rates were however kept in check.

PMI revenues were up from £3.468m in 2008 to £3.58bn in 2009, but the analysts point out that this represented a 1.4% fall in real terms (allowing for RPI inflation). Even so, PMI continued its long term trend of revenues rising each year. A common feature however was consumers looking to trade down on their cover in order to reduce premium costs or increases. Claims costs rose 1% in real terms.

In the health cash plan (HCP) market, contributors fell by 5.3% in 2009 to £2.761m, following a rise of 1.6% in 2008 and 3% in 2007. The individual and employee paid sector fell by 12% in 2008 and 2009. Many individuals cut back on non-essential spending during this period, L&B says.

However, to some extent that fall was offset by a 36% increase in 2008 and 2009 in employer paid plans—which now cover 399,000 people. 'Despite the recession, employers have shown an increasing willingness to fund a low ticket health and wellbeing product' L&B says.

Overall, HCP premiums decreased by 1.9% in 2009 to £488m, underpinned by marginally higher average premiums. Benefits paid declined by 7.1% in real terms to £334m which L&B attributes to a marked reduction in healthcare spending during the recession.

The number of subscribers to dental plans fell 2% in 2009 to 3.259m, following growth of 1.5% in 2008, 10% in 2007 and 31% in 2006. The vast majority of these (81.5%) were in dental capitation plans. Overall the capitation sector fell by 2.1% in 2009 and the dental insurance sector by 1.3%.

Spending on standalone dental cover reached £553m in 2009, with £477m spent on private capitation fees and £75.8m on dental insurance premiums.

Laing & Buisson's *Health & Care Cover—UK Market Report 2010* costs £795 from www.laingbuisson.co.uk.

On 19 July the **ABI (Association of British Insurers)** revealed its latest data on PMI sales.

It recorded the number of subscribers falling 5% to 3.365m, while the number of people covered fell 4.6% to 5.938m. Gross earned premiums fell 0.7% to £3.444bn, while claims incurred rose 0.9% to £2.679m.

On UK healthcare trusts, the number of subscribers fell 1.1% to 615,000 with people covered down 1.5% to 1.094m taking total coverage to 7.032m.

Table 1. UK healthcare trusts 2002-2009 000s

| Year | Subscribers | People covered |
|------|-------------|----------------|
| 2002 | 404 | 704 |
| 2003 | 444 | 786 |
| 2004 | 510 | 910 |
| 2005 | 538 | 960 |
| 2006 | 585 | 1,021 |
| 2007 | 623 | 1,136 |
| 2008 | 622 | 1,111 |
| 2009 | 615 | 1,094 |

Table 2. UK PMI 2002-2009. No of subscribers 000s

| Year | Corporate | Personal | Total |
|------|-----------|----------|-------|
| 2002 | 2,282 | 1,124 | 3,406 |
| 2003 | 2,264 | 1,091 | 3,355 |
| 2004 | 2,223 | 1,052 | 3,274 |
| 2005 | 2,254 | 1,012 | 3,266 |
| 2006 | 2,345 | 1,030 | 3,375 |
| 2007 | 2,377 | 1,024 | 3,401 |
| 2008 | 2,522 | 1,021 | 3,543 |
| 2009 | 2,395 | 970 | 3,354 |

Table 3. UK PMI 2002-2009. People covered 000s

| Year | Corporate | Personal | Total |
|------|-----------|----------|-------|
| 2002 | 4,304 | 1,887 | 6,191 |
| 2003 | 4,207 | 1,826 | 6,033 |
| 2004 | 4,084 | 1,736 | 5,820 |
| 2005 | 4,125 | 1,695 | 5,820 |
| 2006 | 4,188 | 1,691 | 5,879 |
| 2007 | 4,341 | 1,663 | 6,004 |
| 2008 | 4,571 | 1,653 | 6,224 |
| 2009 | 4,384 | 1,554 | 5,938 |

Table 4. UK PMI 2002-2009. Gross earned premiums

| Year | Corporate £m | Personal £m | Total £m |
|------|-----------------|----------------|-------------|
| 2002 | 1,341 | 1,369 | 2,710 |
| 2003 | 1,394 | 1,422 | 2,815 |
| 2004 | 1,433 | 1,422 | 2,855 |
| 2005 | 1,493 | 1,449 | 2,942 |
| 2006 | 1,561 | 1,509 | 3,071 |
| 2007 | 1,696 | 1,545 | 3,241 |
| 2008 | 1,831 | 1,637 | 3,468 |
| 2009 | 1,776 | 1,667 | 3,444 |

Table 5. UK PMI 2002-2009. Underwriting results

| Year | Gross claims incurred £m | U/W loss ratio % |
|------|-----------------------------|---------------------|
| 2002 | 2,136 | 78.8% |
| 2003 | 2,203 | 78.3% |
| 2004 | 2,188 | 76.6% |
| 2005 | 2,255 | 76.6% |
| 2006 | 2,376 | 77.4% |
| 2007 | 2,501 | 77.2% |
| 2008 | 2,653 | 76.5% |
| 2009 | 2,679 | 77.8% |

Source (all): ABI, July 2010

Comment: A disappointing year across PMI, HCPs and dental—albeit largely explained by the recession. As the UK emerges out of recession, the challenge now is to reignite new business, appeal more to personal buyers and to manage claims costs.

Sickness absence falling

Sickness absence is on a downward trend, according to the latest **CBI** absence and workplace survey, which is now sponsored by **Pfizer** (for many years it was supported by **AXA PPP healthcare**).

On the path to recovery was published on 7 June. The survey was conducted between February and April and involved 241 private sector companies and public sector organisations, between them representing 1.28m employees or 5.12% of the UK's workforce.

Employees took 180m sick days in 2009, averaging 6.4 days each the survey found. The cost of that was around £16.8bn plus indirect costs.

That compares to 6.7 days per employee lost in 2007. In 2009, average days lost in the public sector were 8.3, compared to 5.8 in the private sector. By sector, manufacturing saw 5.6 days lost, compared to just 3.7 for professional services and 5.8 for other services.

Interestingly, organisations that recognised trade unions reported an average of 6.7 days lost per employee, compared to 5.3 days for those who did not. However, larger organisations tend to experience greater sickness absence, so that could be a factor behind that statistic.

The average direct cost of absence per employee was a record £595 in 2009, although the average cost varies by sector and especially by salary/wage level.

In terms of sick pay benefits schemes offered:

| | Full pay | Reduced pay |
|--|-------------|-------------|
| Employees with 12 months' service | | |
| Median | 8 weeks | 4 weeks |
| Average | 11.8 weeks | 9.6 weeks |
| Employees with 5 years' service | | |
| Median | 26 weeks | 12.5 weeks |
| Average | 21.25 weeks | 17 weeks |

Major causes of long term sickness were (employers were asked to list their top three causes):

| Illness | Manual | Non-manual |
|---------------------------|--------|------------|
| Back pain | 56% | 37% |
| Non-work related stress | 52% | 57% |
| Other musculoskeletal | 46% | 34% |
| Cancer | 34% | 41% |
| Non-work related injuries | 33% | 23% |
| Heart/blood pressure | 30% | 24% |
| Work related stress | 23% | 36% |
| Work related injuries | 21% | 3% |

The survey also found that employers believe 15% of absence is not genuine. The downward trend in absence was believed to be due to closer monitoring and management (cited by 80% of respondents), more occupational health (36%), changing working culture (36%), medical advances (27%), and a shift to more non-manual work (25%).

Fit notes were generally supported, with 11% of employers believing that they could definitely benefit their rehabilitation policy and 65% that they could possibly benefit it. Only 1% said they would definitely not help.

Three quarters of employers now operate wellbeing policies and the majority also offer rehabilitation.

The report can be downloaded from www.cbi.org.uk.

Top tips for surgery abroad

Travel insurance specialist **P J Hayman** has published a list of top tips for those considering having surgery abroad:

1. Carefully research the type of treatment offered, potential side effects and any international centres of excellence. Also check the surgeon's qualifications and the after care facilities.

2. Speak to the experts. A UK doctor may be able to recommend who to speak to. If not, then contact local standards organisations and membership bodies in the country being considered.

3. Review the budget. Compare all costs involved with those in the UK, especially regarding travel.

4. Remember it is not a holiday. The majority of complications arise within ten days of surgery so leave sufficient recovery time, don't plan too much activity and ensure the flight home is not booked too soon.

