e-Protection Review

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

Welfare Reform Bill is 'biggest shake up of the system for 60 yrs'

On 17 February, the Government published its controversial *Welfare Reform Bill* in what Secretary of State for Work and Pensions, Iain Duncan Smith promised was 'the biggest shake up of the system for 60 years'. The new Bill's key elements are:

• Sweeping away 'a patchwork of benefits and credits' and replacing them with a new benefit, called Universal Credit, to make work pay.

• Introducing a proper system of conditionality and making sure that unscrupulous individuals are not able to defraud the system.

• A Personal Independence Payment for disabled people targeting support to those who really need it.

• A new system of child support which puts the interests of the child first.

• New powers to tackle the problem of fraud and error.

From the summer, what is described as the biggest back to work programme since the war will aim to help millions of people into jobs. The Work Programme will be delivered by private and voluntary sector organisations and will 'end the culture of a one size fits all approach'.

The Government says that the new Universal Credit, which will replace a raft of benefits, will make more than two and a half million of the poorest people in Britain better off. It will also 'finally make it easier for people to see they will be consistently and transparently better off for each hour they work and every pound they earn', the DWP says. This is reference to the fact that people starting back into the workplace, often on a part-time basis, can find themselves subject to penal marginal rates of tax. Such rates act as a big disincentive for those trying to return to work.

The Personal Independence Payment will replace the existing Disability Living Allowance. There will be a new assessment, which will make greater use of evidence to help determine which individuals will benefit most from additional support.

One issue for all Governments has been that, since the introduction of the Welfare State after the Second World War, welfare benefits have tended to (*Continued on Page 2*)

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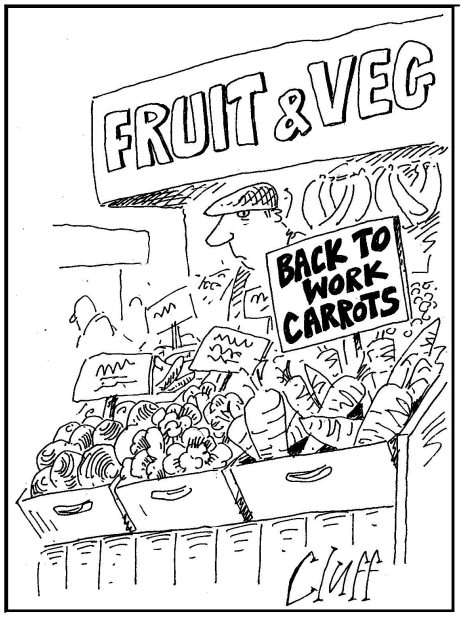
Inside this issue:

Quotes of the month:

"You could argue that all [cancer] patients should be seen within two weeks, of course, and that is certainly a target to strive for. But with resources tightening and services all over the country contracting, this is unlikely to be attained in the near future." Junior doctor Kinesh Patel, writing in the BMJ, 9 February.

'The present Government has now embarked on its programme of welfare reform. Time will tell how well it succeeds in implementing the unthinkable.' Frank Field MP, *The Welfare State—Never Ending Reform*, BBC History website, February 2011.

"The press is not a good arbiter of how best to make a fair NHS." Sarah Thornton, lawyer, writing in the BMJ, 3 February.



Key statistics:

- NHS RTT median wait England December 2010: 7.9 weeks (See Page 12)
- e-Protection Review Long Term Protection Sales Index: 114.1 (Quarter 3, 2010, compared to base 100 in Quarter 1, 2000).
- e-Protection Review Employment Index: 107.094 (To end December, compared to January 2000, see Page 11).

(*Continued from Page 1*) focus on providing cash benefits to those with welfare issues rather than providing individual help to return people to the workplace.

Indeed, there has been a view that it is 'cruel' to ask 'the disabled' to work, especially in times of high unemployment. So, before the implementation of Employment and Support Allowance (ESA) by the previous Government in October 2008, its predecessors Incapacity Benefit and, before that, Invalidity Benefit, were often used to 'top-up' benefits for people who were long term unemployed. A typical 'sympathetic' GP would be happy to agree that a patient was suffering from stress, depression or a bad back, knowing that if their claim succeeded, they would end up with a higher weekly benefit than if they simply claimed Jobseekers Allowance only.

Too easy to write off those with disabilities

Work by pioneering researchers such as Professor Sir Mansel Aylward (keynote speaker at last year's *Protection Review Conference* and Director at the **Centre for Psychosocial and Disability Research** at **Cardiff University**) and others has however shown that such attitudes can be highly damaging. In effect, society has been too willing to write off hundreds of thousands of people, giving them a still barely liveable benefit and little incentive or help to return to the workplace. They have become a forgotten army of non-workers.

The health effects of this apparently 'humane' strategy have been that mortality and morbidity rates for the long term unemployed are higher than for virtually any occupation in the UK (Waddell and Aylward, 2005).

The health risk has been likened to smoking 200 cigarettes every day (Ross, 1995).

Yet, it is a brave Government that seeks to try to change the status quo. Any reform that could result in an individual getting lower benefits risks being seen as attacking the disabled.

One of the largely unheralded successes of the previous Government was introducing welfare reforms that would have the effect of trying to get more people with long term disabilities back to work, without alienating the strong disability lobby.

However, it took more than ten years from the landslide election of New Labour in 1997 before ESA could be introduced. In the event, its introduction met with little real resistance, partly because changes were flagged well in advance and widely consulted on.

GPs' attitudes too have changed. Most GPs now accept that many people with a disability would be better off not only financially but also in terms of their health and wellbeing by being at work. They may not be able to work long hours as a labourer, but with a sympathetic employer prepared to make reasonable adjustments many people can and have become valued members of a workforce, despite their disability.

Research by Cardiff University in fact found that the levels of disability reported by people in work was, generally, higher than for a group of people unable to work because of their disability. In general, the consensus is that unemployment causes ill health, re-employment improves health and there is a gradient of health in work.

Bringing welfare into the 21st century

The challenge for Mr Duncan Smith, whose own work while in opposition (especially as chairman of the **Social Policy Justice Group**) is widely praised across the political spectrum, has been to take the very creaky 60 year old and hugely complex welfare system and to try to bring it into the 21st century.

In particular, his view is that support has to be targeted, the benefits system simplified and incentives brought in to encourage people to seek work. And that both the private sector (including insurance) and the voluntary and charity sectors can play a much bigger role—the issue is not simply one for the State to manage on its own.

The task is made harder by current high levels of unemployment. Some argue it is unfair to reduce benefits when there is no work available. But this confuses the role of welfare. If there is no job available and the rate of Jobseeker's Allowance (JSA) is judged to be too low, that is an argument for raising JSA benefits or for people to consider other actions, such as taking out unemployment or disability insurance, rather than using another type of benefit in a different context.

Mr Duncan Smith also wants to see results far more quickly than some of his predecessors. But this risks awakening the sleeping giant' of the many well-intentioned groups whose role is to (rightly) protect the interests of vulnerable groups such as people with disabilities. Some may argue that the proposed reforms in the Bill will, far from benefiting the disadvantaged, actually harm them.

We shall know over the next few weeks, whether the DWP Secretary will succeed in his blueprint or whether the ambitious Bill will end up being changed as it goes through the sometimes tortuous Parliamentary route.

The role of health and protection insurers will be to look to see how best their products and services can be complementary to the new welfare system and where there are gaps that need to be filled. So, now is a time for more radical thinking in our sector too...

Protection Review dinner sells out

Tables for this year's **Protection Review** dinner, to be held at **The Landmark Hotel**, Marylebone, London on Thursday 23 June have now sold out. Co-chairman Peter Le Beau said: "We have been surprised and delighted that demand has been so high this year, especially given the state of the wider economy. It supports our view that a day that is very business focused but still highly enjoyable makes it a must-attend event and one that can be fully justified as good use of budget and time."

Places are filling fast for the day conference too. Speakers are in the process of being confirmed and the conference will, this year, run a number of themes over the day.

On the training front, work is also well advanced. Generic health and protection insurance training, primarily for advisers, is being piloted in March, with a view to rolling it out across the UK after that. The training initiative is being supported by **The Personal Finance Society** (**PFS**) and by leading health and protection insurers.

CEO Kevin Carr said: "Post RDR, protection is going to be an even more important area to focus on for many advisers. Our generic training will cover not just the fundamentals but issues such as handling objections too. And, because it is generic, it will benefit all advisers and planners." See *www.protectionreview.co.uk* for more details.

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ABI launches new SoBP for CI

On 21 February, the **ABI** (**Association of British Insurers**) published its latest *Statement of Best Practice* (*SoBP*) for Critical Illness (CI) insurance, including new definitions for total and permanent disability (TPD).

Although TPD only makes up around 3% of CI claims, up to 55% of such claims have been rejected in the past and research has shown that many consumers had failed to understand the definition included in their policy.

The new SoBP includes no less than five separate definitions for TPD, and insurers are free to use whichever one they wish. The five are:

• Unable to do own occupation ever again (based on material and substantial duties and in the opinion of 'the relevant specialists' - a phrase that is not further defined in the SoBP).

• Unable to do a suited occupation ever again.

• Unable to do any occupation at all ever again.

• Unable to do three specific work tasks ever again. The work tasks are walking (200 metres flat]; climbing [flight of 12 stairs]; lifting [2kg to table height and holding for a minute]; bending; getting in and out of a [standard saloon] car, and writing [or using a keyboard].

In all cases, an age limit may apply to the definition.

• Unable to look after yourself ever again. This is based on failing three or more tasks (what used to be called activities of daily living). They are: washing; getting dressed and undressed; feeding yourself; maintaining personal hygiene; getting between rooms, and getting in and out of bed.

The SoBP also allows that if the definition used relies on the customer's occupation, that may be re-underwritten, when notification of the change is then required, or it can be ignored or benefit based on the original occupation. If insurers require notification of changes in occupation, the SoBP also provides that they 'should periodically remind the policyholder'. 'Periodically' is not defined in the SoBP. The Statement also includes:

• A change to the definition for Terminal Illness in the light of changing medical science. 'The attending Consultant' (a phrase also, unhelpfully, not further defined in the SoBP) must confirm both that the disease has no known cure (or has progressed to the point where it cannot be cured) and that in their opinion the illness is expected to lead to death within 12 months.

• Greater clarity for the definitions of Cancer (to exclude less advanced cases) and for Parkinson's Disease (requiring permanent symptoms).

• Standardisation of the pre-existing conditions exclusion for Children's Critical Illness Insurance.

The SoBP also includes a section on how CI should be described and we note that CI is now referred to only as CI 'insurance' rather than 'cover' (the ABI went through a phase when it was called CI cover) and that cover can be either 'stand-alone cover' or 'accelerated cover' (must *try to remember that, to be consistent! Ed*).

Comment: *We welcome the fact that TPD is now included in the ABI's SoBP—it has not been an easy or quick journey, with the ABI's first consultation paper published in July 2009 and another in June 2010 … Although having five separate model definitions is not ideal, we understand the reasons behind that. However we note that the ADL definition does not seem to include customers suffering from cognitive impairment (although that may be covered by another definition). Also, is ME (myalgic encephalomyelitis) and similar conditions covered? A customer may expect that it is, an insurer that it is not, so we can foresee issues still arising over such conditions.*

In the SoBP, model definitions now run to five pages and could be longer (or, to be fair, shorter) in some insurers' terms and conditions. They are also still very difficult for customers to fully understand and, in some areas the wording remains vague.

Overall however, this is a step forward, although we do not expect it to be the final step.

Lakey's CI comparison website

Leading protection adviser Alan Lakey, partner at **Highclere Financial Services**, has launched a critical illness (CI) cover comparison website.

The website includes information on the likelihood of a person developing a specific critical illness, based on factors such as age and smoking status. In addition it rates each insurer's CI product and includes technical information on each plan and the differences between providers. Journalists can ask questions and get access to case studies and consumers can get an explanation of what conditions mean and compare providers.

IFAs can access the website for £20 a month or £200 a year and printed PDF documents can also be used as compliance tools. Alan Lakey said: "I want insurance companies to look at the information, compare their products with other providers, and improve their plans."

See *www.criticalillnessinsider.com*.

Comment: *Alan Lakey has long been a leading advocate for protection insurance and has invested a huge amount of time in what looks to be a very worthwhile venture that should benefit customers, advisers and providers too.*

PMI impact on sickness absence

One in seven (15%) employers find private medical insurance (PMI) highly effective in helping to achieve sickness absence management goals and 48% find it has some impact, according to the *Employee Benefits/**Cigna** Workplace Absence Research 2011*, published by the magazine in February. The most effective strategy was absence recording, rated by 22% of employers, followed by occupational health (16%), PMI (15%), childcare vouchers (10%), employee assistance programmes (9%), wellbeing programmes (7%) and group income protection (GIP, 6%).

Only 28% of employers said GIP had some impact, with PMI ranking top (48%) with occupational health, followed by childcare vouchers at 38%. Health cash plans (HCPs) were seen as highly effective by 3% of employers and having some impact by 17%.

6% of employers planned to introduce PMI in the next two years and 12% would consider it. The figures for HCPs were 5% and 19% and for GIP, 5% and 11%.

In terms of employees' mental resilience, the most common worry for workers was increased concern about redundancies (reported by 71% of the 282 respondents), more stress (61%) and decreased motivation (48%).

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Benenden Healthcare and Wiltshire Friendly target brokers

Two specialist mutual providers have announced plans to target the broker market. **Benenden Healthcare Society**, the 105-year-old mutual that provides healthcare to public sector workers, co-operatives and other mutuals such as **John Lewis** and **Nationwide**, has announced plans to sell its low-cost policies through intermediaries for the first time, as it aims to increase its share of the market.

Marc Bell, marketing and business strategy director, said: "Intermediaries are a major route to market for healthcare products and we aim to significantly increase our sales through this channel. Being a not-for-profit organisation means Benenden Healthcare's policies go far beyond typical private medical products, offering a broad range of discretionary cover. This means we compare extremely favourably in the market and anticipate getting good support from intermediaries."

Benenden Healthcare offers health plans at a flat rate of £1.50 per person per week irrespective of a member's age or previous medical history. Rather than compete with the NHS, the Society acts as a back-up by providing treatment if there are lengthy waiting times. It does so by providing benefits on a case by case discretionary rather than contractual basis, so pre-existing conditions are not excluded and members can even receive treatment for problems that pre-date their membership.

Members are treated either at Benenden Healthcare's hospital in Kent or at one of its 15 contracted regional treatment centres.

Wiltshire Friendly has also announced it is targeting the intermediary sector. Spokesman David Macgregor said: "Wiltshire has been providing group income protection schemes on a localised pilot basis for a while now and has decided to spread the word amongst IFAs. We strongly believe that any new entrants into the group IP market should be welcomed and we are convinced that our flexible and innovative approach will create opportunities for new group IP schemes where cover was previously unavailable—not just another provider to add to the re-broking list." Wiltshire's GIP plan is reviewed on Page 8.

Foresters links with CS

Foresters Friendly Society announced on 17 February details of an agreement with **CS Healthcare**, which will benefit members of both organisations through a range of additional benefits. The agreement is the first time two UK friendly societies have offered each others' members direct access to their products and services.

Foresters' members will be informed of CS Healthcare's private health insurance product, Your Choice. The insurer normally only provides health insurance to those who have either worked, or are currently working, in the civil service, public sector or not-for-profit organisations. As a special arrangement between the two mutuals, CS Healthcare's product will be offered to all Foresters' members between ages 18 and 75.

CS Healthcare policyholders will receive information regarding Foresters Friendly Society 50+ Life Plan. This plan offers policyholders a guaranteed cash lump sum payable in the event of their death which can be used to pay outstanding debts and funeral expenses.

Neil Armitage, Foresters marketing director, said: "As consumer trust in the banking sector continues to erode, now is the ideal time for mutual organisations to be pooling their resources, sharing ideas and working to ensure they offer a sum greater than their parts to offer their members greater choice without compromising their traditional values." Russell Stephens, director of marketing, distribution and membership services at CS added: "Both of our societies have long histories protecting the health or wealth of members. We've based our decision to join forces on our common values and principles which put our members first." He added: "We also hope this will be the first of many more examples of mutual societies working together to the wider benefit of members."

Foresters Friendly also offers its members access to a range of health-related benefits. These include Foresters Care, provided by **RED ARC Assured**, which provides practical advice and emotional support to members diagnosed with serious illnesses.

DG pays 99% of IP claims again

DG Mutual, the income protection (IP) specialist for self-employed professionals, paid out 99% of claims for the third year running, with over 50% of claims paid out within one week, it announced on 16 February.

It says the high rates are due to checking all applications thoroughly and conducting thorough medical checks at the outset. Last year, over 50% of all IP claims were paid within one week and over 90% were turned around within two weeks. Infection is still DG Mutual's highest cause of IP claim (claims paid included those for swine flu and viral illnesses), proving it is not just long-term conditions that keep self employed professionals off work.

As a Holloway insurer, in 2010, £195,000 of final bonuses were also paid out to retiring members. Other claims stats from 2010 include the fact that on average, members received an income for 12 working days, the average age of claimants was 46 and 7% of members made a claim in the year.

Businesses not ready for A day

Research from trade body **GRiD** (**Group Risk Development**) has found that 47.0% of employers plan to take no action when 'A day' arrives. From 6 April 2006, firms had to move from the old 'four times salary' maximum lump sum death benefit to a new earnings gap and lifetime limit.

However, they were given a five year transition period, which expires in just over a month's time. Despite that, only 9.8% of firms plan to put a salary cap back into their group risk schemes, 9.2% plan to remove the earnings gap and 32.1% are still undecided. GRiD says that this could leave employers risking potentially huge uninsured liabilities on an employee's death.

Other GRiD research (of 500 firms last October) found that 84% of firms had maintained the value of benefits offered to staff and that 37% were considering increasing their spending in future. And, the proportion of firms offering group risks had gone up from 37% to 41%.

Stakeholders plan safety net for mortgage borrowers

On 9 February, stakeholders across the mortgage sector announced their support for borrowers facing repayment difficulties, as mortgage possessions continue to run at lower levels than many had feared. In a reply to a November paper it commissioned from consumer champion John Howard, the **Building Societies Association** (**BSA**) response, which features contributions from the Government, industry, debt advice charities and commentators sets out the scale of the problem, why it is likely to get worse in future and the schemes currently available to help borrowers who fall behind in their mortgage payments.

It identifies four ways borrowers can be helped:

1. Private insurance.
2. Public insurance in the form of State benefits.
3. Flexible tenure enabling homeowners to become renters of their property.
4. Lender forbearance.

ABI (**Association of British Insurers**) assistant director of health and protection, Nick Kirwan, argued that mortgage payment protection should be an opt out rather than opt in. But, he pointed to a recent **Competition Commission** ruling which means that mortgage payment protection insurance (MPPI) cannot now be taken out at the same time as a mortgage. This he warned, could see more people lose their homes unless they take action to ensure they are adequately protected.

He added that under the **FSA's** proposed Mortgage Market Review (MMR) a borrower—especially a first time buyer—could fail the affordability test if they also take out protection to cover the loan. He said this was: 'yet another barrier to encouraging people to 'do the right thing' by taking personal responsibility for their financial wellbeing'.

And Suzy Awford, vice president Government relations at **Genworth Financial (Europe)**, noted that in Italy, lenders giving high loan to value mortgages need to hold more capital if the borrower is not protected by mortgage indemnity insurance.

The Government has a strong interest in reducing mortgage possessions. The **Department for Communities and Local Government** estimates it costs the Government £16,000 on average when a vulnerable household has its home possessed. And, a report by **NEF Consulting** for the Government found that avoiding the eviction of a family of four can result in a saving to Government of £34,000. But, *Independent* columnist Andrew Hagger warned that the future of SMI (Support for Mortgage Interest) looks unlikely to continue after 2012. He advocates mandatory MPPI cover built-in to mortgages.

Some 36,000 homes were taken into possession in 2010 according to the **Council of Mortgage Lenders** (**CML**), compared to a recent peak of 47,700 in 2009. The CML estimates around 40,000 homes will be taken into possession this year. See *www.bsa.org.uk* for more.

Comment: *MPPI and income protection (with unemployment insurance built in) both have the potential to play a greater role and provide more security to both lenders and homeowners. Indeed can it be prudent lending to lend to someone without suitable cover? But more innovative product solutions are needed if enough homeowners are to be helped.*

Most expect Gov to pay for LTC

Most over 50s expect the Government to pay for their all or most of their long term care (LTC) needs, according to a poll for **Partnership**, which has 80% of the market for LTC annuities in the UK

Unprompted, 81% believed care should be fully funded by the Government, 43% that it should partly fund care and 38% that the better off should contribute to the cost. After being told about the 'demographic time bomb' of there becoming more old than young people, those percentages fell to 79%, 38% and 41%.

One interesting result was that while 15% believed the elderly should make a contribution to care costs, that increased to 18% when those polled were reminded about the demographic changes and the free benefits that older people have enjoyed (including substantial increases in house prices; free university education; child benefit for all families; low cost privatisation shares; final salary pension schemes, and child benefit for all families).

Partnership has launched **Payingforcare.co.uk**, a website that provides impartial, comprehensive and consumer friendly help on all aspects of care. Partnership's research shows that 69% of people now turn to the internet for information on care for older people and that in 2009 **Google** recorded 29m searches on paying for care and related search themes. They also found that 25% of people had no idea who to contact for advice and only 11% would contact their local authority, 4% a financial adviser and 3% a care home. Only 5% felt the social care system was easy to navigate and 76% did not know about any funding products available to fund care.

On 15 February, the **ABI** organised a seminar on LTC funding, at which **Dilnot Commission** member Lord Warner gave an update on the Commission's work. Asked about whether the compulsory pensions debate would affect LTC he felt that: "the social support for compulsion is not there." He added that equity release had failed to win people's hearts and minds too. The Commission's report is expected in July, with a possible White Paper by the end of December.

UK healthcare costs up 4.9%

The cost of providing healthcare and health-related benefits to employees in 2010 rose by 4.9% in the UK—the highest in Europe—where the average was 3.3%. But that was still less than the 6.9% increase in the US, according to **Mercer's** *Pan-European Survey of Employer Health Benefits*, which was published on 17 February. The lowest increase was in Germany (1.5%). The survey polled 556 employers in 14 countries.

Partner Steve Clements said: "Governments are shifting the cost of healthcare to employers and individuals in the form of tighter tax deductions, reduced scope of public healthcare services, privatisations, higher cost sharing and eligibility restrictions or opting-out schemes."

The poll found that 72% of employers required no employee contribution but that varied from 80% in France to just 8% in the UK (but 47% for dependant coverage).

Where a contribution was required, it averaged 46% of the total cost or 68% for dependant coverage.

For more see *www.mercer.com*.

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News briefs:

• On 14 February, the **Competition Commission** published a draft notice of its intention to make an order prohibiting certain activities regarding the sale of payment protection insurance (PPI). Details at *www.cc.gsi.gov.uk*. Consultation closed on 22 February. In essence the order brings into effect its previous rulings, including banning selling PPI at the same time as a loan.

• The **European Union's** Omnibus II Directive, which will have the effect of delaying the full implementation of Solvency II until 2023, will broadly benefit smaller and niche insurers, who will have more time to implement changes, according to **Fitch**.

• A **Canada Life** survey found that 19% of workers do not know how long their employer would continue to pay their salary if they could not work due to illness. 30% thought it would be beyond three months and 12% thought they would get full salary throughout their illness. One in ten had no idea how much they would be paid if off work ill. If they could not work, 41% would rely on savings, 21% on State benefits and only 12% on income protection. 46% said that if out of work for a year they would have lost their confidence (75% of women and 28% of men).

• **Friends Life** is to be the new name for **Resolution's** combined businesses, comprising **Friends Provident**, **Bupa Health Assurance** and part of **AXA's** life business. The group expects to have around 10% of the group risk market.

• 44% of people with mental health issues have had severe or crisis debts, compared to just 9% of the rest of the population, according to research by **moneysavingexpert.com**.

• The number of business failures fell by 12.1% last year to 23,000 from 26,000 in 2009, according to **Equifax**.

• **WPA** has increased the NHS Car Parking benefit under its NHS Top-up and Flexible Health plans from £50 to £300 a year for cancer sufferers (otherwise, it remains at £50). **Macmillan** has reported that cancer sufferers on average go to hospital 53 times during the course of their treatment. Premiums still start from an unaltered £1.79 a week for the NHS Top-up plan. WPA has also teamed up with the **Forum of Private Business** to offers its products to FPB members.

• **Aegon** has launched an online trust analyser tool, to enable advisers to determine which of their clients' protection products should be written in trust.

• **FSA** chairman Lord Turner has backed the regulator's new and more intrusive approach to financial services regulation, as set out in its discussion paper DP11/1. Options being considered include product pre-approval and banning some products, as well as price interventions and preventing non-advised sales. Some product features could also be banned or mandated and minimum standards set, and additional competency requirements for advisers could be introduced too. See *www.fsa.gov.uk* for more.

• From January 2013, all approved persons will need a certificate from an accredited body (a statement of professional standing) to show they meet appropriate professional standards the **FSA** has said. Advisers will have to complete at least 35 hours of CPD a year, of which at least 21 hours must be structured.

• In the last quarter of 2010 the **Financial Ombudsman Service** (**FOS**) received 644 complaints about travel insurance, 418 about whole of life insurance, 230 on term assurance, 157 on IP, 120 on CI, 115 on pet and livestock insurance, 112 on PMI and dental insurance and 81 on personal accident insurance, out of a total of 50,738 complaints—half of which (24,955) were about payment protection insurance (PPI). 47% of IP and PMI complaints were upheld, compared to 33% of CI and 24% of term complaints. Overall, 53% of consumer complaints were upheld, but that included 66% of all PPI complaints.

• 41% of IFAs reported growth in income in Q4 of 2010, up from a low points of just 13% in Q3 of 2009 according to **NMG's** quarterly *IFA Trends*. Average income increased by 3% compared to a year before. On 1 January, risk management specialists **SelectX** joined NMG, to become **NMG SelectX**.

• 46% of working women describe themselves as the main earners in their family and 44% say they are responsible for making the family financial decisions, according to **Bright Grey's** *Women and Protection Report*. But, 53% said they had no life insurance cover, 84% had no income protection, 78% no CI cover and 81% no PMI. **Opinium Research** polled 2,010 adults in January

• **Zurich's** protection business reached a new peak in the third quarter of 2010, reaching a market share of 7.7% it says, up from 5.3% in the same period of 2009. It also paid out on 91% of CI claims in 2010, with cancer accounting for half of all CI claims and heart attack 12%.

• **Pharmaceutical & General Provident Society** has announced that it paid 98.46% of its income protection claims received in 2010, "...and obviously 100% of valid claims," according to CEO Paul Brierley.

• **LV=** says it paid out 93% of its CI and 92% of its IP claims in 2010, both up from 90% in 2009.

• **BHSF** has launched a benefit club. It includes access to the **Network Benefit** website, a 24/7 GP helpline, counselling and advice lines, an online health assessment and a lost keys service. The cost is just £3 a month.

• **LifeSearch** says it arranged £4bn of protection cover last year, and saw a 10% increase in under 35s taking out cover. In total it protected 45,000 lives and noted 34 rate changes by insurers. Interestingly, 20% more women than men bought CI cover from LifeSearch last year.

• Group risks are to be exempted from the Government's default retirement age provisions, its response to recent consultation has made clear.

• **Nationwide** has signed a five year deal to market **L&G** protection and investment products to its customers. 150 jobs will be created to give branch-based advice.

• Thought you had a problem with churning? Research by **Confused.com** found that only 40% of people had been with their current home insurance provider for three or more years, and only 5% for ten years or longer. Only 13% had never switched home insurer. Only 70% had been with their current insurer for more than a year.

• A sign of the times? 80% of employees think the quality of sandwiches at their business meetings has fallen, according to a recent survey conducted by office design company **Maris Interiors**. The average cost of sandwiches per person at meetings is now £3.80 compared to just under £6 when the survey was first conducted in 2006.

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Pick of the month

We review some interesting and innovative solutions this month. First, newly renamed Ageas Protect resuscitates the low cost concept and brings it to protection, while PruHealth launches a good range of new plans to take over from its and Standard Life Healthcare's old PMI plans.

We welcome a new provider too—at least to the intermediary market, though it has been in existence since 1887, so it's not really that new… Welcome, Wiltshire Friendly, with its flexible approach to GIP.

Our pick of the month though is Unum, for its Select plan, which combines marketing support, simplicity and good basic group risk benefits to help expand the market.

Ageas Protect Low Start

Ageas Protect is the new name for what, until the start of this year, was **Fortis Life**. Low Start is a new variant on Ageas' existing products.

The low start concept was popular back in the 1980s with mortgage endowment products and enables customers to buy the same cover at a lower initial monthly premium. Annually, that premium increases and will eventually be higher than that on a regular premium plan. Over time, it is a more expensive way to buy cover, but has the significant advantage of lower premiums at outset.

The low start route was popular as it helped customers' cashflow in the all-important early days of their mortgage. High inflation rates then meant that mortgage costs tended to remain broadly the same (unless interest rates changed), while income could be expected to rise rapidly. The idea fell out of favour, partly because many customers did not fully understand what they had bought.

Cover itself can be term assurance (which includes terminal illness benefit and optional waiver of premium) or that can be combined with critical illness cover.

The initial premium can be up to 30% cheaper than for a level premium plan, with the exact figure and rate of annual increase depending on age and policy term. A similar result could be achieved through an annually renewable policy, but that would not guarantee future premiums.

If the customer chooses not to increase their low start premium in future, the plan can continue, but with a lower sum insured. Ageas says its low start system is suitable for customers in their mid 30s and above but not for younger customers, where the price saving in the early years is likely to be too low to justify the low start route.

Plus points: *Most customers are used to household and motor insurance premiums rising every year, so low start life insurance that does the same can appeal to people on tight budgets. Built on a proven product at a lower initial cost, where premiums and premium increases are guaranteed and can fit with a customer's expectation of rising income in future. If future premium increases cannot be afforded, the sum assured can be cut accordingly.*

Not so plus points: *Ageas' low start route is not suitable for customers whose net spendable income is unlikely to rise in real terms in future. The plan cannot be used for younger clients (often, those who would most value having lower initial costs) and can end up costing considerably more overall than an equivalent level premium plan. One issue for Ageas will be whether intermediaries look to move clients to another provider once premiums start to rise in future years.*

Contact: 0845 600 6829 or *www.ageasprotect.co.uk*.
Rating (max 5). Innovation: 4. Overall: 3.75.

PruHealth Business Healthcare

Since taking over **Standard Life Healthcare's** PMI book last year, **PruHealth** now has over 700,000 members and an 11% market share of the UK PMI sector.

From 1 March PruHealth is launching a new range of personal, business and corporate plans to take over from its existing PruHealth and Standard Life Healthcare products (new plans only, initially). Our review is based on the new age-rated Business Healthcare proposition, which is built around having Core Cover, which provides:

- Full cover for in-patient and day-patient hospital fees, specialist fees and diagnostic tests.
- Out-patient MRI, CT and PET scans.
- Core cancer cover.
- Added benefits. These are home nursing; NHS hospital cash benefit; childbirth cash benefit; parent accommodation, and private ambulance.

Customers can then choose:

- From four underwriting types.
- One of five excess levels (from £0 to £1,000) and whether per claim, per year or Vitality-linked.
- Premier, London, Countrywide or Local hospitals.
- To enhance out-patient cover (choice of six options up to full refund); out-patient diagnostics (up to full cover); therapies benefit (£350 a year or full refund); psychiatric cover (£15,000 or £29,000 a year, including a £1,500 out-patient limit); private GP helpline; personal health fund (health cash plan style benefits – optical; dental; health screens; physiotherapy; chronic prescriptions or enhanced gym discounts); employee assistance programme; emergency overseas cover; dental cover, and worldwide travel cover.

A linked Vitality programme rewards healthy lifestyles through awarding points. This reduces future premiums on Personal plans or gives discounts from reward partners on Business and Corporate plans. Discounts are available on spending e.g. health screens, gym membership, holidays and stop smoking sessions. Members also earn Vitality points through healthy eating at **Sainsbury's** and also have access to a range of health-related information and advice.

Plus points: *PruHealth has managed the tricky issue of bringing two providers' plans together in a proposition that links a menu/option approach with another variation on the Vitality concept. Adding a Personal Health Fund (giving HCP style benefits) should be useful in these straitened times too, meaning many employees can benefit every year rather than (on average) just every four years (on a typical PMI only plan). The Vitality approach has won many fans since 2004.*

Not so plus points: *Not a simple product, so it takes time to learn. Can be expensive if all options are chosen. Requires employees to take an active role (through Vitality) to get the best benefits out of the plan.*

Contact: 0800 328 3962 or *www.pruhealth.co.uk.*
Rating (max 5). Innovation: 4. Overall: 4.

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Unum Select

Unum's latest initiative in the group risks market, Unum Select, is an inclusive group risk plan that aims to expand the group risk market. It is available on Standard (traditional employer funded group risk) or Voluntary bases.

The plan enables employers to have life, income protection and critical illness cover within one group risk plan. The most significant factor is that the plan can be funded wholly or partly by the employer or by the employee. So, an employer that wants its workforce to have the benefit of group risk cover could set up a plan wholly funded by the employees themselves.

A core element is a worksite education programme. This provides a tailored approach to communicating with staff about the benefits being made available to them and can include group presentations, internet and phone and one to one meetings with 'Unum Select enrollers' - Unum staff who come into the workplace to educate the workforce on the need for financial protection and what is and what is not covered.

Unum points out that only 1 in 10 employees currently has income protection cover from its employer, while the Government is moving towards people taking more responsibility for their own welfare and protection.

Worksite marketing has been very successful in the US and, in the UK in areas such as health cash plans, but it remains an under-used distribution channel in the UK. Linking that with a choice of protection covers, ease of buying (including online quotes and administration) and a focus on employee benefits education will, Unum believes, help take group risks away from being largely limited to high earners to opening up benefits to all employees.

Within the plan, Select Life Cover on a voluntary (i.e. employee funded) basis requires 'active enrolment' of employees, and includes guaranteed insurability (GI, the equivalent of free cover limits on traditional group life). Up to £250,000 of cover is available (or up to twice that on standard employer funded plans, which must cover at least 75% of eligible employees). Employers can contribute a fixed monetary contribution or make a partial (up to 75%) contribution or allow employees to pay the whole amount.

Select Income Protection pays up to £36,000 a year on voluntary plans and offers a range of deferred periods, and benefit terms from as little as six months up to a maximum retirement age of 70.

Select Critical Illness Cover provides up to £100,000 on Standard plans. Spouse's and children's cover is also available.

Under voluntary schemes, Unum asks a 'handful' of health and lifestyle questions, then applies a simple accept or reject underwriting approach.

The plan is already being sold by selected IFAs, with a wider roll-out by April. The first employer to sign up to Select was **Incisive Media**, publisher of *Cover* magazine.

Plus points: *Aims to expand the group risk market to a much wider group of employees through a combination of ease of access, worksite marketing and simple group risks alone or in combination. Enrollers can help IFAs get to more people more effectively. Plans can be wholly employee funded but still benefit from guaranteed insurability. Simple yes/no underwriting based on minimal information.*

Not so plus points: *Not every IFA likes 'help' from insurers as this risks losing control. Minimum levels of participation apply. Some may see this as Unum trying to make US ideas work in the culturally different UK.*

Contact: 01306 887766 or *www.unum.co.uk.*

Rating (max 5): Innovation: 4.5. Overall: 4.25.

Wiltshire Friendly Group Income Replacement

Although established as long ago as 1887, Trowbridge based **Wiltshire Friendly Society** is still largely unknown, at least in intermediary circles. But, that could change, as it has now decided to actively target the intermediary market. Membership is over 6,000 and the mutual organisation specialises in income protection products. In 2009, over 98% of claims received were paid.

The Group Income Replacement plan covers from five lives (although, as with many other features, such limits are not set in stone and may be negotiable, especially for good business) and covers up to 75% of income. That can include pension contributions, NICs and other non-pay benefits, and maximum benefit is £37,500 a year. A wide choice of deferred periods is available, from four weeks (even available to blue collar workers) to 52 weeks. Benefits can be paid to retirement age or for a limited benefit period of one or two years.

Accident Cover is a unique benefit that gives back to day one cover if an employee is injured by a non-work related accident and is off work for at least one week. An own occupation incapacity definition is used on all plans. Continuation of Cover is automatically included, allowing leavers to continue cover on a personal basis. Standard commission is 12% a year. And, employees can 'top-up' the cover provided by their employer.

One recent service introduction has been Big T tele-interviewing, with **Medicals Direct Group**.

Plus points: *Very flexible approach (although only for the right risks we would expect). Blue collar workers are welcomed. Built-in Accident Cover and Continuation of Cover, and Big T tele-underwriting is available too.*

Not so plus points: *Not an organisation that is yet well-known to the broking community (which can cause teething problems, especially as some intermediaries may have little understanding of the types of risk such providers want to attract). Relatively low maximum benefit and the plan lacks the third party add-ons now becoming increasingly popular.*

Contact: 01225 752120 or *www.wiltshirefriendly.com.*

Rating (max 5): Innovation: 3.5. Overall: 3.75.

Literature review: Laing's Healthcare Market Review 2010-2011

The latest (23rd) edition of **Laing & Buisson's** mighty tome on the UK healthcare market is now available.

As in previous years, it includes a (58 page) chapter on medical insurance, as well as chapters on private acute health services, primary medical care, mental health and learning disability services and care of elderly and physically disabled people as well as articles and a directory of providers. *Laing's Healthcare Market Review 2010-11* costs £410, from 020 7833 9123. Recommended reading.

New breast cancer test

UK geneticists have developed new DNA sequencing methods and data analysis techniques for the faster identification of hereditary breast cancer. **NewGene**, a specialist molecular diagnostic company jointly owned by **Newcastle Hospitals NHS Foundation Trust** and **Newcastle University**, has developed an advanced gene sequencing process to successfully identify all mutations in the coding regions of two genes associated with inherited breast cancer - BRCA1 and BRCA2.

In the first application of its type, NewGene is successfully using the **Roche** 454 GS-FLX platform for complete sequencing of all BRCA genes. The breakthrough follows two years of assay development work with specially developed data analysis software to enable high volume testing of gene sequences to be undertaken at a level not previously possible.

This technology platform represents a much faster and higher capacity DNA sequencing process than is associated with the traditional Sanger technique used for this type of testing. The availability of the advanced test to UK and European healthcare providers will mean the earlier identification of family members at risk of developing breast cancer.

In addition, by reducing the cost of testing, health trusts will be able to extend hereditary breast cancer screening to those who may not currently qualify for gene sequencing. The test service can be provided at around half the cost of current NHS breast cancer hereditary testing and has a results turnaround time of as low as four weeks. The current NHS target for hereditary breast cancer testing is eight weeks and actual timescales can be longer. The new breast cancer test has already been successfully used in gene testing work carried out for the **Northern Genetics Service**.

Breast cancer is the most common cancer in women in the UK, making up around 30% of all female cancers. There are around 40,000 new cases of breast cancer reported each year and between 5-10% of cases are the hereditary form of the disease.

Bowel disease raises clot risk

Inflammatory bowel disease more than doubles the risk of a potentially fatal blood clot in the legs or lungs (VTE), reveals research published online in the journal *Gut* in February. