e-Protection Review

(incorporating HealthCare Insurance Report)

from Peter Le Beau MBE, Andy Couchman, Kevin Carr

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Protection Review and PFS plan to launch independent training

Protection Review is looking to team up with the **Personal Finance Society** (**PFS**) to provide independent specialist protection training aimed at improving knowledge and understanding of the industry at all levels. The training will cover all aspects of the market on an interactive basis including products, underwriting, claims, regulation, sales and technology and will make relevant reference to any current or future protection qualifications.

The plan is to pilot the training at the beginning of 2011 as part of a series of other *Protection Review* initiatives going forward, which will include the annual conference, book, awards dinner plus a new improved website.

Fay Goddard, CEO of the Personal Finance Society (PFS), stated: "As the leading professional body for financial advisers, our mission is to guide the financial advice community towards higher levels of professionalism. The PFS is always keen to support initiatives designed to improve the quality of advice. We are in discussions with the Protection Review with a view to developing professional training for the protection market that will bring benefits to both advisers and their clients".

Co-funded by insurers and reinsurers, the sessions should begin early in 2011 and will be open to anyone to attend, including intermediaries, para-planners, non-advisers and life office staff (including underwriters) as well as the media. Although product providers will be welcome to attend, they will not present nor influence the content of the training, which will remain independent and will be delivered by a range of presenters including intermediaries, independent experts and the Protection Review team.

Protection Review CEO, Kevin Carr, said: "The idea of unbiased protection training has been called for, and talked about, for as long as I can remember. One of our key aims is for this training to be delivered by independent experts, including intermediaries, with the core purpose of improving knowledge and understanding of the protection industry, without promoting any specific products. We hope this initiative will continue to improve the protection industry of tomorrow."

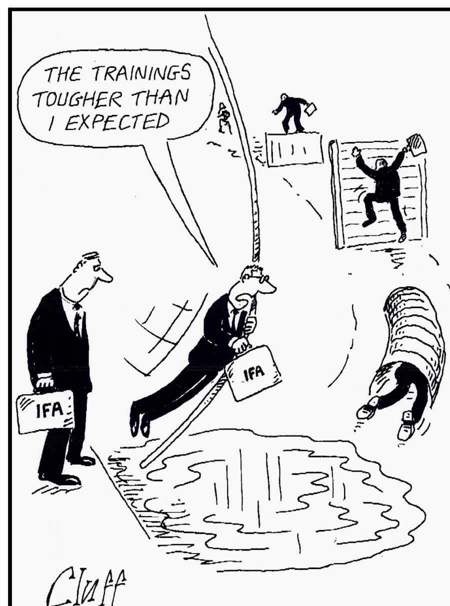
Peter Chadborn of IFA **CBK Colchester** said: "With the exception of some good provider seminars and marketing material there is precious little (*Continued on Page 2*)

Quotes of the month:

'William Beveridge has been called up a lot lately in posthumous vindication. But surely, if Beveridge were devising a welfare state today, he would not invent the structure that, as much by accident as design, we have in 2010.' *The Times* Leader article, 6 October 2010.

"It is unacceptable that so many people have been written off to a lifetime on benefits." Minister for Employment, Chris Grayling, 11 October 2010.

"I worry that if you ask people to pay for financial advice they won't bother getting it at all." Martin Lewis, consumer champion and head of Money Saving Expert, speaking at a Treasury Select Committee meeting on 19 October 2010.



Key statistics:

- NHS RTT median wait England August 2010: 8.3 weeks (See Page 11)
- e-Protection Review Long Term Protection Sales Index: 109.6 (Quarter 2, 2010, compared to base 100 in Quarter 1, 2000).
- e-Protection Review Employment Index: 107.230 (To end August, compared to January 2000, see Page 11).

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(*Continued from Page 1*) protection-focused training available in the industry. Individual provider seminars are very welcome although they tend, naturally, to promote the wares of the host. There is therefore a need for well-informed, broad-ranging independent protection training, hosted by an unbiased source".

The *Protection Review* team is currently building the training content and welcomes ideas and input from across the industry. Which is where you come in…

Your views are sought

We are very keen to hear from *e-Protection Review* readers as to what should and should not be in the training (we are also keen to hear from you if you if you would like to talk to us about partnership opportunities, either of the training or of other elements of Protection Review).

For example, how much should be technical training, to what extent should the sessions cover external factors such as State benefits and how much attention should be paid to marketing? Also should we focus on individual clients or include groups, and should we focus on particular product areas or cover all needs, including medical insurance, dental plans and health cash plans?

Clearly, there is still some way to go before we sign off the first sessions, but the aim of involving you now is simply to ensure that you have the maximum opportunity to get involved and to let us know your views.

You also have the opportunity to plan your own marketing initiatives in 2011, taking account of the planned training days.

But why is Protection Review getting involved in such initiatives?

Our three principals—Peter Le Beau, Andy Couchman and Kevin Carr—all have considerable experience in the health and protection insurance sector, and all are passionate about protection.

In addition, we have long held the view that intermediaries need more support if they are to help raise levels of protection in the UK.

The role the whole industry plays

Product providers, professional and trade bodies and training organisations have all played a key role in getting protection messages across to intermediaries, as has the trade press. In particular, publications such as the weekly *Money Marketing* and *Financial Adviser* titles, as well as the monthly *Health Insurance* and *Cover* publications and online sources such as *IFA Online* have all played an important role and we hope will support this new initiative too.

In terms of their professional background, Kevin Carr has been a leading protection and mortgage adviser as well as, most recently, a top product director and PR guru, Peter Le Beau has been a leading reinsurer and is co-chairman of the influential **Income Protection Task Force** (and last year was awarded the MBE for his services to insurance and charities) and Andy Couchman has been a leading product marketer and author of a number of books, reports and online training materials covering the health and protection insurance sector. In addition, Andy has reviewed well over 500 health and protection products over the past decade and a half and all three principals continue to work with leading providers on strategic, communications and product and service development matters.

We think that as well as our experience, expertise and passion, we also bring independence. Many advisers have told us that that is important, not least because there can be conflicts around CPD (continuing professional development) and their own independence if advisers are perceived to be too influenced by individual providers.

PFS: the leading professional body

The PFS is a natural partner in this initiative. It is the professional body for financial advisers and has around 27,000 members in the UK. It also has a track record of promoting excellence and professionalism.

Protection Review already works with the PFS too.

Since 2008, one of the highlights of the annual *Protection Review* book has been the survey of PFS members.

Sponsored by **Fineos**, this unique survey indicates what a broad cross-section of advisers (most of whom are not health and protection specialists) think about issues in the health and protection insurance market.

In this year's survey, PFS members ranked 'raising consumer awareness' as the best way to boost protection business. Intermediaries themselves can play a key part in that through their promotion of the need for health and protection insurance, first to their clients, and then through them to their wider families and businesses.

More than half (52.5%) of those polled also thought that more technical training from providers would help give advisers a greater emphasis to personal protection insurance. And 60.7% wanted more marketing support too.

Such support, when coming from an independent, specialist source and in conjunction with an organisation with the reputation that the PFS has, means all intermediaries can benefit from the training envisaged. As well as intermediaries, their support staff and providers' own staff would also benefit from the same common platform, so helping promote better understanding. So do please e-mail *kevin@kevincarrconsulting.co.uk* to make your views known.

Comment: What's the point of failing CPD?

The latest (October/November) issue of *CII Journal*, the six times a year journal of insurance's leading professional body, includes a section on Disciplinary matters, notes *ePR* editor Andy Couchman.

Like previous issues, many of these relate to CII and PFS members who have a professional qualification but who have failed to provide CPD (continuing professional development) records as required by the CII CPD scheme, despite numerous requests and a final warning.

Why? Without knowing the individual circumstances, it is not fair to criticise the individuals named (and 'shamed') but, based on previous experience, it is likely that many of these i) probably do enough CPD already, but ii) have refused to supply proof of that.

Some get hung up on not wanting to fill in 'official forms' (a bit ironic for anyone whose career is in insurance…) or take exception to being asked to prove that—in a word—they are 'professional'.

Insurance is no different to any other profession—if you want your peers, your customers, your colleagues and your bosses to regard you as being professional you have to behave as a professional. And that means making CPD part of your life. Develop your own recording system by all means but do it! Investing in knowledge is never time or money wasted, but you do need to have proof of having done it too.

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Progress closes as Bupa sells long term arm to Friends

Two major changes to the long term protection insurance market were announced in October, as insurers consider their future in the light of forthcoming regulatory changes.

Progress from Royal Liver, the UK's first ever e-only protection provider launched in 2004, closed to new business on 30 September. A statement on the same day said: 'The decision to close to new business is based on the Society's primary objective, which is to manage its resources in the best interests of its policyholders. As such, its focus is on actively managing its capital position. Due to capital constraints, the Society is not in a position to continue to invest in the long term prospects of the Progress business.'

Existing policies are not affected nor will the decision to close to new business affect **Royal Liver's** continuing discussions with **Royal London** regarding a potential merger.

Progress used **Vertex Financial Services** as a third party administrator and its subsidiary **OtterRisk Solutions** as its underwriting partner. By doing so, and by embracing technology, Progress was able to employ a very small head office team in an aim to drive costs down and service levels up. Some 90% of its applications required no GP Report, while clean cases could go on risk within ten minutes, it boasted. As recently as June 2010, Progress won a five star award for its service from **FTAdviser.com**.

Later, on 15 October, **Bupa** announced that it was selling its long term protection arm, **Bupa Health Assurance Ltd** (**BHA**) to **Friends Provident Life and Pensions Ltd**, part of the **Resolution** group.

Friends Provident CEO Trevor Matthews said: "This acquisition will strengthen our group risk product range and improve the profitability of our individual protection business."

BHA will continue as a standalone business for up to one year. CEO Steve Payne will report direct to Trevor Matthews. As part of the deal, Friends and Bupa are examining ways in which Friends can introduce Bupa private medical insurance to its distribution channels and markets and Bupa can introduce Friends' products to its distribution channels and markets.

Then, on 24 October, the *Sunday Times* reported that the **Co-operative** group is planning to sell its £18bn life assurance business, having earlier sold its IFA arm to wealth manager **Ashcourt Rowan**. CEO Neville Richardson is believed to have appointed **Deutsche Bank** to consider the sale, as he apparently plans to focus on Co-op's 350 branches rather than its direct salesforce.

Earlier this year, Friends also acquired **AXA's** life business and **Vanbreda** fell to **Cigna** in August.

Rumours persist too of other insurers apparently planning to sell their protection arms or to withdraw from the UK market. Despite that, **Aegon** has confirmed its commitment to the market, on the back of 25% cost savings targets including pulling out of group risks.

Comment: *So, what's going on? There is no single overarching issue—a number of factors are at play here.*

First, providers are looking at the implications of the forthcoming Solvency II and ***FSA*** *RDR (Retail Distribution Review) regulatory changes, which affect required solvency margins and distribution. In itself, these are big strategic issues—so it is no surprise the market may have more willing sellers and more willing buyers, with predators seeking scale. In addition, Bupa's long term arm was always a slightly uncomfortable fit with its other businesses and, on its own, was too small to leverage and extend the Bupa brand name very much further.*

Protection sales continue to be dominated by price, which has meant providers having to pare costs, only to see others following suit to negate any advantage they may have created. M&A (mergers and acquisitions) activity or IT changes such as straight through processing (STP) all help drive costs down, but so long as price dominates, insurers will have little scope to create competitive advantage, other than continuing to try to drive down price and to acquire scale.

As we point out on Page 13 though, there are limits to how far that strategy can continue, so we may see more CEOs looking to embrace innovation more in future.

In particular, both clients and intermediaries need to be weaned off judging products on price alone. That may be hard in say the term assurance market—where relatively little value can be added elsewhere—but it is feasible for other products.

In the short run, more M&A activity is likely; long term, providers need to create and communicate their brand values better, and to make protection insurance a more desirable buy than it is at present. Government retrenching on welfare will help, but providers will also need to take decisive action themselves to switch on not just end consumers but also intermediaries and perhaps create new distribution channels too.

40m unclear on State benefits

Nearly 40m Britons are unclear of what kind of financial support they would get from the Government if they or a family member was diagnosed with a serious illness, according to **Scottish Provident's** *Financial Safety Net report*, published on 18 October.

- 71% of 2,044 people polled online between 26 and August 2010 by **Opinium Research** said that the current unemployment benefit was not enough to live on (15% did not know).
- 57% said that disability benefits were not enough to live on (18% did not know).
- 80% did not know what benefits were available.

ABI promotes industry LTC case

The **Association of British Insurers** (**ABI**) has published two new papers on long term care.

A Sustainable Future for Long Term Care sets out the role of the insurance industry in providing expertise and products and how the industry has the potential to play a major role. It also argues that 'clear incentives are essential to persuade people to take personal responsibility for their future needs'.

A Brief Guide to Long Term Care Insurance explains the main types of LTCI cover and the need for them. It refers enquirers to the **Society of Later Life Advisers** (**SOLLA**) or **Association of Independent Financial Advisers** (**AIFA**) for financial advice and information.

European protection gap €10trn

The life insurance protection gap across 12 key Continental European countries is €10,000bn (€10trillion) according to a new survey by **Swiss Re** launched on 27 September.

The European Insurance Report 2010—Customers for Life, polled more than 11,000 consumers and found that many have a clear need for life insurance but are unaware of how it can help deal with the financial impact of death, illness or disability. The report also found that only 11% claim to be 'well positioned financially' if the worst happens, while 26% would rely on government handouts.

Many people overestimated the amount of cover they actually had, and others said they would rely on savings in the event of death or a serious illness or disability.

Perceived cost is a barrier to buying cover, whereas life insurance products are in practice affordable and within the price people are prepared to pay. 48% said price was an issue, but nearly half would pay €20 a month for €100,000 of term cover.

The report also argues that while consumers are at ease with existing distribution channels (97% were happy with at least one distribution channel), insurers need to engage better with consumers and build trust in the industry. One in ten consumers said trust was the main barrier.

The protection gap could be met by consumers paying premiums of €25bn a year (i.e. the effective value of the untapped market to insurers). If a single insurer could capture just 1% of that, it would be worth an additional €250m a year to them, Swiss Re points out.

BBA's judicial review on PPI

The **British Bankers' Association** launched a judicial review on 8 October of the **Financial Services Authority's** (**FSA's**) complaints handling measures regarding payment protection insurance (PPI).

The FSA immediately responded that it would 'vigorously' contest the review and said it expected firms to continue handling complaints while the process was ongoing. It pointed out that in the past five years (since it took over PPI regulation in 2005) more than a million complaints about PPI had been made to firms and that it had taken enforcement action against 24 firms for sales failings.

Which? CEO Peter Vicary-Smith said: "It makes you wonder what planet the banks are living on. Not content with the billions they have made from this overpriced, flawed and frequently missold product, the banks now seem to be trying to wriggle out of implementing changes that would ensure consumers are treated fairly."

The BBA says the review is about the ability of the FSA and FOS 'to apply new standards to old sales'. A result is expected by early 2011.

Employee wellbeing strategy up

Almost half (46%) of companies have an employee wellbeing strategy in place, compared to 33% in 2009 and 30% in 2008, according to The 2010 **Chartered Institute of Personnel and Development** (**CIPD**) *Absence Survey*, in partnership with **Simplyhealth**.

Despite tough economic times, 22% of firms spent more on wellbeing in 2009, while only 9% spent less. Those who evaluate their wellbeing spend were also more likely to increase spending in 2011, Simplyhealth noted.

The report also found that 35% of employers have reported stress-related absence up over the past year. It is now the main cause for persistently high levels of long term public sector absence.

73% of manual and 79% of non-manual public sector employers ranked stress as a top five common cause of absence, compared to 35% and 50% of private sector firms.

Average annual absence was 9.6 days per employee in the public sector and 6.6 days in the private sector.

To download a copy see *www.cipd.co.uk/research/_how-fit-is-your-organisation*.

PWC warns of RDR waste

In a speech at the **Association of British Insurers** (**ABI**) Solvency II conference on 20 October, **PwC** partner Charles Garnsworthy urged the insurance industry not to waste the competitive advantages the directive creates. He commented: "Solvency II is a great opportunity for insurers to transform how investors, analysts and policyholders perceive the security and value the sector adds. This opportunity may be wasted as many firms are so bogged down in what they need to do to comply.

"Many insurers will need to rethink where and how they want to compete, as there will inevitably be aspects of some businesses that no longer make sense. It is worrying that we are hearing about people being taken out of product design and innovation to work on compliance, as Solvency II offers the chance to stand out from the pack."

The capital rules under Solvency II will fundamentally affect insurers' investment options, returns, how they run their businesses and even which products they sell.

Mr Garnsworthy commented: "It is understandable that technical details and the cost and upheaval of compliance are top priorities, but there is a real danger insurers might lose sight of the strategic impact of Solvency II. Solvency II will be a catalyst for managing risk and capital more efficiently and is a real chance for the industry to send a clear message to the markets that it can respond swiftly and decisively to opportunities."

2 in 3 put off healthcare by cost

Almost 80% of Britons are worried about the cost of healthcare and many are postponing or cancelling treatment as a result, according to online health insurance provider **Health365.com** (part of **Westfield Health**).

The survey of 1,000 UK adults by **Your Say Pays** found that over a quarter (27.6%) had put off seeking healthcare for more than six months due to cost, and 19.4% for between one and six months.

The percentage that had put off or cancelled treatment included:

• Dental check-up	31.6%
• Dental treatment	33.1%
• Optician's appointment	20.7%
• Optical prescription charge	20.7%
• Other treatments	6.7%
• Doctor/hospital appointment	11.9%
• None/never have	35.9%

Protection sales flat in Q2

Sales of individual long term protection insurance plans were largely flat in the second quarter of 2010, according to the **ABI's** (**Association of British Insurers'**) latest stats. The number of policies sold was down marginally, although new annualised premiums remained the same:

Table 1. Long term protection sales Q1 2010 vs. Q2 2010

	Sales 000s		Premiums £m	
	Q1	**Q2**	**Q1**	**Q2**
Whole life	**123**	107	29	26
Term—non-mortgage	**250**	244	**93**	93
Term—mortgage	**172**	174	**58**	58
Income protection	**26**	28	12	12
Standalone crit ill	**5**	5	**3**	3
Crit ill rider	114	124	59	62
Totals	**690**	682	**254**	254

Compared to the same period of 2009, sales volumes were up 12%, with new annualised premiums up by 5%:

Table 2. Long term protection sales Q2 2009 vs. Q2 2010

	Sales 000s		Premiums £m	
	2009	**2010**	**2009**	**2010**
Whole life	104	107	**26**	26
Term—non-mortgage	**219**	244	**93**	93
Term—mortgage	**154**	174	**57**	58
Income protection	30	28	12	12
Standalone crit ill	4	5	3	3
Crit ill rider	98	124	51	62
Totals	**609**	682	**242**	254

Note: Figures in bold are different to the figures in *HCIR 117* and *ePR 125*, reflecting changes as the ABI updates figures when new information becomes available. Note: there is an element of double counting in our data, as CI rider sales are also included in each product's data.

Taking into account both Q1 2010 and Q2 2009, protection sales may have flattened out again. Compared to Q2 of 2010, term assurance (both mortgage-related and 'other') sales have grown, as have critical illness rider sales, but whole life and income protection sales have remained flat.

In the whole life market, guaranteed acceptance plans (essentially, those sold to the over 50s) made up almost 98,000 of the 104,000 sales. However, their annualised premiums accounted for just £15.958m of the total annualised premiums for all whole life plans.

The market for mortgage related term plans continues to be subdued, reflecting the state of the underlying mortgage and housing markets.

At this point last year we said that the challenge for insurers remained to increase interest in their protection products and a key element of that will be training and motivating intermediaries to channel more of their efforts into encouraging potential customers to take action to buy cover now. That view still holds good—intermediaries need access to low cost, independent training and motivation to encourage them to see protection as a bigger part of their overall advice portfolio.

This is an area where **Protection Review** has strong views and, as we set out on *Pages 1 and 2*, we are working hard with the **PFS** to help ensure that that can come about from as early as Q1 of 2011.

Table 3 compares sales in Q2 of 2010 with those in Q1 of 2000 and enables us to index sales since then. The overall *e-Protection Review Protection Sales Index* fell from a revised 110.0 in Q1 of 2010 to 109.6 in Q2 of 2010:

Table 3. Long term protection sales Q1 2000 vs. Q2 2010

	2000	**2010**	**Index**
Whole life	111	107	96.4
Term—non-mortgage	168	244	145.2
Term—mortgage	137	174	127.0
Income protection	41	28	68.3
Standalone crit ill	22	5	22.7
Crit ill rider	141	124	87.9
Totals (inc LTCI)	622	682	109.6

Compared to 2000, term sales (even in the mortgage market) are considerably higher in 2010 than they were then, while whole life sales have recovered somewhat but are still below 2000 levels.

The big losers remain income protection and critical illness cover. Fundamentally, demand for both should not be lower than it was almost a decade ago, so the fall in sales volumes must be due to other factors.

That includes lack of trust (now addressed through a range of initiatives, particularly led by the ABI), perceived underwriting complexity and more ratings, and technical complexity (many IFAs have poor knowledge of IP issues for example, although IP specialists and the **Income Protection Task Force** are addressing that).

Looking at the group market, Table 4 shows sales of plans in terms of new annualised premiums.

Table 4. Group protection sales 2009 and 2010

Product	**Q2 2009**	**Q1 2010**	**Q2 2010**
Group life	46	33	44
Group critical illness	2	4	5
Group income protection	26	23	20

Again, income protection is the big loser in this group. That reflects concerns of employers about funding GIP for ageing workforces, especially given the move away from fixed retirement ages. Disappointingly, that has not yet had a knock-on positive effect on individual IP sales.

Group CI sales are up, albeit from a low base, while group life sales are up on Q1 of 2010, but marginally below Q2 of 2009.

Overall, protection sales in the second quarter of 2010 were ahead of what some in the industry feared, although we are convinced that they remain below the sector's true potential.

A key element of that—given that generally, premiums remain very competitive and significantly below those available a decade ago, is that many intermediaries have focused on being 'wealth advisers' in recent years rather than seeing protection as a profitable bedrock on which to build their other business.

The implementation of the **FSA's** RDR (Retail Distribution Review) from the end of 2012 gives the industry an opportunity to change that—almost regardless of what the actual implications of the RDR will be. That is the main challenge, as Government cutbacks create strong external drivers that should also benefit the protection sector.

News briefs:

• Following its acquisition of **Network Insurance Brokers**, **BHSF** has announced its intention to move into the personal accident insurance market too. It currently has 2,800 corporate and 400,000 individual customers.

• In a letter to *The Times* published on 14 October, **Macmillan Cancer Support** criticised the 'anachronistic' rules of insurance law that leave protection policyholders with inadequate legal resource. 'In a minority of cases the unwarranted rejection of claims inflicts further stress at what is already a difficult time,' the charity's head of campaigns, Mike Hobday, wrote. The **Law Commissions** have published a number of proposals to change key elements of insurance law around disclosure and other issues.

• **Counsel and Care**, the national charity, has formally launched a new refreshed website to better meet the needs of older people, their families and carers, as well as professionals and other interested parties. The revamp was funded by a grant from **The Clothworkers Foundation**. See *www.counselandcare.org.uk*.

• The **Financial Services Skills Council** is converting to become a charity and changing its name to the **Financial Skills Partnership**. The changes are expected to take place early in 2011.

• The **British Insurance Brokers Association** (**BIBA**) has responded to a **HM Treasury** consultation paper on regulation to call for it to be more proportionate and cost effective. Brokers pose a low risk, it points out.

• The **F&TRC Protection Forum** has produced a draft *Good Practice Statement* for business retention systems, setting out how providers should notify advisers when direct debits are missed or cancelled, so that customers can be contacted. Feedback is open until 4 November—see *www.adviserforum.org/goodpracticenotes/default.asp*.

• 64% of 1,500 workers polled for **Aviva UK Health** believe that NHS services are superior to the health benefits available in other countries, it reported on 14 October. 17% wrongly believed they would automatically qualify for free healthcare abroad and 41% that as a UK citizen they automatically qualify for free healthcare within the EU and Commonwealth.

• Allowing advisers to write policies in trust online without a wet signature has seen trust cases more than double in the past four months **Fortis Life UK** (soon to be rebranded **Ageas**) has reported.

• **Laing & Buisson** has improved and updated its *Fair Price for Care* model, which is used to determine the price that should be paid for residential and nursing care. See *www.laingbuisson.co.uk*. The original dates back to 2002.

• **Selectx** and Karin Lloyd have developed a claims technology survey to help determine how best technology can meet claims needs. See *www.selectx.co.uk*.

• Benefits spending in 2010/11 will include £11.7bn on Disability Living Allowance; £9.1bn on Employment and Support Allowance and Incapacity Benefit; £7.5bn on Jobseeker's Allowance; £5.2bn on Attendance Allowance; £1.6bn on Carer's Allowance, and £0.8bn on Severe Disability Allowance *The Times* revealed on 1 October. Biggest spends are on retirement pensions (£69.7bn), Tax Credits (£29.3bn), Housing Benefit (£20.9bn) and Child Benefit (£11.9bn). Figures come from **HM Treasury** and the **IFS**.

• IP provider **Holloway Friendly** has introduced tele-underwriting for applicants. A two page application form is followed by phone contact. Holloway expects to need 80-90% fewer GPRs (GP reports) as a result.

• **LV=** is offering a 5% discount on its income protection premiums for the rest of the year.

• Nearly half (45%) of the UK population takes no exercise, while just 29% exercise the recommended three times a week, according to **Scottish Widows**.

• Research by *Community Care Magazine* has found that 8 in 10 councils will not be meeting older people's low or moderate care needs by next year.

• Many large US health insurers are dropping child only health policies the *BMJ* reported on 1 October. Since 23 September, US health insurers have been required to cover children's pre-existing medical conditions when they take out new cover.

• The **FSA** has ruled that firms that sell pure protection products under the COBS rather than ICOBS sourcebook will not have to apply the rules on adviser charging, but they will have to disclose how they are remunerated if associated with investment advice.

• Financial lead provider **Leadbay** is offering IFAs and specialist PMI advisers a new source of business. Advisers can source client leads, research products and analyse cover terms. The firm started as a mortgage lead provider in 2005 and has since provided over 2.5m leads.

• Janet Wilson (59) and Wendy (Jo) Clark (56) allegedly created false invoices and scammed other companies out of £175,000 in 2005 and 2006 while trading as **Your Health Plus Limited**, Reading Crown Court was told in September. The case continues.

• The **Equality and Human Rights Commission** has launched an online starter guide to the *Equality Act 2010*, legislation that brings existing equality law into one place. See *www.equalityhumanrights.com/ea2010*.

• A strong mutual sector would promote effective competition and mitigate against systemic risk in the financial services industry according to a new 48 page report from the **University of Oxford** for lobby group **Mutuo**.

• More than half (60%) of people simply accept annuity quotes, even though 40% of people could get better rates as a result of their health or lifestyle, according to the **Fair Investment Company**.

• **Friends Provident** has launched a bespoke SRT (Speed, Responsiveness and Technology) Protection Toolkit and a new website at *www.friendsprovident.co.uk/srt*.

• The **Financial Ombudsman Service** (**FOS**) has published proposals to increase the maximum award it can give from £100,000 to £150,000.

• Over 30m Britons do not have a will (up from 28m last year), even though 92% know who they want to leave their assets to when they die, according to **Unbiased.co.uk**. 87% of under 35s do not have a will.

• Apologies. Due to a printing error, Page 15 appeared in last month's paper copies where Page 2 should have been and Pages 2-14 were all one page out. The PDF versions were correct.

• *e–Protection Review* has a new ISSN (International Standard Serial Number). It was ISSN 1461-5746 and is now ISSN 2045-5925. All else is the same...

Pick of the month

This month's reviews cover a wide spectrum of needs. Canada Life has introduced a raft of changes to its Group Critical Illness plan, while PruProtect has launched the latest evolution of its Serious Illness Cover plan. Both offer worthwhile improvements over what went before.

Our Pick of the Month is also a variation of an existing theme. In this case, WPA has taken the basic and well-established health cash plan concept and added a range of in-built and optional benefits to reposition it as an NHS top-up plan that can act as either a top-up to private medical insurance or as a standalone solution in its own right.

Canada Life Group Critical Illness

Canada Life, the UK market leader for group life, has updated its existing group critical illness (CI) policy.

Quotes are available now and scheme renewals change from 1 January 2011. The main changes are:

• Partnerships with **RED ARC** and **Best Doctors** from 1 January. These will provide enhanced individual support for employees and their families. RED ARC's service includes unlimited access to a personal nurse adviser, who can also arrange further help if needed. That can include a home visit from a specialist nurse, a course of therapy or a programme of counselling. Best Doctors' service provides medical second opinions from consultants highly ranked by other doctors.

The range of conditions covered has been extended from 7 to 12 conditions. Added core conditions are:

Motor neurone disease
Parkinson's disease
Alzheimer's disease
Dementia/pre-senile dementia
CJD (Creutzfeldt-Jakob disease).

• Core cover can be extended to a further 26 conditions. These are aorta graft surgery; aplastic anaemia; bacterial meningitis; balloon angioplasty; benign brain tumour; blindness; cardiomyopathy; coma; deafness; encephalitis; heart valve replacement or repair; HIV infection (selected occupations only); liver failure; loss of hands or feet; loss of independent existence; loss of speech; open heart surgery; paralysis of limbs; primary pulmonary hypertension; progressive supranuclear palsy; pulmonary artery surgery; respiratory failure; rheumatoid arthritis; terminal illness; third degree burns, and traumatic head injury. Permanent and total disability and spouse's and children's benefits are also included.

• A claims helpline to assist claimants and scheme members with the claims process, including validation and claim form completion.

Improved terms and conditions include the maximum free cover limit being increased to £500,000 and the survival period reduced to 14 days.

Plus points: *The two new third party services add to the value of the plan to end users, as do the new conditions covered. It is good to see additional marketing support being offered too and the fact that Canada Life has made it easier for intermediaries to sell and clients to buy such cover through the changes in underwriting limits.*

Not so plus points: *Both individual and group CI are now complex propositions that still do not provide fully comprehensive cover for those who suffer any critical illness—primarily because they lack an effective 'catch all' overarching definition. That said, these changes should prove popular with intermediaries and clients looking for more cover in tough economic times without having to pay significantly more for that cover.*
Contact: 0845 223 8000 or *www.canadalife.co.uk/group*.
Rating (max 5): Innovation: 3.5. Overall: 4.

PruProtect Serious Illness Cover plan

PruProtect announced the latest evolution of its Serious Illness Cover plan on 21 October.

The main changes are adding eight new conditions, seven of which are unique in the UK market. They are:

• Lumpectomy for ductal carcinoma in situ of the breast (DCIS).

• Carcinoma in situ of the oesophagus—requiring surgery.

• Severe inflammatory Crohn's disease.
• Encephalitis.
• Craniotomy.
• Guillain-Barré syndrome.
• Spinal tumours.
• Pemphigus vulgaris.

PruProtect says that it now covers over 100 conditions with its Primary Cover and 161 conditions under its Comprehensive Cover version. Seventeen of its definitions also now exceed the **ABI** (**Association of British Insurers**) standard definition. Indeed, as part of its changes it has also introduced a number of enhancements to some of its other conditions, including heart attack.

Where a cancer exclusion is applied, the premium rate will be reduced accordingly, reflecting the fact that the customer's cover is not as wide as it would otherwise be.

As well as applying to all new plans, the changes are also being applied to existing plans. The changes took effect from 23 October.

The plan itself is effectively a critical illness plan that pays out on the severity of the condition and offers Vitality points to actively encourage customers to adopt healthy lifestyles. The company reports that sales in the first half of this year were, at APE of £11m, up 98% on the same period of 2009. It now has around 36,000 policies.

Plus points: *The new changes mean even wider cover than before, and all changes are also being introduced to improve existing plans too. Reducing premiums where an exclusion applies (e.g. on cancer) is a very positive step.*

Not so plus points: *Although PruProtect can claim to cover more conditions than any other critical illness insurer, its plans are also, by definition, more complex. That is not so much a criticism as a recognition that intermediaries need to take the plan seriously (sorry about the pun...) and ensure they are familiar with its complexities before they recommend it. As with Canada Life's plan, there is also still no overall 'catch-all' benefit, although the philosophy of making improvements retrospective is in itself a very positive development.*
Contact: 0845 601 0072 or *www.pruprotect.co.uk*.
Rating (max 5): Innovation: 4. Overall: 4.

WPA NHS Top-up

WPA's new health cash plan offers standard HCP type benefits plus a range of built-in and add-on benefits that aim to top-up what is already available on the NHS. The plan is available in individual, corporate company paid and corporate voluntary (the main market for HCPs) versions. Three price levels are offered with either 75% or 100% reimbursement.

A voluntary scheme with up to 49 employees could pay from £7.76 a month for Level One benefits with 75% reimbursement or up to £21.00 a month for a Level Three plan with 100% reimbursement.

A Level Three plan would pay annual sums of up to:

- Dental: £150.
- Optical: £150.
- Therapies: £300.
- Specialist consultations and second opinions: £250.
- GP services: £150.
- New baby (cash lump sum): £200.
- Hospital stay: £50 a night/day up to 20 days.
- A&E attendance: £20 per visit (max three visits).
- NHS car parking (only when visited as an in-patient): £50.

All versions of the plan include a 24/7 helpline. In addition to the above benefits, a number of options (the 'extras') can be added to the basic plan. These options pay the following annual maximum benefits:

- Scans and screens: £200 (adding this benefit costs an additional £1.00 a month).
- Mycancerdrugs: £50,000 lifetime benefit (cost £4.20 a month or £10.00 for smokers).
- European cover including air ambulance: £100,000 (cost £1.00 a month).
- Cosmetic surgery: £20,000 (cost £3.00 a month). This benefit pays for reconstructive plastic surgery for certain scars e.g. on the face.
- Face to face counselling and helpline: six sessions (cost £1.00 a month).
- Allergy testing: £80 (cost £0.50 a month).
- Dental trauma: £10,000 (cost £2.50 a month).
- Personal accident: up to £15,000 (cost £0.50 pm).

On corporate paid schemes, employers receive a monthly allowance of between £0.50 to £1.50 to offset against the cost of adding extras if they have 3-249 staff, or £1.00 to £2.00pm for larger schemes. Until the end of March 2011, commission is 40% initial and 5% renewal.

Plus points: *This plan takes the well-established HCP concept and adds a number of benefits to position it as a top-up to what people already get on the NHS. By so doing, it will appeal to a wide range of company and individual clients either as a low cost standalone solution or to supplement PMI cover. Cover can be very inexpensive (less than £1 a week for basic company paid cover). Pricing is transparent, and the basic and add-on features all meet real needs. WPA points out that in the Netherlands, 80% of people choose to top-up their basic State health cover.*

Not so plus points: *Can be expensive e.g. a top of the range plan with all options would cost £13.70 on top of the basic plan premium (i.e. up to £34.70 per employee a month for a small voluntary scheme at Level Three with 100% indemnity. Having more options adds complexity. One marketing challenge is that many brokers still overlook the opportunities that HCPs offer.*

Contact: 0800 783 0 784 or *wwwwpa.org.uk/topup*.
Rating (max 5): Innovation: 4.5. Overall: 4.5.

Product design issues…

Trust is a complex topic. It's probably easier to describe lack of trust rather than having trust. Yet, for all insurers and their customers, trust is the very essence of the contract that exists between them.

Partly, trust is so important because insurance is an intangible. The customer gives the insurer the information it asks for and, on the basis of that, the insurer assesses the risk then makes an underwriting decision to offer terms (or not), set the premium and decide what exactly will and won't be covered.

Then, the trusting customer pays the trusting insurer a premium every month until such time as (certainly in the case of health and protection insurance) something happens and a claim is triggered. These days, insurance offers rather more than that, if you take into account the raft of 'soft' and third party benefits often included (e.g. helplines, advice and counselling as well as rehabilitation and information), but the fundamental underlying benefit is still a mainly financial benefit if something goes wrong.

Only then does the customer really know that the insurer will pay their claim (or not). Only then usually, does the insurer make full enquiries to ensure that it should pay out.

It's all about trust.

So what happens if that trust breaks down? First, customers are likely to vote with their feet if they do not trust insurers to pay out—why pay for something you don't believe will pay out when you need it to?

Second, if the insurer does not trust its customer, it may seek more and more evidence to try to discover whether the customer has been as honest as they should.

If it does go wrong, customers can appeal to a higher authority in the company, complain via their broker or IFA (a good reason to have a broker or IFA), to the FOS or go to law. The insurer can simply refuse to pay and wait for the customer to take further action.

Apart from the Ombudsman at the FOS, there is no independent mechanism to ensure fair play other than the rather cumbersome and complex law on insurance contracts, which is based on rather ancient legislation and a raft of complex legal precedents decided by case law.

Some insurers have very robust and independent (or as independent as they can be) appeals procedures. They may even set out their 'claims philosophy' and require that any claim turned down be signed off by a director or claims committee for example, so taking out any risk of a single individual being biased or simply wrong.

But would a better alternative be to have a more independent claims appeal system? It would not be easy to implement, but could be run under the auspices of say the insurer's non-executive directors and be autonomous. Not a perfect solution perhaps, and care would be needed to avoid spurious appeals, but a key step to more trust?

Outcomes from single hospital rooms not necessarily better

An unpublished study by **York Health Economics Consortium** and **The Hillingdon Hospital Trust**, seen by *Nursing Times* (19 October), reveals that giving patients their own hospital room does not improve infection rates or lengths of stay and may increase the likelihood of falls. The nine month study was based on 1,289 patients in gastroenterology, haematology and general medical wards and on 120 patient questionnaires.

At Hillingdon Hospital, 92% of patients wanted their next stay to be in a single room and patients reported that a private bathroom was a 'huge component of satisfaction' that gave real privacy and dignity. However, 12% had feelings of isolation and 18% said they felt lonely, and it was reported that patients in single accommodation preferred those rooms with a better visibility of nurses.

Although there is a perceived need for more single rooms, **RCN** head of policy, Howard Catton, said it was also vital to have bays for those wanting social interaction.

There was no evidence of decrease in length of stay and a small reduction in infection rates in the study wards was attributed to declining rates of Clostridium difficile throughout the hospital.

However the change to more single rooms had also increased cleaning costs by 75% and medication costs rose by 28%, but this cost was partly balanced by a reduced cost for sleep medication. The **Department of Health** has said that single rooms should comprise 20-50% of all accommodation in new hospital developments.

Comment: *It is difficult to comment on unpublished research, but this does look to be a surprising finding and may not be replicated in independent rather than NHS hospitals.*

Chronic back pain linked to unemployment says report

The *Pain Proposal*, new research from pharmaceutical company, **Pfizer**, presented to the **European Parliament** on 29 September, shows that one in five Europeans are unable to work at all as a result of chronic back pain.

The survey, of 2,019 people with chronic pain from 15 European countries, suggests that of those able to work, 61% felt their condition impacted directly on their employment status.

The report says there are inefficiencies in treatment that are resulting in 'increasing healthcare costs and prolonged patient suffering'.

Persistently noisy workplaces linked to heart disease risk

Research among more than 6,000 employees aged from 20 upwards who had been part of the *US National Health and Nutrition Examination Survey* shows that a persistently noisy workplace more than doubles an employee's risk of serious heart disease, especially among young male smokers.

Workers were grouped into those who endured noise at work for at least three months that was loud enough to make it difficult to talk at normal volume, and those who did not.

The association was particularly strong among workers under 50, who made up more than 4,500 of the total sample. They were between three and four times more likely to have angina or coronary artery disease or to have had a heart attack.

Men and smokers in this age group were also at greater risk. Blood tests did not reveal particularly high levels of cholesterol or inflammatory proteins, but did reveal higher than normal diastolic blood pressure, a condition known as isolated diastolic hypertension, that is an independent predictor of serious heart problems. See: *http://press.psprings.co.uk/oem/october/oem55269.pdf.*

Bacterial enzymes could present greater threat than MRSA

Delegates at an infection prevention conference in Bournemouth were told that bacterial enzymes known as extended-spectrum beta-lactamases (ESBLs), which are the result of genetic mutation to common Gram negative bacteria such as Escherichia coli and Klebsiella pneumoniae, could be more difficult to prevent and contain than MRSA or C *difficile*, *Nursing Times* reported on 28 September.

Overuse of antibiotics had 'facilitated ESBLs survival and subsequent dissemination'.

According to a study last year, only half of intensive care units had a policy on antibiotic use.

Surgery not always the answer

Nurses could help save £150m a year by helping patients make better decisions about elective surgery and also to consider alternatives to surgery, especially where an operation is of questionable benefit to a patient's health, *Nursing Times* reported on 8 September.

A US evaluation of shared decision aids suggests they reduce take up of surgery by between 20% and 25%. A UK analysis suggests 10% in this country, as surgical rates are not as high as in the US.

Reducing the need for knee replacements could save £40m, cataracts £24m and hernia operations £13m. Nearly one third of patients reported that their quality of life had either not changed or had worsened after undergoing groin hernia, varicose vein, hip and knee operations.

Six in ten heart attack patients now have primary angioplasty

Figures from the ninth annual *Myocardial Ichaemia National Audit Project* show that for the first time, patients who have a heart attack in England are more likely to be treated with primary angioplasty, (63%), than with thrombolysis.

BMJ 2010; 341: c5402 reported on 30 September that three quarters of patients who had an angioplasty were treated in a heart attack centre. 89% of eligible patients in England and 71% in Wales were treated with primary angioplasty within 90 minutes of arrival at the heart attack centre and 79% of eligible patients in England (76% in Wales), were treated with primary angioplasty within 150 minutes of calling for professional health.

Medical briefs:

• Danish research has found that men whose partner has breast cancer were 39% more likely to develop mood disorders severe enough to warrant hospital admission. The authors suggest screening of partners of cancer patients in general and breast cancer patient partners in particular to help prevent these disorders developing. See: *www.canceronlinejournal.com*.

• A study reported in the *British Journal of Cancer* of more than 2,000 parents and siblings of 500 women diagnosed with breast cancer before the age of 35 showed an increased risk of other cancers in both male and female relatives. **University of Melbourne** researchers found an increased risk of breast, prostate, lung, brain and urinary tract cancers that could indicate a new cancer genetic syndrome. See: *www.bjcancer.com.*

• The **Health Protection Agency** is in the early stages of developing an immunotherapeutic treatment that will use antibodies to neutralise toxins produced by Clostridium *difficile*. The treatment could be used in conjunction with antibiotics or may be a replacement for them. See: *www.hpa.org.uk*.

• A test for tuberculosis that is sensitive enough to detect a single molecule of DNA and which should take less than an hour for a result rather than the eight week wait of the present test, has been developed by researchers at the Health Protection Agency. See: *www.hpa.org.uk*.

• £388bn is the predicted global cost of dementia this year, which represents more than 1% of the world's gross domestic product, according to the **King's Fund** and Sweden's **Karolinska Institute**.

• Spanish researchers have discovered a genetic risk factor for osteoporosis and bone fractures. The research, in *Calcified Tissue International*, shows of 944 women studied, those who had two copies of the T allele (TT genotype) had twice the risk of suffering osteoporotic fractures than women with one T (CT genotype) or those with no T (CC genotype) allele. See: *www.tinyurl.com/TT-osteoporosis*.

• US research in *Molecular Cancer Research*, suggests that stress, including physical stress caused by intensive exercise one or two days before cancer treatment, may make the treatment less effective. Intensive exercise activates a protein that could trigger events that allow cancer cells to survive treatments such as chemotherapy and radiotherapy. See: *www.tinyurl.com/stress-cancer-cell*.

• Early surgery appears to be best for adults with an asymptomatic carotid stenosis, rather than a 'wait and see' strategy. Early surgery cut the risk of a later stroke by around half over ten years, *BMJ* 2010; 341: c5275 reported on 29 September.

• The **Resuscitation Council** has published revised guidelines for teaching and performing cardiopulmonary resuscitation. They advise chest compressions with rescue breaths for healthcare professionals and trained lay rescuers, whereas untrained bystanders to a cardiac arrest should seek help and do compression only CPR until an expert arrives. See: *www.resus.org.uk/pages/guide.htm*.

• **Bupa** announced on 27 September that it has sold **Guardian Homecare** to **City & County Healthcare**. Guardian Homecare, which employs 400 people operating from five regional offices, provides personal care and support to people of all ages in their own homes.

• *Nursing Times*, 5 October reports that the number of overweight people in Scotland has fallen for the first time in 15 years. However more than one in ten Scottish boys were considered morbidly obese.

• An editorial in the *Annals of Internal Medicine* suggests that for now, doctors should probably assume that thigh length compression stockings provide, at best, modest protection against venous thromboembolism in people immobilised by a stroke, *BMJ* 2010; 341: c5275 reported on 29 September. Low dose heparins, cautiously prescribed, remain the best option for people without contra-indications the editorial said.

• New research in the *Journal of Occupational and Environmental Medicine* suggests more than 10% of sick leave may be caused by unhealthy lifestyles and obesity. A Dutch study between 2005 and 2009 of 10,624 workers in 49 companies, found obese employees were 55% more likely to take long periods of sick leave than those of normal weight. Smoking, obesity, and insufficient fruit and vegetable intake were linked to lower productivity levels.

• A US and Taiwanese study has concluded that people with impaired kidney function are at a higher risk of stroke than people with normal kidney function. A second UK and Icelandic study has found that even the earliest stages of chronic kidney disease are linked to a higher risk of coronary heart disease. See *www.bmj.com/cgi/doi/10.1136/bmj.c4249* and *c4986*.

• German research has shown that binge drinking can induce reversible changes in the myocardium and serological markers that are consistent with an inflammatory reaction, *BMJ* 2010; 341: c5275 reported on 29 September. The researchers said that a single binge is unlikely to trigger an acute cardiac event, at least in healthy people, but the story may be different if the binge drinking continues.

What is the Parliamentary and Health Service Ombudsman?

The **Parliamentary and Health Services Ombudsman** was set up in 1967 to provide a service to the public by undertaking independent investigations into complaints that Government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service. Health complaints are governed by the *Health Service Commissioners Act 1993*. In its latest year (2009/10) the Health Service Ombudsman (HSO) closed 15,579 health complaints. Of those, 63% were upheld or partly upheld. The most common complaints (6,304 or 44%) were about hospital, specialist and teaching trusts, followed by complaints about GPs (2,419 complaints). The most common complaints were about failings in clinical care and treatment and the attitude of staff. A poor explanation or an incomplete response were the most common reasons for dissatisfaction with NHS complaint handling.

Complaints must first be addressed to the appropriate NHS body and only once an unsatisfactory final decision has been given may the complaint be made to the HSO. Complaints may be about someone else (e.g. a deceased relative).

The current Health Service Ombudsman is Ann Abraham, and the website is *www.ombudsman.org.uk*. Separate ombudsmen apply for health complaints in Scotland, Wales and Northern Ireland.

Spending review targets welfare

The Government's Comprehensive Spending Review (CSR), announced on 20 October, introduced a number of cuts in a £7bn of savings package that adds to the £11bn of savings announced in the June Budget. The main health and welfare changes included:

- Health spending will be protected but even so will only grow by 0.4% in real terms over the course of the Spending Review period (i.e. to end 2014/15). That includes a 1.7% increase in the resource budget but a 17% decrease in capital spending.
- Health spending is expected to rise from £103.8bn in 2010/11 to £105.9bn in 2011/12, £108.4bn in 2012/13, £111.4bn in 2013/14 and to £114.4bn in 2014/15.
- An additional £2bn a year by 2014/15 will support social care through the NHS and local government, aiming to break down the barriers between health and social care.
- The NHS is targeted to achieve £20bn of annual efficiency savings by 2014/15, including a 33% cut in the administration budget and a reduction in arm's length bodies from 18 to a maximum of 10 by 2014.
- The previous Government's plans to extend free prescriptions and to provide one-to-one nursing care for cancer patients have been scrapped.
- The Department for Work and Pensions' budget will rise from £151.6bn in 2010/11 to £163.7bn in 2014/5, with resource spending up 2% in real terms.
- However, its core budget will be cut by 26% in real terms by 2014/15 including cutting corporate overheads by 40% in real terms and reducing the cost of benefits processing by 27% in real terms.
- The temporary extended Support for Mortgage Interest changes due to expire in January 2010 will now be extended by a further year.
- State pension age will rise to 66 for men and women from November 2018 to 2020, having knock-on effects on the cost of private workplace benefits.
- Incapacity benefit is to be means tested and proposals will be published to replace all working-age benefits and tax credits with a single, simple universal credit. In effect this means that those with working partners will be most affected.
- Those in the Work-Related Activity Group will receive contributory ESA for a maximum of one year in future. Around 1m claimants will be affected. This will save £2.0bn pa by 2013/14.
- The Working Tax Credit will be frozen for three years from April 2013 (saving £625m pa by 2014/16) and changes in eligibility from April 2012 will save £390m pa.
- From 2012/13 people receiving the mobility element of Disability Living Allowance will have it withdrawn if they enter residential care, saving £135m pa by 2014/15.

More details at *www.hm-treasury.gov.uk*.

Other recently announced welfare changes include:

- 4 October. The Chancellor announced that total household benefit payments will be capped from 2013 on the basis of average take-home pay for working households (estimated to be around £500 a week in 2013). This will save £270m pa by 2014/15.
- 4 October. The Chancellor also announced that from 2013 Child Benefit will be withdrawn from all households with at least one higher rate taxpayer. This will save £2.5bn pa by 2014/15.
- 11 October. People in Burnley and Aberdeen became the first long-term Incapacity Benefit (IB) claimants to be reassessed for their ability to work, as part of the plan to move people from IB to ESA.
- 18 October. A single fraud investigation service is to be launched to try to cut the current £5.2bn a year lost through fraud and error in benefits and tax credits. Tougher penalties will also be introduced.

Additional announcements were expected as we closed for press—more next month.

Unemployment figures mixed

Unemployment in the three month period June to August fell from 2,467m to 2,448m, according to the latest *Labour market statistics*, released by the **ONS** on 13 October.

During the same period, employment remained at 29.158m. This means that the *e-Protection Review Employment Index*, which is a proxy for the growth in size of the main health and protection insurance markets since 2000, remained at 107.230. this index compares the latest employment figure with the 27.192m figure recorded for the first quarter of 2000.

The number of Jobseeker's Allowance claimants in September rose from 1.4663m to 1.4731m. The number of inactive people aged 16 to 64 fell in June to August by 66,000 to 9.28m. The number of vacancies in the three months to September was down 30,000 to 459,000.

Earnings in the three month period to end August were up 1.7% on a year before (up from 1.3%) or by 2.0% excluding bonuses (up from 1.6%).

On 12 October the ONS announced that in September the Retail Prices Index (RPI) was 4.6% higher than a year before, down from 4.7% the month before. The Government's preferred Consumer Prices Index (CPI) was unchanged at 3.1% in September.

RTT median stays at 8.3 weeks

The median Referral to Treatment (RTT) wait for NHS hospital admission remained at 8.3 weeks in August, according to a **Department of Health** Statistical Press Notice: *NHS Referral to Treatment waiting times data - August 2010*, released on 14 October.

For non-admitted patients the median wait was 4.4 weeks (up from 4.3 weeks in July).

The 95th percentile time wait for patients entering an RTT pathway was 20.0 weeks for admitted patients and 15.0 weeks for non-admitted patients.

NHS to track more HAIs

From January, the NHS will be required to monitor and report on more healthcare associated infections (HAIs), Health Secretary Andrew Lansley announced on 5 Oct.

This will include meticillin sensitive staphyloccus aureas (MSSA—where infections have risen from 2000 to 2009) and E.coli, where reports have risen 37% since 2005.

In 2009 there were 25,532 reports of E.coli and 9,249 of MSSA.

Patients at risk of infections from hospital bed transfers

Nursing Times, 5 October, warned that nearly one in ten hospital patients are put at risk of infection because they are being transferred between wards for no good clinical reason. Figures suggest that nationally there are around 1.3m such patient bed moves each year. Where wards are full, patients are admitted to inappropriate wards and then moved. Ward transfers are a well-understood cause of infection outbreaks and also can result in care notes being misplaced and observations missed.

In response to a freedom of information request made by the journal, only 48% (42 trusts) of the 88 trusts that responded provided information on the number of times a patient was moved.

7% (6 trusts) provided information on the number of clinical and non-clinical moves and 40% (35 trusts) provided information on patients placed in an inappropriate ward. Many trusts said their IT systems could not provide such information and to collate such data they would have to go through patient records and notes.

Delay in diagnosis and its effect on cancer survival

The comparatively poor survival rate of British patients with lung and other cancers is associated with a more advanced stage at presentation, according to an editorial in *BMJ* 2010; 341: c5134, 22 September.

Along with Denmark, which has a similar record, Britain has access to specialist services through primary care, where GPs can treat patients with ambiguous symptoms for some time.

Many such patients can be managed successfully without incurring the cost of referral and investigation because they do not have cancer, but other patients are kept in primary care during which time a curable early cancer can become an incurable metastatic disease by the time a diagnosis is made. The editorial suggests the effects of the contradictory functions we ask of GPs—to be a diagnostician and gatekeeper—should be investigated.

First health outcomes published

The first study of patient reported outcome measures, (PROMs), for four surgical procedures in English NHS hospitals have been published, *BMJ* 2010; 341: c5143 reported on 20 September.

The self-completed questionnaires measure a patient's health status or health related quality of life and have been a requirement since April 2009.

Data from the first year, to April 2010, show that of patients undergoing hip replacements, 87% reported the worst level of general health before their surgery but the biggest gain in general health after surgery.

For knee replacement the figure was 77%. 96% of hip and 91% of knee replacement respondents recorded joint related improvements. Some 88% of varicose vein patients said their condition had improved after surgery. For those undergoing groin hernia operations and varicose vein surgery, 49% and 55% respectively, reported better general health after surgery – a much lower percentage, but their general health had been substantially higher before the operation.

NHS market based reform stifled by 'closed shop' providers

An investigation by thinktank **Civitas** into the impact of market based reform in the NHS has reported that the development of a market in the NHS has been stifled by a 'closed shop' of NHS providers, *BMJ* 2010; 341: c5437 reported on 4 October.

The report says the idea that the NHS was something more than a health system and the emotive notion of the 'NHS family' encouraged a counter-productive 'them and us' attitude and this was the most important factor in stifling the market.

Political briefs:

• On 14 October, Financial Secretary to the Treasury, Mark Hoban, announced that, from April 2011, the annual pension allowance will be cut from £255,000 to £50,000. From April 2012 the lifetime allowance will reduce from £1.8m to £1.5m. On defined benefit schemes, a factor of 16 (previously 10) will be used to calculate the value of benefits. New carry back provisions will help avoid a one-off accrual 'spike'. The new rules do not apply or may be reduced in ill health cases.

• Lord Young of Graffham has produced a report, *Common Sense, Common Safety*, making a series of recommendations on health and safety, all of which the Government has accepted. In essence, it aims to restore 'common sense' to health and safety issues and to reduce red tape. See *www.cabinetoffice.gov.uk* for more.

• The NHS needs to listen harder and learn more, according to *Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2009-10*.

• Consultation papers on patient choice and on information were published by the DH on 18 October.

• GP salaries have fallen for the third year running to £105,300 before tax in 2008-9, *BMJ* 2010; 341: c5111 reported on 16 September. Gross earnings for GP partners have risen (up 2.6%) however, this is outstripped by the cost of running a practice (up 5.1%). GP salaries were £97,700 in Wales, £89,700 in Northern Ireland and £86,500 in Scotland, (down 2.9%, 1.5% and 1.0% respectively since 2007-8).

• Doctors' leaders warned ministers on 12 October that increased tuition fees could leave medical students with a debt bill of £100,000. Lord Browne's report on student funding contains proposals to charge fees up to £12,000 a year and also a recommendation that students should pay higher rates of interest on their student loans. with loan repayment starting at £21,000 rather than the current £15,000.

• The **Royal London Homeopathic Hospital** has been renamed the **Royal London Hospital for Integrated Medicine**. This summer the **BMA** called for NHS funding for homeopathy to be stopped.

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Innovation and leadership

*The **Chartered Insurance Institute** (**CII**) and **Cass Business School** have recently jointly published a report on how leaders view innovation. ePR editor Andy Couchman, one of the report's authors, describes why a better understanding of how to harness innovation is more important than ever for health and protection leaders.*

Think of innovation and the chances are that the first thing that comes to mind is product innovation. We are constantly bombarded—from TV's *Dragons' Den* to advertising—with information on new products and services and why they are better than what has gone before.

But think a little deeper and you quickly realise that innovation goes way beyond that. In health and protection insurance the rise of tele-underwriting and straight through processing (STP), the introduction of third party services and helplines, internet quotes and applications, portals, worksite marketing, new distribution channels, paying claims by direct credit and a host of other initiatives are all examples of innovation. It is too easy too to think that innovation must be completely new—when what is more important is innovation that is new to the business.

To find out more about how today's leaders think about innovation, a research group from the CII and Cass Business School undertook a major project involving 20 in-depth interviews with CEO level leaders. 40% of these were in the insurance field, the rest from other financial services areas, the law, industry and the public services.

The report found that strategy and innovation are changing and that organisations need to be more aware of innovation opportunities and to link them more with their strategy. They can no longer rely on M&A or cost cutting.

Using unstructured interviews, the group used the technique of cognitive mapping to map out what leaders thought about innovation. One key finding was that too many leaders have too narrow a view of innovation.

Traditionally we think of innovation in three main areas—offerings (or product), management and process. But, various academic researchers have seen this as too narrow a definition. The research group took the view, based on the results of its interviews, that innovation could be considered in six main groups and they describe this as an 'innovation palette'. The innovation palette consists of:

1. Offerings. These are new to the organisation products and/or services.

2. Markets. Breaking out to serve new customer markets not served before.

3. Processes. Redesign of processes that produce the organisation's offerings, to improve efficiency and effectiveness. New organisational structures to provide better customer focus.

4. Distribution. New distribution routes or ways of reaching out to customers.

5. Customer experience. Innovation in the way customers or clients interact with the organisation.

6. Management. Finding new ways of managing, especially in terms of the relationship between an organisation and its staff.

Using this palette, leaders can consider various initiatives within their organisation and categorise them into the six headings. Interestingly, the research found that many leaders, while recognising the value of innovation, took too narrow a view of the types of innovation they could consider. As the need to embrace greater innovation increases, so this could become a limiting factor.

For example, the innovation types mentioned by interviewees were coded and then grouped into the following categories:

1. Offerings	90%
2. Markets	25%
3. Processes	55%
4. Distribution	30%
5. Customer experience	40%
6. Management	55%

Despite all the leaders interviewed being highly regarded in their field, none referred to innovations that could be classified into all six categories of the innovation palette. In short, we found that leaders were taking too narrow a view of how they could improve their organisations.

But we wanted not just to report on our findings but also to offer practical help to leaders to enable them to take constructive action to improve matters. So, the report features information on innovation, including the palette, but also a toolkit to enable organisations to enhance their planning processes. The report recommends a three stage process to start the innovation journey:

• Step 1. Conceptualise the innovation palette. The management team should first review its long term (three to five years) objectives, then consider which forms of innovation are needed to achieve these objectives, ranking them in order.

• Step 2. Look for drivers, barriers, enablers and outcomes. A SWOT (strengths, weaknesses, opportunities and threats) analysis will help the team identify internal and external drivers. Barriers or obstacles can then be identified and grouped. Then the group can identify the actions that should be taken to overcome each barrier – these are the enablers and may themselves be a series of actions. Finally, the desired outcomes can be mapped.

• Step 3. Review. This is the process of checking that all barriers have been identified, that every barrier has one or more corresponding enablers, and taking time to identify the leadership style that is needed.

Once these three steps have been completed, an innovation road map can be developed. Innovation barriers can be reviewed, an implementation path identified and the most appropriate leadership style identified.

Why bother? After all, this all sounds like rather a lot of work and, on its own, all it does is identify a possible way forward that, in practice, could take years to achieve.

One reason is that a key finding in the research was that too little attention is paid to innovation or to the leadership style that will best ensure appropriate innovation types to adopt and, eventually, outcomes. The result can be stagnation or worse.

As one interviewee put it: "If you don't change, innovate, you will go backwards."

The report can be downloaded in full from *www.cii.co.uk/pages/research/researchandsurveys.aspx*. You can view both the short executive summary and full 48 page report.

The Spending Review

If we did not know before, we now know that the Government is serious about its Comprehensive Spending Review (CSR—see Page 11). We asked Peter, Kevin and Andy for their thoughts on what this means to the industry.

Peter Le Beau

Peter Le Beau commented: "I generally quake when the cutters are in the ascendancy because I find people who are predisposed to cutting rather than building are dangerous and often counterproductive, but the Spending Review does genuinely need not only to be draconian but also to rationalise a system that is top heavy with bureaucracy and exceedingly complex.

Chris Grayling is being portrayed in some sections of the press as a mad zealot bent on implementing a savage new coalition mentality which restricts entitlements to welfare and slashes budgets. I don't buy this at all. The system needs radical reform simply to be operable and beyond operable it needs to be fair.

The proliferation of different benefits at marginally different levels adds layers of complication that are wholly unnecessary and a simpler system with greater transparency will be a big step forward.

When Labour brought in its reform of the Incapacity Benefit (IB) system and created Employment and Support Allowance (ESA) it accompanied its introduction with fierce rhetoric that was apparently aimed at those who were either classified wrongly or who were in receipt of benefit erroneously.

A figure of one million was mentioned but the reality is that, so far, ESA methodology has not demonstrated the sort of teeth it purported to have.

It's not only taxi drivers and pub bores who want to see more people actively seeking and finding appropriate work (if there is any). Most reasonable people are sympathetic to Professor Sir Mansel Aylward's profoundly held belief that 'Work is good for you'.

The problem is that implementing such a radical new system while a recession lingers on (and ask small businesses if they believe it is over...) is dangerous and prone to create an erroneous impression of the workability of a slimmed down and tougher system. Timing is everything—as most politicians will tell you!"

Kevin Carr

Kevin Carr said: "We are beginning to realise that we can't just take one Government statement in isolation - we need to look at the combined effects of all the various statements from all the various sources. Take the CSR announcements on 20 October for example; Chancellor George Osborne announced welfare cuts of around £7bn, which is quite an eye opener.

But, you have to add on previous welfare cuts already announced, and that takes the total to around £18bn. All these announcements are telling us something - that increasingly the welfare safety net is going to be a real last resort for many people. The message we have got to get across is that it doesn't have to be like that.

Consider that the average working person is already paying the Government about £3,000 a year just to fund the NHS and even more to fund welfare, and the cost of the average life, CI or IP product looks incredible value given how much more we offer than the State does. In addition, our solutions are personalised - based on you, your lifestyle and your income and spending and not on what the State thinks you need as a bare minimum.

That all adds up to a real strategic opportunity for IFAs and brokers.

We've seen the gradual transfer of risk over the years from Government and large institutions towards individuals, especially in pensions, and now we are seeing it more than ever before with protection, which is the foundation of financial planning.

Firms now need to look seriously at the opportunities - how can they capitalise on a reduced welfare budget, on people needing to work more years and on their need to continue to expand their own businesses?

Those are the issues that intermediaries will increasingly need to focus on over the next few months."

Andy Couchman

Andy Couchman said: "For more years than I care to remember, our industry has been accused of short-termism. We are often so focused on everyday issues that we sometimes miss the big issues, the big opportunities and, occasionally, even the big deadlines.

The ABI and others are doing great work in helping the industry become 'part of the solution, not part of the problem'. But every firm needs to take its own stance.

Put simply, if the Government reigns in welfare spending, which it is now doing and, indeed, targeting, people have a range of opportunities. They can do nothing—which means that if the worst happens the worst results will ensue. And, be in no doubt, the welfare system is increasingly designed to give people the very minimum they need to survive. Few would really want to live on that.

Or, they can increase their savings. But low interest rates, falling property prices and the fact it takes time to build up savings makes this a weak choice too. Besides, if you've built up your savings, do you really want to have to spend them on getting over a short term problem?

Or they can insure. But income protection sales are still way down on even a decade ago (*see Page 5*), while payment protection insurance sales have fallen at a rate many stones would be impressed by…

The irony, when you look at the sales stats, is that protection insurance is cheaper in many cases than ever before, yet the real, practical, everyday, problem solving benefits are hugely greater and getting better all the time.

But what, if anything, should individual firms do?

As we set out on *Page 13*, there are practical ways in which any business can look to embrace innovation more. That does not mean having to invent something completely new to the world—but it does mean doing something different today and tomorrow to what you did yesterday. That need not incur large costs and it need not involve huge risks.

But, unless firms embrace their latent talent to do things differently and better, across the board, we risk failing to take advantage of the opportunity we now have."

IB age and duration distribution

The table below shows the Incapacity Benefit and Severe Disablement Allowance caseload by age of claimant and by duration of claim in February 2010:

Age	<3m	3-6m	6-12m	1-2yrs	2-5yrs	5yrs+
Unknown	0.08	-	-	-	0.02	0.05
16-17	-	-	0.04	0.77	-	-
18-24	0.54	0.54	1.75	20.29	48.33	20.82
25-34	1.29	1.28	2.69	27.04	71.86	147.05
35-44	1.98	2.20	3.95	40.97	110.38	302.13
45-49	1.18	1.34	2.49	24.11	68.78	216.46
50-54	1.13	1.27	2.56	23.08	69.67	245.74
55-59	1.15	1.25	2.78	24.38	78.04	299.21
60-64	0.33	0.42	0.95	12.38	47.04	213.50
65+	0.02	0.02	0.05	0.07	0.48	30.63
Total	7.63	8.33	17.26	173.10	494.61	1476.60

Total caseload and percentage of claimants that have been claiming 5 years or more

Age	Total	5 years and over
Unknown	0.08	62.5%
16-17	0.81	0%
18-24	92.28	22.6%
25-34	251.21	58.5%
35-44	461.61	65.5%
45-49	314.37	68.9%
50-54	343.45	71.6%
55-59	406.82	73.5%
60-64	274.63	77.7%
65+	31.28	97.9%
Total	2,176.53	67.8%

Source: *http://83.244.183.180/100pc/ibsda/cnage/ctdurtn/a_carate_r_cnage_c_ctdurtn_feb10.html.*

Comment: *The above tables indicate the size of the Government's problem in reforming incapacity benefits.*

Of 2.2m claimants (not all of who actually receive benefit), over 1.4m (more than 2 in 3) have been claiming for five or more years and over 900,000 have been claiming for ten years or more. Many of these people want to or could work but have no confidence in their ability to find and keep work and so have become benefit dependent. Most are not benefit 'cheats' but they do require help if they are to be weaned off benefits.

People news

• **Department of Health**. Una O'Brien has been appointed the department's new Permanent Secretary. She was previously director general of policy and strategy at the department.

• **Labour Party**. John Healey was appointed Shadow Health Secretary on 11 October by new Labour leader Ed Miliband. Other members of his team are Diane Abbott (Shadow public health minister), Emily Thornberry, Derek Twigg, Liz Kendall, Lord Beecham and Baroness Thornton. Douglas Alexander is Shadow Work and Pensions Secretary and his team includes MPs Stephen Timms, Karen Buck, Margaret Curran and Rachel Reeves.

• **NFU Mutual**. Ian Leech has been appointed sales and agency director and also joined the group's main board. He takes over from operations director Alan Harris, who retires in June 2011.

• **Simplyhealth**. Chartered accountant Richard Harris has been appointed a non-executive director.

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 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. Which professional body is Protection Review talking with about adviser training?
2. How many IB claimants have been claiming for more than ten years a) 90,000, b) 290,000 or c) 900,000?
3. What was the Government's CSR?
4. How big is the European protection gap?
5. Working in a persistently noisy workplace increases the risk of which medical condition?

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Denplan Dental Benefits Survey

• The most important factor affecting types of benefit offered was value for money, with 66% of employers citing this as a factor. That ranked ahead of cost and regularity of use.

• 23% of companies polled offered a dental benefit.

• The most common method used by companies when researching benefits was brokers. 32% cited brokers as an important factor; 11% as the one key factor.

• 34% of companies thinking of adding benefits were considering adding a dental plan. That compared to less than 10% looking to add private medical insurance.

• Of companies reviewing their benefits package, 45% said they would compare costs with other providers to ensure they received best value for money.

• 16 % of companies were planning to reduce the number of benefits offered to employees in 2010.

• 15% were planning to add employee benefits but to limit the number of new benefits offered due to the economic climate.

• 75% of companies felt that a dental plan enhances employee wellbeing and 90% of companies and 77% of employees that good dental health supports overall wellbeing.

• The most important factor that influenced employees about which company funded benefits to take-up was regularity of use (57% of respondents), compared to value for money (48%) and cost (40%).

• The equivalent figures for when employers were funding their own benefits were 62%, 67% and 64%.

• 43% of employees questioned said they visited a dentist every six months (down from 59% in 2009), with 68% visiting at least once a year.

• The average cost of a routine private dental examination varied from £36.25 in Northern Ireland to £49.82 in the South East of England. Average for Wales was £44.57 and for Scotland £47.82.

• 14% of employees had already cut down on the frequency of dental visits on cost grounds and 41% said they would cancel an appointment on cost grounds. 64% were aware of the rising cost of dental care.

• 59% of employees said they would consider a dental plan if their company offered it.

• 17% of employees said they would never cancel their employer offered dental benefit, compared to 12% for PMI and 10% for health cash plans.

• Dental plans were the benefit most likely to be purchased by employees with their own money.

• The key factor for companies when looking at choice of dental plan provider was simplicity of product (24%), compared to price (23%) and broker recommendation (11%).

• 46% of companies said that a dental plan helped them retain existing employees. 21% of employees said a dental plan was an important benefit that kept them loyal to their employer.

Source: *2010 Dental Benefits Survey*, Denplan, (*www.denplan.co.uk*). Based on a poll of 6,000 corporate decision makers by Denplan and 1,486 employees by YouGov in March 2010.

Employee Benefits/Friends Provident Adviser Research 2010

Table 1. Top considerations in selecting advisers

To supply expertise not held in-house	80%
Level of expertise	67%
To get a broader view of benefits	49%
Costs/fees	48%
For advice and to buy products	39%
Fulfil a resource requirement unavailable in-house	33%
To buy specific products	12%

Table 2. Impact of present economic environment on use of consultants and/or advisers

No change in use of advisers	76%
Using advisers less	16%
Using advisers more	9%

Other key findings included:

• 20% of respondents review their advisers at least annually, 33% about every two years, 31% about every three years, 11% less often and 6% never.

• The main reason to change adviser was to achieve better value (60% of those who had changed), poor service levels (44%), policy to review regularly (36%), required different expertise (24%) and previous relationship breached rules/regulations (6%).

• 34% of advisers were remunerated by fees; 11% by commission; 20% a mixture of both; 1% a share of savings and 32% did not use them for overall benefits strategy.

Source: *Employee Benefits/Friends Provident Adviser Research 2010*, based on poll of 662 HR/benefits managers in August 2010. See *www.employeebenefits.co.uk*.

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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