5. Get the right level of insurance. Specialist travel insurance is essential, as conventional travel insurance excludes travel for the purpose of having treatment abroad. Specialist cover will be more expensive but is necessary.

1 in 3 US LTC plans short term

One in three (32%) individual consumers buying a long term care (LTC) policy in the US in 2009 chose to have a three year benefit window rather than whole life benefit, according to a report from the **American Association for Long Term Care Insurance**.

The trend risks customers being underinsured but the report points out that only 13.1% of people buying a policy with a benefit term of three years actually claimed for more than three years. The figures for four and five years were 7.6% and 4.5% respectively.

Bupa improves IP plan

Bupa has introduced a raft of improvements to its income protection plan. These include reduced premiums where a medical condition is excluded and access to the **Best Doctors** service. In addition, by verifying a customer's salary at application stage, Bupa now guarantees that even if their situation changes, they will receive the agreed amount if they make a claim. This is a big step forward, as disputes over income can cause problems at claims stage and mean that each customer is effectively underwritten twice.

More women 'financially important'

By 2030 one in four women will be their home's major breadwinner according to research by **AXA**.

A quarter (27%) of women with dependant children now claim to have sole responsibility for paying the family mortgage, with 30% solely responsible for paying household bills. AXA estimates the value of women's roles around the home at £23,000 a year, yet only 38% of women have any life cover and only 18% protect themselves against critical illnesses. Those that have cover have, on average, £90K of life and £80K of CI cover.

Worryingly, 37% of women say they have no need for protection insurance.

Sickness absence falls for third year in manufacturing: Unum

UK sickness absence rates fell for the third year in a row in 2009, according to a study by **Unum** with the manufacturers' organisation **EEF**.

The average employee took 5.6 days sickness in 2009, compared to 6.8 days in 2007 and, 44% of employees took no time off in 2009.

The report says that 41% of employers saw a decrease in short-term sickness absence and 32% a fall in long-term sickness absence over the previous two years.

Other Unum research has found long-term sickness absence due to stress has fallen by 10% over the past four years, and now accounts for just 23% of all long-term sickness absence.

Another survey found that 21% of working people have no financial back-up in case they run into problems if an unforeseen event occurs.

A quarter (25%) of workers would have to rely on their partner and 24% on their family. On average, UK workers could only survive four weeks without full pay.

Unum also found that almost half of all UK workers have been off work for more than a week due to illness or injury at some time and around 2m workers currently in employment have had to take time off for six months or more—around 1 in 15 workers.

Unum has also launched a Master Trust for its group life plans, which means that claims can be paid out free of Inheritance Tax. The insurer has also upped its maximum free cover limit from £1.75m to £1.8m, removed the time limit on late entry, increased the maximum lump sum from 12 to 20 times salary for many schemes of more than 20 lives, increased the travel restriction rule from £15m to £25m and now offers free cover from three rather than five lives.

Travel insurers pay out £274m

Last year travel insurers paid out £274m in meeting the costs of emergency medical treatment for UK travellers who fell ill abroad the **ABI** announced on 16 July.

The cost of medical expenses claims has leapt by over 270% in the last five years it added.

In total, some 366,000 claims for overseas medical treatment were received, a number which has risen three-fold over the last five years. Medical treatment now accounts for 60% of the total cost of claims paid by travel insurers, compared to 33% five years ago.

The most common claims were for ear infection, allergies and heart problems.

Examples of claims include £49,000 for a coronary artery bypass graft and emergency flight home for a US holidaymaker, £16,500 for a husband and wife who separately suffered back injuries and £10,000 to attend to and fly back a child who suffered head injuries from falling rocks in Slovenia.

Comment: Many holidaymakers risk not being covered by not informing their insurer of any pre-existing condition, while traditional travel cover can mean a new underwriting check each time a policy is taken out. Yet, few consumers understand the risk they run in such situations.

The opportunity for health and protection insurers is to offer comprehensive medical only or full travel cover as part of a long term product, which can avoid both issues. The big advantage is that the perceived value to the customer is significantly greater than the actual cost to the insurer.

Law Commissions asks on fraud

The Law Commissions of England and Wales and of Scotland published a consultation paper *The Insured's Post-Contract Duty of Good Faith* on 9 July.

In it, they ask what should happen if a policyholder makes a fraudulent claim on their insurance, and call for clarity in the existing law.

The paper suggests that the courts are currently applying the right policy but that the cases are incompatible with Section 17 of the Marine Insurance Act 1906. Under that section, an insurer is entitled to deny the whole insurance contract in the event of a fraudulent claim and may also demand back any money paid out to a policyholder on any previous claims.

In practice, the courts are reluctant to apply this remedy but instead they have said that the whole of any fraudulent claim (even if the fraud only affects part of the claim) should be rejected but that other claims should not be affected. The paper also asks what should happen on fraudulent claims arising on joint and group insurances.

Consultation is open until 11 October. The paper can be downloaded from the Law Commissions' website at www.lawcom.gov.uk/insurance_contract.

ABI figures show that in 2009 some 122,000 fraudulent insurance claims were uncovered, up 14% on 2008. The value of these claims was £410m so, 4% of all claims by cost were fraudulent.

Many bogus liability claims were for personal injury and these included a man who claimed he had fractured his hand after falling over a pothole in the street, when in fact he had sustained the injury after he punched a wall during a domestic dispute.

A young woman claimed to have tripped over a loose pavement, when she had actually jumped down some stairs while running away from security guards on suspicion of shoplifting. And head injuries claimed to have been caused by falling over, were actually sustained when the claimant was hit on the head by a baseball during a fight.

Bupa publishes work evidence

Bupa, The Work Foundation, RAND Europe and C3 Collaborating for Health have jointly published a new study, *Healthy Work: Evidence into Action*.

The study, published on 29 June, examines over 600 pieces of evidence on the effectiveness of a broad range of workplace health interventions and identifies how stakeholders can respond to the challenges of productivity and public health.

The report shows how the benefits of employers taking positive action to reduce sickness absence can pay dividends. It also warns of the risks of doing nothing and argues for increased Government support for this area.

A copy of the report can be obtained from Bupa's website at www.bupa.com.

News briefs:

- *Protection Review* subscribers can access a number of slides used at the Protection Review conference at the www.protectionreview.co.uk website. Click onto 'Forum' and you can download the slides from there. If you haven't already registered, simply register online there too.

- Family income benefit (FIB) can cost less and pay out more than traditional (level) term assurance **Life-Search** says. It gives the example of a male aged 40 who could have £150,000 level term for 20 years from **Royal Liver** for £8 a month, or £13,767 a year from **LV=**. The latter would pay out up to £275,340 and would only pay out less if the customer died after ten or more years into the policy (by which time the financial need if he had children is likely to be less anyway).

- **Medicals Direct Group** has acquired competitor **Medibureau** for an undisclosed sum. Established in 2000, Medibureau arranges medicals and pathology testing plus other services for a number of life insurers. The enlarged group's turnover will now be approaching £30m.

- First person to pass the **CII's** new IF7 (*Healthcare insurance products*) exam) was **Premier Choice** appointed representative Brian Walters. The group is now requiring all its staff to take and pass the new exam within 12 months. We hope that other intermediaries—and insurers for all their broker and customer facing staff—will follow. IF7 coursebook editor Andy Couchman is already regretting not negotiating a royalty payment...

- Talking of AC, watch out for publication soon of an important new report from the **CII** and **Cass Business School** on leadership and innovation. The report is based on interviews with top level leaders from across the financial services and other industries and includes practical exercises to help leaders better understand and embrace innovation, as well as drawing some significant conclusions from its studies. AC is quite excited about it...

- US health insurers **Humana**, **United Health Group** and **Aetna** have all expressed interest in taking on GP consortiums' administration work as part of the reforms being planned for the NHS.

- The **F&TRC Protection Forum** is developing a draft good practice statement on business retention processes, a key operational and tactical issue for many intermediaries. The **Finance & Technology Research Centre (F&TRC)** is a specialist consultancy set up by IT guru Ian McKenna that advises on the use of technology in the personal finance market.

- Adrian Fawcett, CEO of **BMI Hospitals**, has criticised PMI insurers for failing to design policies tailored to different segments of the population. See the August issue of *Health Insurance* magazine for his full comments.

- A survey by **Gracechurch Consulting** found that 84% of **Lloyd's** brokers feel 'very positive' about conducting business at Lloyd's, up from 67% in 2008.

- One in five UK employees admits that the last sick day they took was for personal reasons rather than because they were ill, according to **Aon Consulting**.

- The **Association of Financial Mutuals** is meeting **HM Treasury** officials to explore whether income protection insurance could sit alongside State benefits for those long term ill or disabled.

- **Partnership** has pulled out of the pre-funded long term care insurance market but may re-launch if Government proposals for LTC include insurance plans. Sales failed to take off when such plans were heavily marketed in the mid 1990s and in recent years Partnership has been the only major player still in this sector.

- Employers adopt a damaging drinks culture by encouraging employees socialising in pubs and only 7% would discourage their employees from drinking alcohol, according to **Aviva's** latest (fourth) *Health of the Workplace* report. It is not just the UK though—on a recent factfinding tour in Germany, ePR editor Andy Couchman was surprised to find that production line workers at a major car plant could drink company supplied beer while working. The company relies on worker team peer group pressure to ensure that the system is not abused. Can't see that working in Swindon or Coventry...

- **Chartis Direct** has launched **CancerCare**, a product designed to sit alongside a PMI policy. The plan pays either £25,000 or £50,000 on diagnosis of a specified cancer. More in our next issue.

- **Friends Provident** has launched a new online seminar on houseperson's cover. With over 2m housewives, a growing number of househusbands and 2.5m with 'mini jobs', FP sees big potential in this market.

- **Bupa International** has joined with **Joint Commission International (JCI)** to develop a quality assurance programme for its 7,500 recognised providers worldwide. The aim is to reassure customers that they will get the highest levels of treatment across the world.

- **Engage Mutual** has launched a new health cash plan. Full review in our next issue.

- **Healix** now offers discounted **Nuffield Health** club membership to its Healthcare Trust clients.

- **Exeter Friendly** has produced a new *Underwriting Guide* to help brokers better understand its underwriting processes. It also now offers 20% premium discounts to non-smokers on two of its PMI plans.

- Errors. On Page 3 last month we referred to the income protection gap as being £190m of annual benefits. It should of course have read £190bn. Our excuse is that that was the figure quoted in **Swiss Re's** press release—but we should have know better!

- Our nominations for 'hero' at the Protection Review events on 15 July—apart from our own team we would highlight two. First, Nick Starling for admirably stepping into Kerrie Kelly's shoes (not literally—do pay attention...) to deliver the after dinner speech. Second, to Professor Sir Mansel Aylward. It had originally been planned that he should start the conference but a higher call came through... So, instead, at the start of the conference he was at Windsor at his own investiture. Despite that he was determined to still address the conference and we were only too delighted that he was able to join us later, to give a really excellent presentation. His passion for our industry and what it could do to help people with problems reminded us of another great medical friend of ours, Dr Marius Barnard—the 'inventor' of critical illness cover. As an industry we can learn a lot from other industries and professions, and the two doctors both remind us that simple messages, backed by the authority of really knowing your subject, are a recipe for success whatever the subject.

Pick of the month

This month's products are again a diverse bunch. Saga offers guaranteed premiums with an incentive to be tele-underwritten, while Pulse's Harbour plan offers life cover to those with HIV, albeit at relatively low levels.

Partnership offers an interesting mortgage funding vehicle for its single premium Care Plan but our Pick of the Month is Westfield, for its new innovative direct to consumer Health365 brand.

It's not perfect, but deserves to succeed and includes some innovative touches, not least around its use of video as an online sales tool. The key question is now how more consumers can be encouraged to seek out such cover in the first place.

Health365

Health 365 is a new online direct to consumer health insurance product offering simple, quick and affordable health cover from £15 a month.

Health365 is a new sub-brand for leading health cash plan provider **Westfield Health** and is its venture into online insurance.

The plan itself has four modules and two premiums levels (min and max), which apply to the Core and Therapies benefits (the other two are fixed). Reimbursement is 100% up to the policy limit and customers must choose at least one module in addition to the Core module:

- Customers must choose Core Health Cover. This pays for or towards therapies (up to £300 or £600 a year—for min or max), optical (£100 or £200) and dental (£100 or £200) costs and pays a nightly rate up to £40 or £50 for up to five nights a year for hospitalisation.

- Scanning and screening. This pays up to £150 a year. Scans must be consultant referred.

- Consultation. Pays up to £150 or £600 a year.

- Surgery Choices. Covers 60 common surgical procedures and pays up to a lifetime limit of £100,000. These are listed and explained in the policy document. This element of the plan is underwritten by **Great Lakes Re-insurance (UK)**.

A key element of the proposition is the website. This not only includes text and PDFs of things like policy summaries and documents but also short videos explaining each element of the plan. These are available in both high and low definition and each lasts around 30-50 seconds and gives a simple overview. The videos each took around half a minute to load—but that is more a reflection of the very slow broadband rate in ePR's rural office location than a criticism of the website (although a factor for all providers to be aware of when considering complex websites).

The website allows the customer to build their own plan by deciding who should be covered (individual, couple or family) and how much of each level of cover they want.

An individual choosing maximum benefits would pay £39 a month, a couple £78 and a family £85 a month. Rates are not age dependant.

Plus points: Simple to understand and buy. Well set out interactive website makes buying easy. Videos are a useful bonus. Choice of cover options. No age or gender ratings. A cut price alternative to traditional PMI and HCPs.

Not so plus points: More limited cover and choices compared to many PMI and HCP plans. The internet is popular for buying such as motor insurance, but success to date in the protection and health insurance areas has been more limited. The videos can be slow to load and give little factual information about cover levels.

Contact: 0845 2 100 365 or www.health365.com.

Rating (max 5). Innovation: 4. Overall: 3.5.

Partnership Care Plan Payment Option

Partnership's Care Plan Payment Option (CPPO) is a fixed rate loan that enables people to fund their long term care, without having to sell their family home.

The loan has a fixed rate of 6.99% and is secured against the family home. The mortgage loan is then used to purchase a Partnership Care Plan, which is a single premium plan that provides a guaranteed income for life. If those payments are made direct to a registered care provider, the income is tax free. The CPPO can be for a lesser amount, e.g. if the customer wants to use some of their realisable capital to help fund their care.

All interest is rolled up during the customer's lifetime and the loan and interest is usually repayable on death or on the earlier sale of the home. However, the customer can repay part (minimum £5,000) or all of the CPPO at any time, without penalty.

Partnership offers a no negative equity guarantee so that the CPPO and accumulated compound interest will never be greater than the proceeds of selling the home.

If death occurs within six months of taking out the Care Plan, there is effectively a money back guarantee.

One benefit of the scheme is that, after the mortgage is completed (where there must be vacant possession), the customer can rent out their home or allow a relative to stay there (subject to Partnership's agreement). That also allows the customer to return home should they wish to do so later.

Plus points: Helps pay for a single premium care plan, without selling the family home. That may be attractive where say a spouse still lives there or where the elderly person does not want to relinquish their home when they have to go into care. In practice, few will then return home, but the psychological benefit of that option may be important to them. Or, they may choose to rent out the home (or allow a relative to stay there), so generating additional income.

Not so plus points: 6.99% may look expensive for a fixed rate loan in the current market, but most 'general' fixed rate mortgages are for fixed terms (1-5 years is common), may have early redemption penalties and require interest to be paid monthly. That said, one downside of this arrangement is that interest can quickly build up—the capital sum borrowed will almost double over ten years (although many people going into residential care will not live that long). This is a specialised and complex area and few IFAs specialise in it. Customers should always take independent legal advice before embarking on such arrangements. There may be better options available. Not every property is suitable for this arrangement (or for renting at an attractive rate and renting also gives rise to other costs).

Contact: 0845 108 7240 or www.partnership.co.uk.

Rating (max 5). Innovation: 4. Overall: 3.5.

Saga Guaranteed Life Insurance

Saga's new plan is underwritten by PruProtect and is a guaranteed life insurance policy for those aged between 50 and 85 living in the UK.

Premiums are fixed for life at outset, as is the sum assured. On death within the first year, all premiums are returned but the full sum assured is payable after one year (compared to two years on many similar plans) or on accidental death at any time.

Acceptance is guaranteed regardless of health and, on acceptance, customers also get a £20 Marks & Spencer voucher. If the sum assured is used to pay for a funeral with Co-operative Funeralcare, it will pay an additional £250 towards the costs i.e. customers effectively get a £250 discount on their funeral.

Premiums cease at the policy anniversary after the customer's 90th birthday but benefits are whole life. The literature also says: 'We're currently able to offer you and your family access to a free and confidential service offering practical and emotional support at a time of need'. However, we could not find reference to that in the policy provisions and assume that this is simply an additional extra contractual service. Whatever it is, we think it's probably a good thing!

Customers can also choose to 'take the Saga Challenge'. This means phoning the freephone number (below) and answering four simple questions regarding their health. If those answers are satisfactory, the sum assured is automatically increased by 15% and the plan also offers full payout from day one, rather than having a one year accidental death only full sum assured.

Plus points: *Simple product with fixed rates and guaranteed acceptance and just a one year rather than two year initial 'waiting period' before full cover kicks in. The Saga Challenge offers the prospect of better cover for answering just four questions with no downside too—if the customer is not accepted for this, they still get the basic plan benefits. Additional £250 if the funeral is arranged through the Co-op and a £20 M&S incentive also encourages take-up of the plan.*

Not so plus points: *We have criticised the value for money element of such plans before and this plan is no different—a long living customer could find that they pay in rather more than their family gets out. Many customers would be better off consulting an IFA who could then choose the most appropriate cover for them, although the risk is then that they may be rated or rejected by the insurer.*

Contact: 0800 015 1903 or www.saga.co.uk.

Rating (max 5): Innovation: 3.5. Overall: 3.

Pulse Insurance Harbour

Pulse specialises in 'helping people that have been turned down by other insurance providers'.

This policy, which is underwritten at Lloyd's, is a ten year term assurance policy and is available to UK citizens.

The plan is targeted at people with HIV and offers up to £200,000 of accidental death cover (other options are £10K, £50K, £100K and £150K) and either £10,000 or £25,000 of life cover. Pulse says that, crucially, it does not require a doctor's report or for the applicant to undergo a medical examination and adds that there are currently around 83,000 people living with HIV in the UK.

A male aged 30-34 could pay £15 a month for £10K of accidental death benefit and £10K of life cover. Increasing the life cover to £25K would take the monthly premium up to £40. For £200K of accidental death benefit the monthly premium would be £55 or £80 for £10K or £25K of full life cover too.

There is a seven page application form to complete, which includes a range of medical and other questions.

Plus points: *Medical developments have meant that many people with HIV can now go on to lead long lives, but they may still find it difficult or impossible to obtain any life cover. This plan offers them that life cover (albeit only relatively small sums), complete with accidental death benefit too, which can be for a much larger amount (up to £200K).*

Not so plus points: *Expensive compared to normal rates term assurance—although such cover is very unlikely to be available. Not available if the customer has AIDS. We are not fans of accidental death benefit—if the need is for money on death the cause of death is largely irrelevant. However, for those with HIV, 'normal' life cover may be unavailable. And not everyone with HIV will die from non-accidental causes.*

Contact: 01280 841430 or www.pulse-insurance.co.uk.

Rating (max 5): Innovation: 4. Overall: 3.

Product design issues...

Saga's over 50s plan is interesting in that it includes both an incentive and a safety net to be tele-underwritten, writes editor Andy Couchman.

The incentive is that if you can answer four questions to the satisfaction of the underwriter you get more cover and you get it earlier. And the safety net? If you can't satisfy the underwriter you still get the plan's 'normal' benefits. Saga even dresses it up as a 'challenge' - and most of us are happy to rise to those.

This heads you win, tails you don't lose approach is not new. Back in the 1990s I worked with (then called) **PPP lifetime care** and one of the reasons it attained market leadership—in an all too short period when long term care insurance was the up and coming new idea—was offering guaranteed acceptance. In essence, every risk would be taken on, only the price charged would vary. Of course, you could get to a point where the price charged was simply uneconomic, but then the customer's financial adviser would simply advise them not to buy or they would decide not to go ahead themselves. Not perfect, but it meant that customers had less fear of rejection.

It's like going on a blind date. You may go on a blind date with friends, knowing that the evening may or may not be what you hoped for. But would you go if the deal was that your date could reject you at the start and you would then have to go home on your own. Thought not...

Is protection cover any different? One reason why guaranteed life cover has been a major growth areas in recent times is that insurers cannot reject their customer.

The challenge is how best to achieve that. One way is to have a standard level of cover, with exclusions, for every applicant, but then to offer better terms for those who 'pass' the tele-underwriting. Such a plan would look hopeless on most portals, but are advisers so shallow that they cannot look beyond that? It may require a change in attitude for many, but who will be the first to try it?

Hip resurfacing remains effective option in certain subgroups

Despite recent safety warnings about hip resurfacing, (where the head of the femur is preserved and shaped to receive a metal cap or resurfacing), for certain subgroups this remains an effective option, *BMJ* 2010; 341: c3459 reported on 7 July.

Younger patients are likely to need multiple hip replacements in their lifetime and functional outcome deteriorates with multiple revisions, so hip resurfacing can delay this process by adding an additional step before total hip replacement.

Young, physically active men have the worst results in terms of implant survival for total hip replacement, with a Swedish 2004 report giving a 73.5% implant survival rate at 13 years in 3,122 men under 50 compared with 95.7% in 30,809 women older than 75. Women have significantly poorer results for hip resurfacing because they tend to have smaller components fitted which have a greater risk of revision than larger components.

Improvement in long term cancer survival is welcomed

Survival rates for some cancers have doubled over the past 40 years in England and Wales, *BMJ* 2010; 341: c3750 reported on 12 July. Those diagnosed with breast, bowel or ovarian cancer or non-Hodgkin's lymphoma are now twice as likely to survive for at least ten years as people diagnosed in the 1970s.

The at least ten year survival for breast cancer in women rose from 38.9% in 1971/2 to 77% in 2007 and for bowel cancer patients the figures rose from 23% to 50%.

Survival for at least ten years for ovarian cancer patients and non-Hodgkin's lymphoma rose from 18% to 35% and 22% to 51% respectively over the period studied.

Leukaemia patients were over four times as likely to survive for 10 years than patients in the 1970s with a rise from 8.1% to 33.2%.

Only small improvements were recorded for lung and pancreatic cancer. Ten year survival rates rose from 3.2% to 5.3% and from 1.9% to 2.8% respectively.

Care homes feel the squeeze

Laing & Buisson announced on 25 June, in the words of chief executive William Laing: "exactly how punishing this April's round of local authority care home fee increases has been".

Care homes looking after the 170,000 council supported elderly people in independent sector care homes in England have been offered an average uplift of just 0.5% for the financial year 2010-11. The East Midlands fared best with a 1.4% increase offer by councils, but with costs rising at an estimated 2.1% per annum, the English care home sector faces a squeeze in margins that could affect even those companies with low debt, if the freeze continues for the next three or four years of public expenditure cuts.

Care homes in Scotland and Northern Ireland, however, received a comparatively generous uplift of 2.1% and

2.0% respectively. The *Annual Survey of UK Local Authority Baseline Fee Rates 2010/11* from Laing & Buisson, price £60. See: www.laingbuisson.co.uk.

Painters' bladder cancer risk

Painters are significantly at risk of developing bladder cancer and the risk increases the longer a person works as a professional painter. The key risk factor for the disease is smoking, but painters are exposed to some of the same chemicals that are found in cigarette smoke. After adjusting for some painters being smokers, painters were still 30% more likely to develop bladder cancer than the general population. See: <http://press.psprings.co.uk/oem/july/oem51565.pdf>.

Prolonged mobile use may be linked to tinnitus

A study has found that regularly use of a mobile phone for four years or more seems to be associated with a doubling in the risk of developing chronic tinnitus. Patients who had used a mobile before the onset of tinnitus were 37% more likely to have the condition and those who used their mobile for an average ten minutes a day were 71% more likely to have the condition than those in a comparison group. See: <http://press.psprings.co.uk/oem/july/oem48116.pdf>.

Obesity in over 65s reflects 'lifetime of gaining weight'

The prevalence of obesity in the elderly in the UK is greater than among young people. In England in 2008, 77.1% aged between 65 and 74 were classed as obese or overweight, *BMJ* 2010; 341: c3585 reported on 5 July.

Among those aged 16 to 24 this figure was 33.5%. In Scotland and Wales in 2008, those aged 55 and 64 were most likely to be overweight or obese (79% and 68% respectively). In Scotland, however, almost one in ten (38%) of 16 to 24 year olds were obese. David Haslam, chairman of the **National Obesity Forum of England and Wales** said: "We tend to gain weight gradually year by year up to a peak of about 70, and then we start to lose it again. This figure reflects a lifetime of gaining weight." The 40th edition of *Social Trends* is at www.ons.gov.uk.

Suicide attempt method predicts subsequent suicide

A Swedish study of 48,649 people admitted to hospital due to a suicide attempt between 1973 and 1982 has found attempted suicide by poisoning was the most common method (84% of attempters) and was linked to the majority of later suicides (4,270). However the highest risk for eventual suicide (54% in men and 57% in women) was found for attempted suicide by hanging, strangulation or suffocation.

People were six times more likely to successfully commit suicide if they had attempted suicide by these methods previously, after adjusting for age, gender, education, immigrant status and psychiatric illness. See: <http://www.bmj.com/cgi/doi/10.1136>.

Medical briefs:

- People who stay in education longer have a lower risk of developing dementia but the reason why has been unclear. A new study led by Professor Carol Brayne of the **University of Cambridge** and published in *Brain* on 26 July found that people with different levels of education have similar levels of brain pathology but those with more education are better able to compensate for the effects of dementia. Such people can better cope with a lot of changes in their brain before showing dementia symptoms.

- Researchers from **Portsmouth University** have found the more caffeine people consumed the more they saw this as a positive thing. Those who never drank coffee were more likely to associate caffeine consumption with negative words like 'failure' while heavy caffeine drinkers were more likely to link it with positive words such as 'success'. Caffeine is addictive but heavy consumers don't feel their habit carries social stigma, the authors concluded. See: *Psychology of Addictive Behaviors* (2010) 24: 274-281.

- A new charity **Acornn (Academic Clinical Oncology and Radiobiology Research Network) – Action Radiotherapy** that aims to raise £5m to improve radiotherapy treatment for patients was launched on 13 July. See: www.acornn.org.

- A US study has found that HPV infections (human papilloviruses), heighten the risk of developing common skin cancers like basal cell and squamous cell carcinomas by more than one and a half times compared to those people with no HPVs. See: www.bmj.com/cgi/doi/10.1136/bmj.c2986.

- The charity **Counsel and Care** has produced a handbook on choosing, paying for and living in a care home. The *Care Home Handbook* is available free of charge and can be downloaded from: www.counselandcare.org.uk/helpingyou/carehomehandbook.

- **Harvard School of Public Health** has warned that drinking sugar-sweetened beverages can increase the risk of type 2 diabetes and cardiovascular risk as well as obesity. Sugar sweetened drinks should not be the main source of hydration. The findings confirm the link between excess weight, poor diet and cardiovascular disease. See: www.hsph.harvard.edu.

- **Alliance Medical** needs an immediate cash injection of £150m *The Times* reported on 22 June. Britain's biggest independent provider of MRI scans was bought in 2006 for £600m by **Dubai International Capital** which in turn is unlikely to be bailed out by the Dubai Government which is facing its own debt crisis, the paper said.

- Italian research published in the journal *Gut* shows that bowel cancer screening is significantly less likely to pick up cancerous changes in summer than in winter giving rise to the risk of malignancies developing undetected between screenings. See: <http://press.psprings.co.uk/gut/july/gut200873.pdf>.

- Men who carry a faulty BRCA2 gene have a 1 in 15 (7.1%) chance of developing breast cancer by the time they reach 70 and 1 in 12 (8.4%) by age 80 with a lifetime risk for men in the West with the faulty gene of between 6% and 9%, a risk sufficient to warrant raising awareness, the authors concluded. See: <http://press.psprings.co.uk/jmg/july/jmg75176.pdf>.

- Swedish research published in the *Annals of Rheumatic Diseases* using 2,000 people between ages 18 and 70 all of whom had confirmed rheumatoid arthritis (RA) and another 2,000 randomly selected healthy people has found routine jabs, such as flu and tetanus, do not trigger the development of long term inflammatory conditions including RA. See: <http://press.psprings.co.uk/ard/july/ard129908.pdf>.

- The prevalence of Huntingdon's disease may be double the current estimates of 6-7 cases per 100,000 of the population (1970s and 1980s figures). The **Huntingdon's Disease Association** is aware of 6,702 people with symptoms and new estimates suggest the minimum prevalence in England and Wales must be at least 12.4 per 100,000 population. Huntingdon's disease is the only genetic disease for which the insurance industry is allowed to enquire about the results of predictive tests. See: *BMJ* 2010; 340: c3516.

- A US study in the journal *Nature* reports that the so called master cells that give rise to aggressive skin cancers such as malignant melanoma have been identified. Eight out of ten melanomas are found at the early stage and treated, but unless the newly discovered 'stem cells' in advanced skin cancer are wiped out, the treatment will fail.

- A Dutch study looking at 1,325 obese people aged 28-75 found 90 were metabolically healthy with a normal cardiovascular risk profile and no increased risk for heart or blood vessel disease. The authors suggested that periodic evaluation of their risk profile remained essential, *Nursing Times* reported on 29 June.

- **Age UK** research shows that one in three people aged over 65 suffer a fall each year at an estimated cost to the NHS of £4.6m a day. Introducing strength and balance programmes can reduce falls by as much as 55%. However one in five older people could not remember the last time they took any exercise.

What is Counsel and Care?

Counsel and Care is a national charity working with older people, their families and carers to get the best care and support. It provides personalised in-depth advice and information, which also informs its research and campaigning work.

The organisation was set up in 1954 by **King's Fund** researchers Bob Graham and Joceline Owen as the **Elderly Invalids Fund**, which changed to Counsel and Care for the Elderly in 1974.

The charity's Advice Service offers help and support to around 250,000 people a year and advises on a range of community care issues, including finding and paying for care, welfare benefits and hospital discharge. As well as its website, it also produces detailed factsheets and guides and has a single needs grants programme. Its Policy and Communications team works to influence Government, the media and other stakeholders. The team also commissions research through respected academics.

Chief executive is Stephen Burke (since 2005) president is Davina Hodson and chairman is Sushil Radie. Trustees include **Bupa's** Dr Clive Bowman. The organisation's website is at www.counselandcare.org.uk or phone 020 7241 8555.

Commission on LTC set up

On 20 July, Health Secretary Andrew Lansley set up a **Commission on the Funding of Care and Support** (see Page 14) under chairman Andrew Dilnot.

The Commission has less than a year to recommend an affordable and sustainable system of funding long term care (LTC). In announcing the Commission, Mr Lansley said; "The Commission should judge funding models against set criteria, which it should agree, and present to the Government for approval, within the first two months. The assessment should include the following criteria:

Choice: offering an affordable choice to individuals, carers and families across a range of care settings, and helping people plan and prepare for the future.

Fairness: for individuals, families, carers and wider society.

Value for money: securing the highest quality care outcomes within the available resources.

Sustainability: ensuring the costs to the State are sustainable in the context of an ageing population."

The Commission's initial views need to be made available to be included in the forthcoming spending review, which places it under tight time constraints.

Comment: Andrew Dilnot is a good choice of chairman—he sat on the **Rowntree Committee** on LTC funding amongst other things—and will be acutely aware of the need to make the Commission's recommendations both realistic and sustainable (something the 1990 Royal Commission on LTC funding failed to do except, arguably, in its minority report). The new Commission will look at various models, including Derek Wanless's partnership scheme. The protection industry could be involved in possible solutions around both insurance (individual or with the State) and equity release. Could this preface a revival in interest in LTC from insurers?

Employment up in May

Employment levels in the UK rose in the three months March to May to end at 28.984m according to the latest *Labour market statistics*, released by the **ONS** on 14 July.

The *Protection Review Employment Index* rose from 106.153 to 106.590. This index compares the latest employment level with the 27.192m figure recorded for the first quarter of 2000 (January to March) and is a proxy for the growth in size of the main health and protection insurance markets since then.

Unemployment for the period fell from 2.472m to 2.468m, while the number of Jobseeker's Allowance Claimants for June 2010 also fell, from 1.4811m to 1.4601m.

By the end of May, the employment rate was 72.3%, with 7.8% unemployed and 21.3% 'inactive'.

Total pay including bonuses rose 2.7% year on year, or by 1.8% excluding bonuses.

On 13 July an **ONS Statistical Bulletin** announced that inflation, as measured by the Consumer Prices Index (CPI) had risen by 3.2% for the year in June 2010, compared to 3.4% in May. The Retail Prices Index (RPI) which is the main index used by insurers, also fell—from 5.1% to 5.0%. Both figures are still above the Government's target for inflation, but the trend is encouraging.

Indeed, economic indicators, including for GDP, have been better recently than many pundits expected.

NHS White Paper launched

Health Secretary Andrew Lansley launched *Equity and Excellence: Liberating the NHS* on 12 July. The White Paper focuses around devolving power from Whitehall to groups of GPs. Both Strategic Health Authorities and Primary Care Trusts will be 'phased out'.

The aim is also for services to be more joined up, with local authorities having a new role to support integration across health and social care.

The principle will be 'no decisions about me without me' Mr Lansley said. See www.dh.gov.uk for more.

The Health Secretary is also looking to cut NHS management costs and reinvest the savings made in patient care. The overall reduction in management costs by 2013/14 will be £850m, which is a 46% reduction on the 2009/10 management costs. The revised Operating Framework sets out changes to the use of targets in the NHS. These include:

- removal of targets around access to primary care;
- removal of top-down performance management of the 18 weeks referral to treatment target; and
- reduction of the 4 hour A&E target threshold from 98% to 95%.

Comment: We support the principles behind these reforms, but much will depend on the detail and the additional costs of change (£2-£3bn) have to be factored in too. Merging the DH and DWP was perhaps too much to ask (although it already applies in Northern Ireland) but the new proposals may make that unnecessary anyway. The proposals also suggest a shift in power away from hospitals and consultants more towards community based, primary care led health.

IDS sets out Welfare agenda

In a speech on 30 June, Secretary of State for Work and Pensions, Iain Duncan Smith, set out his agenda for welfare reform. The Work Programme includes the transition to get people off Incapacity Benefit and will involve the voluntary sector and other groups. Schemes will be decentralised and tailored to support jobseekers and will be run on a payment-by-results basis when they are rolled out early next year.

1.5m of the 2.5m on Incapacity Benefit will be migrated to Employment Support Allowance and given intense, personalised support to get back into work.

He added that in a second phase, the benefit system will be reformed to make work pay. It will also be simplified, and made more efficient and understandable.

Overuse of imaging in US

Legal, regulatory and educational reforms have been called for in the US to control the overuse of diagnostic imaging and protect patients. *BMJ* 2010; 340: c3429 reported two commentaries on 30 June. One that said much of diagnostic imaging was unnecessary and expensive and the other warned that the overuse of computed tomography (CT) is potentially unsafe.

Around 10% of Americans have a CT scan each year, a number that is growing, and many doctors have bought their own machines and refer their own patients.

Comment: The UK has similar albeit smaller, issues.

Political briefs:

- The number of complaints to the **Health Ombudsman** has more than doubled, from 6,780 in 2008/09 to 14,429 in 2009/10. Part of the increase is due to the closure of the **Healthcare Commission** in March 2009, which means that the Ombudsman is now the second and final point of contact for anyone having an NHS complaint in England. 44% of the complaints (6,304) were about hospitals, 17% (2,419) about GPs and 17% (2,411) about primary care trusts. See *BMJ* 2010;341:c3840.

- Doctors have found that one in ten of the medical records held on the pilot version of the new NHS database are inaccurate, the *Mail on Sunday* reported on 18 July. The £600m scheme, known as the 'Spine', aims to place most patient records on a national database where they can be accessed by doctors all over the country in an emergency.

- A report from the Scottish Parliament's health committee reveals that between 2002 and 2009 the number of medical staff in Scottish hospitals doubled and there was a 76% increase in nursing staff, *BMJ* 2010; 340: c3522 reported on 30 June. It says many have been employed in jobs of no productive value during years of financial growth and the committee warned that the financial challenge facing the NHS inevitably means that cuts will need to be made in contentious areas.

- On 23 June, the **BMA** and the **Academy of Medical Royal Colleges** called on the Government to end misleading advertising about private health screening.

- The US spends most on healthcare and gets less for that spend, a **Commonwealth Fund** report; *Mirror, mirror on the wall: how the performance of the US health care system compares internationally* claims. It found the US spent \$7,290 per person on health care in 2007 (16% of GDP) and ranked last on the cumulative measures rated. The Netherlands had the highest overall health index and spent \$3,837 per person (9.8% GDP). The UK ranked second.

- The UK has been ranked top of 40 countries for quality of death by **The Economist Intelligence Unit**. The UK's hospice movement and statutory involvement with the care of people who are dying were key factors in the assessment.

- Fewer than half the people in the UK who are at high risk of stroke are getting carotid endarterectomy to improve blood flow in the veins in their neck, an audit by the **Vascular Society** claims. Surgeons carry out around 4,500 such procedures each year, compared to an estimated 10,000 patients who could benefit from the operation. See www.vascularsociety.org.uk.

- Spending on social security benefits increased by 122% in real term from £69bn in 1978/9 to £152bn in 2008/09 according to figures released by the **ONS** on 2 July. 60% of the £196bn managed by the **DWP** in 2008/09 went to people of retirement age. 13% (£17.5bn) went to people with disabilities not related to age. The figures come from *Social Trends 40*.

- The **Health & Safety Executive** has reported that in 2009/10 the number of people killed at work fell to a record low—just 151 deaths.

- The **Health Protection Agency** reported on 9 July that hundreds of people had died because of the recent spell of hot weather *The Times* reported on 10 July.

Very hot weather can lead to problems for the elderly and those with long term health problems. A severe heatwave is likely to result in more early deaths than a year's worth of road traffic accidents.

- The Government has announced that the State pension age will rise to 66. Each extra year of working life is forecast to increase GDP by 1% (around £13bn). At present there are also plans to raise the State pension age to 68 by 2046.

- An international study from the **Organisation for Economic Cooperation and Development** reveals that inefficiency and waste in NHS spending was cutting UK life expectancy by around three years and four months, the *Daily Mail* reported on 3 July.

- A Swedish study of 10,000 men aged 50-65, published online in *The Lancet Oncology*, has found that prostate screening reduces mortality risk. Prostate cancer was diagnosed in 1,138 men in a group who underwent PSA (prostate specific antigen) screening and 718 in a control group. During a 14 year follow-up, prostate cancer mortality in the PSA screening group was almost half that of the control group. See: www.thelancet.com/journals/lanonc.

- Guidance on preventing cardiovascular disease through diet has been issued by **NICE** (the **National Institute for Health and Clinical Excellence**). It calls for a reduction in adult salt intake to a maximum 6g per day by 2015 and falling to 3g daily by 2025. Manufacturers should reduce hidden saturated fat and low salt and saturated fat products should be cheaper than high content equivalents. Trans fats should be eliminated from processed food and takeaways. See: www.guidance.nice.org.uk/PH25.

- More and more US doctors are refusing to accept patients with government sponsored Medicare and Medicaid insurance, with Medicare reimbursing doctors about 78% of what private insurers pay and Medicaid (for the over 65s) paying less. Also a growing number are refusing to accept patients with private health insurance, the kind that most US citizens get with their job, *BMJ* 2010; 340: c3476 reported on 29 June.

- A survey by *Health Service Journal* has found nearly one third of NHS managers were considering leaving the health service.

- **Unison** is calling for all healthcare assistants (HCAs) to be registered and for there to be national minimum competencies. The union, which represents 100,000 HCAs, says there is a wide variation in pay, training and scope for advancement.

- New data on the US health website will allow people to compare the quality of services in 4,700 acute care, critical access and children's hospitals against a national average. Based on data submitted from hospitals and Medicare claims, the website, called *Hospital Compare*, could also be used in a value based purchasing programme beginning in 2013. See: *BMJ* 2010; 341: c3743.

- Good news for Muslims. Indonesia's **Ulema Council** has ruled that civet coffee—the world's most expensive—is halal. The drink is made from beans eaten, fermented and excreted by cat-sized civets, then roasted.

- Trafford General Hospital in Manchester has announced that parking fees are to be dropped, the *Daily Mail* reported on 2 July. Only another 172 hospital trusts in England to go...

Mortality lowest ever

Women in England and Wales had, on average, 1.96 children in 2009, according to *Births and deaths in England and Wales*, published by the **ONS** on 21 July. This is up from 1.63 children in 2001 but down from 2.93 children in 1964.

Also in 2009 there were 6,573 deaths per million population for males and 4,628 per million for females.

Since 1999 age standardised mortality rates have fallen by 26% for males and 22% for females to their lowest ever levels.

There were 706,248 live births in 2009, up from 594,634 in 2001 and 604,441 in 2000. There were also 3,688 stillbirths (5.2 per thousand births).

A quarter (24.7%) of live births were to mothers born outside the UK (this has increased every year since 1990, when it was 12%).

There were 491,348 deaths registered in England and Wales in 2009, compared to 509,090 in 2008 and 553,532 in 1999. The last time deaths were below 500,000 was in 1952.

Cancer accounted for 29% of deaths (2,068 deaths per million population for males and 1,489 per million for females). Since 1999 death rates from cancer have fallen by 15% for males and by 12% for females.

For more details and to download information see www.statistics.gov.uk/statbase/Product.asp?vlnk=14409.

Table 1. Deaths in England and Wales 2009, selected causes only, by sex

| Cause | M | F |
|-----------------------------------|--------|--------|
| Infections and parasitic diseases | 2,567 | 3,183 |
| ...of which HIV | 166 | 90 |
| ...tuberculosis | 196 | 144 |
| Neoplasms | 74,016 | 66,481 |
| Of which... | | |
| ...trachea, bronchus, lung cancer | 17,053 | 12,965 |
| ...malignant melanoma | 1,044 | 814 |
| ...breast | 66 | 10,374 |
| ...prostate | 9,402 | 0 |
| ...bladder | 3,021 | 1,454 |
| ...brain | 1,910 | 1,403 |
| ...non-Hodgkin's lymphoma | 2,188 | 1,805 |
| ...leukaemia | 2,279 | 1,711 |
| Diseases of the blood/immunity | 457 | 569 |
| Diabetes mellitus | 2,458 | 2,820 |
| Mental/behavioural | 5,909 | 12,112 |
| Diseases of nervous system | 8,003 | 9,405 |
| Of which: | | |
| Motor neuron disease | 971 | 818 |
| Parkinson's disease | 2,809 | 1,980 |
| Alzheimer's disease | 1,930 | 4,264 |
| Multiple sclerosis | 339 | 673 |
| Epilepsy | 527 | 410 |
| Diseases of circulatory system | 77,636 | 82,143 |
| Diseases of respiratory system | 31,786 | 35,773 |
| ...of which asthma | 337 | 681 |
| Diseases of digestive system | 11,974 | 13,256 |
| Diseases of skin etc | 609 | 1,240 |
| Musculoskeletal system | 1,314 | 2,827 |
| Genitourinary system | 4,873 | 7,125 |
| Pregnancy, childbirth | - | 63 |
| All accidents | 6,811 | 5,106 |

| | | |
|----------------------------|---------|---------|
| Of which... land transport | 1,692 | 529 |
| ...falls | 1,823 | 1,770 |
| ...drowning/submersion | 162 | 43 |
| ...smoke/fire | 161 | 118 |
| ...poisoning by narcotics | 547 | 101 |
| ...intentional self-harm | 2,701 | 756 |
| ...assault | 216 | 102 |
| All causes, all ages | 238,062 | 253,286 |

It is interesting to look at the median age group at death for certain causes too:

Table 2. Median age group for selected causes

| Cause | M | F |
|-----------------------------|-------|-------|
| HIV | 45-54 | 35-44 |
| All neoplasms | 75-84 | 75-84 |
| Lung etc cancer | 75-84 | 75-84 |
| Malignant melanoma | 65-74 | 75-84 |
| Breast cancer | 75-84 | 75-84 |
| Prostate cancer | 75-84 | - |
| Brain cancer | 65-74 | 65-74 |
| Leukaemia | 75-84 | 75-84 |
| Diabetes mellitus | 75-84 | 85+ |
| Motor neuron disease | 65-74 | 75-84 |
| Parkinson's disease | 75-84 | 85+ |
| Alzheimer's disease | 85+ | 85+ |
| Multiple sclerosis | 55-64 | 55-64 |
| Acute myocardial infarction | 75-84 | 85+ |
| Stroke | 85+ | 85+ |
| Asthma | 85+ | 85+ |
| All accidents | 85+ | 85+ |
| Land transport accidents | 15-24 | 15-24 |
| Narcotics | 35-44 | 25-34 |
| Intentional self-harm | 35-44 | 45-54 |
| Assault | 35-44 | 35-44 |

As population numbers decline at older age bands, so the relative risk of death from any cause at older age groups increases. To some extent therefore, the data in Table 2 calls into question the value of products such as critical illness cover, which typically only run to retirement age or below (i.e. below the age at which most people will die from those conditions). However, insurance is needed most during people's working lifetime rather than in their retirement years, because any serious illness or death is likely to stop the flow or reduce the flow of income into the family unit. In other words, people still need CI cover!

Health inequalities rising

Inequalities in mortality between different areas of the UK have almost surpassed those seen shortly before the economic crash of 1929 and the economic depression of the 1930s according to a study in the *BMJ* on 23 July. Inequalities in age-sex standardised mortality below age 75 in England and Wales have increased every two years from 1990/91 to 2006/07 without exception.

In 1990/91 people in the poorest areas were 1.6 times more likely to die than those in the most affluent areas. By 2006/07 this figure had increased to two times.

The study was carried out by researchers at the **University of Sheffield**.

Protection Review Conference thoughts

We asked Protection Review's directors for their thoughts on this year's Protection Review Conference, which was held at the Marriott, Grosvenor Square, London on 15 July. What was the key impression for them?

Kevin Carr:

'What was the one key point I took from this year's Protection Review events? That our industry, if there is such a thing (which was hotly debated at the conference) needs to collectively decide on what it actually wants to achieve going forward. Otherwise we will never get very far and will continue to be a group of self-interest organisations and individuals who primarily exist to criticise, compete with and occasionally commend each other.

Do all parties really want to grow the industry? I'm not convinced. Future market factors, such as Solvency II, are impacting on tomorrow's market today and if premiums begin to rise, the number of new policies being sold could fall significantly, as switching and churning becomes a thing of the past.

If there isn't a collective aim, for whatever reasons, we are better off knowing it so that we can stop wasting time and money trying and failing to act collectively and instead focus on individual businesses. Or building the garden while the house burns, as some might say.

Yes, there are leaders, but they lead individual businesses with different agendas to their competitors. Yes, there are passionate people, but are they passionate enough, and about the right things? The industry needs to act quickly but is desperately lacking coherent direction and leadership.'

Peter Le Beau:

'What was my key impression from this year's Protection Review conference? It was that some people work in the protection industry and do the job as well as they can but it is at the end of the day just a job. They could equally well work with the same conviction and enjoyment in the plumbing or birdseed industry for example. This is not a criticism; it is an observation, albeit a very frank one.

For others, protection is a passion and people in this category really believe that we need to be much more energised as an industry in getting the value of our products known to the press and other media, the Government and, above all, the public.

They are restless about how effectively we communicate this message, and believe we need to do much more. My take from the conference is that several of these people exist but not nearly enough. To succeed we need more passionate advocates for protection and less bystanders.'

Andy Couchman:

'One phrase I heard a lot during the day was 'being seen as part of the solution, not part of the problem'.

As an industry we have spent much of the banking crisis keeping our heads down and not wanting to be part of the problem (we had too much of that with various mis-selling scandals over the years), but did we really want to be seen as the solution either?

The fact is, many are comfortable with the current broker/IFA led model and benchmarking themselves against broadly similar thinking rivals. But, if we want to make a real breakthrough and help the majority rather than the minority of the UK's working population, we have to change the model—and that will not be pain free.

Certainly, there will still be a place for intermediaries—indeed, in absolute terms their role is likely to expand. But, to get to the mass market requires mass marketing of products that may have to set aside some of our most cherished specialisms, such as underwriting.

The question is whether we are hungry enough to want real success or are we content to focus on what we know and what we know we can do well but could do better. It's a challenge, but the short window of opportunity we have now is maybe a once in a generation chance.'

Commission on the Funding of Care and Support

The issue of funding individuals' long term care (LTC) has long been a thorny issue and its history is not really one to be proud of.

When the NHS was set up in 1948, LTC was not specifically included, leaving the NHS to pick up some of the responsibility only. From 1992, local authorities took over responsibility for LTC funding (although the NHS continues to have a responsibility for continuing care—a hard to define need that has given rise to great uncertainty and sharp practice over the years). Most care (and especially residential care) is however means tested, with complex and different rules applying in each country of the UK (with Scottish residents generally getting the best deal).

A 1990 Royal Commission recommended that personal care be funded by the Government, but that was only adopted in Scotland. Instead the UK Government largely ignored the Commission's recommendations.

In the run up to May's election, the outgoing Government sought to gain all party agreement on the way forward but the Tories saw that as a trap and refused to take part, at least initially.

On 20 July however, Health Secretary Andrew Lansley set up a **Commission on the Funding of Care and Support**. Led by the able (and media friendly) economist (ex IFS) and academic (principal of **St Hugh's**, Oxford) Andrew Dilnot, supported by commissioners Lord Norman Warner and Dame Jo Williams, it has less than a year to make its recommendations, and the Government plans to publish a White Paper on the way forward in 2011.

The commission's terms of reference are to examine and provide deliverable recommendations on:

- How best to meet the costs of care and support as a partnership between individuals and the State.
- How people could choose to protect their assets, especially their homes, against the cost of care.
- How, both now and in the future, public funding for the care and support system can be best used to meet care and support needs.
- How its preferred option can be delivered, including an indication of the timescale for implementation, and its impact on local government (and its finance system), the NHS and, if appropriate—financial regulation.

People news

• **ABI (Association of British Insurers).** Director general Kerrie Kelly stepped down from her role on 15 July 'to return to Australia for personal reasons'. Director of life and savings, Maggie Craig, will take over as acting DG until a replacement is found.

• **Blossoms Healthcare.** Claire McCusker has been appointed commercial manager.

• **BMA (British Medical Association).** Sir Michael Marmot has been appointed president for the term June 2010 to June 2011.

• **Buck Consultants.** Mike Roberts has been appointed executive managing director.

• **Bupa.** Divisional MD, UK and North America, Fergus Kee, is leaving after 18 years with the organisation to pursue other opportunities. He is succeeded by Alison Platt who becomes divisional MD for Europe and North America. Mark Ellerby, MD of Bupa Care Services, becomes responsible for Bupa Home Healthcare. Martin George becomes MD, group development.

• **Canada Life Group Insurance.** Dan Crook has transferred internally to take up the new role of head of sales (London) and strategic partnerships. Bob Free is now head of sales (Bristol) and Colin Matson takes over from retiring Peter Cole as customer relationships director.

• **Fineos. Protection Review** co-chairman Peter Le Beau has been appointed a non-executive director.

• **Fortis Life.** Mark Anders has been appointed head of sales. He was previously head of sales at **Bupa**.

• **Health Shield.** Courtney Marsh has been appointed its first chief risk officer. He was previously at **Oliver Wyman**.

• **Jelf.** Jason Britton has been appointed executive director of its **Manson Warner Healthcare** division. He was previously with **Bupa**.

• **Mercer.** John Anderson is head of its Health & Benefits UK division. He was previously with **AXA PPP healthcare** as director of new business development. Deborah Cowell has been appointed a principle and senior consultant. She was previously head of **Hewitt's** health and risk benefits group.

• **National Friendly.** Alan Lewis has been appointed chairman, succeeding the retiring Don Burgess.

• **PMI Health Group.** Iain Laws has been appointed account director.

• **Premier Choice Healthcare.** Sarah Vernon has been appointed senior accounts manager for the Midlands/North regions. She was previously with **TL Risk Solutions (Towergate)**.

• **Sovereign Health Care.** Mike Bower has been appointed chairman, taking over from Mark Hudson.

• **Unum UK.** CEO Susan Ring is stepping down (although she will continue in an advisory capacity until February 2011). Jack McGarry, senior vice president of Unum US takes over as CEO of Unum UK. Marco Forato has been appointed chief marketing officer, having transferred from Unum US.

e-Protection Review T&C

Our regular training and competence (T&C) section consists of five questions that test your knowledge of what is happening in the health and protection insurance world. Each question is covered somewhere in this issue of *e-PR*.

All you have to do is answer the questions, check your answers against the newsletter (or log on to and see the Forum section at www.protectionreview.co.uk) and then record your answers. Over time you build up additional evidence of your training and competence. This issue's questions are:

1. Who recently stepped down as director general of the ABI?
2. Who has been appointed to head up the Government's new Commission on LTC?
3. What is the median age group in which someone is most likely to die from cancer?
4. Which is likely to be the more expensive private hospital treatment—a coronary artery bypass graft (CABG) or a total hip replacement?
5. Approximately what were PMI premiums in 2009 i) £2.5bn ii) £3.5bn or iii) £4.5bn?

Do you find TCIR useful? Would you like it in a different form or more questions? Please let us know.

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Private hospital treatments

| Treatment | From | To |
|-----------------------------------|---------|---------|
| Breast lump removal | £1,530 | £2,500 |
| Cardiac catheterisation | £2,000 | £3,450 |
| Carpal tunnel release | £900 | £2,100 |
| Cataract removal | £1,700 | £3,250 |
| Colonoscopy | £1,100 | £1,650 |
| Coronary angioplasty | £8,800 | £14,175 |
| Coronary artery bypass graft | £13,650 | £17,000 |
| Cruciate ligament repair | £3,675 | £6,400 |
| Gall bladder removal | £3,850 | £6,350 |
| Gastroscopy | £700 | £1,750 |
| Grommets insertion | £1,300 | £1,750 |
| Haemorrhoids removal | £1,575 | £3,075 |
| Hernia repair | £1,650 | £3,800 |
| Hip replacement | £8,200 | £10,300 |
| Hysterectomy | £5,000 | £6,700 |
| Hysteroscopy | £1,375 | £1,875 |
| Knee arthroscopy | £1,650 | £3,150 |
| Knee replacement | £9,300 | £14,600 |
| Laparoscopy | £1,900 | £2,775 |
| Mastectomy | £3,450 | £5,200 |
| Prostate surgery (TURP) | £4,050 | £5,100 |
| Tonsillectomy | £1,650 | £2,375 |
| Varicose vein surgery (both legs) | £2,300 | £3,300 |
| Varicose vein surgery (one leg) | £1,650 | £2,300 |
| Varicose vein laser treatment | £1,170 | £3,400 |
| Wisdom teeth extraction | £1,425 | £1,700 |

Guide prices are normally for a fixed all-inclusive price.

Source: *Guide prices for private medical treatment*, Spire Hospitals, July 2010. www.spirehealthcare.com.

Top 10 health insurers 2008

1. Bupa (1)
2. AXA (2)
3. Aviva (3)
4. Standard Life Healthcare (4)
5. Cigna International
6. WPA (6)
7. BCWA (now Simplyhealth) (8)
8. Munich Re (9)
9. Genworth Financial (7)
10. Groupama (10)
11. Prudential (12)
12. Exeter Friendly (11)

Source: ABI, July 2010. 2007 position in brackets

Employers' objectives in providing health benefits to staff

| Reason | Obj | Ach |
|--|-----|-----|
| Improving the health and welfare of staff | 64% | 54% |
| Reducing sickness absence | 51% | 51% |
| Improving productivity | 27% | 23% |
| Complying with health and safety regs | 25% | 44% |
| Getting employees back to work asap | 24% | 51% |
| Being seen as an employer of choice | 17% | 28% |
| Being seen as a caring employer | 14% | 50% |
| Reducing workplace stress | 11% | 27% |
| Preventing future health issues for staff | 9% | 31% |
| Controlling costs | 8% | 26% |
| Improving staff retention | 8% | 28% |
| Improving recruitment by keeping up with the benefits offered by competitors | 5% | 18% |
| Improving recruitment by offering better benefits than competitors | 5% | 16% |
| Being seen as providing a duty of care | 5% | 36% |
| Reducing musculoskeletal problems | 2% | 20% |

Note: the two columns show the percentage of respondents citing that reason as a top objective, and the percentage reporting having been successful in achieving that objective. It is interesting to note a disconnect—many more firms are achieving benefits than setting out to achieve them.

How will the current economic climate affect employers' provision of healthcare benefits in next 12 months?

| | |
|---|-----|
| Under more pressure to reduce costs | 39% |
| Will review providers to get a better deal | 38% |
| No effect on spend on healthcare benefits | 31% |
| Need to communicate benefits better to staff | 22% |
| Have to consider which benefits to offer | 20% |
| More emphasis on benefits that tackle stress | 13% |
| Review fees/commission paid to brokers etc | 13% |
| Will rebroke benefits | 13% |
| Will focus more on wellbeing benefits | 12% |
| Will be harder to justify cost | 7% |
| Plan to restructure insurance h/care benefits | 6% |

Source: *Healthcare Research 2010*, Employee Benefits magazine June 2010. Base max 402 employers.

Protection Review: financial services consultancy and communications solutions

We provide bespoke marketing and strategic consultancy and communications services to firms across health and protection insurance, led by three of the best-known names in the industry. Our expertise, knowledge and contacts enable us to help clients maximize their potential in a fast and cost-effective way.

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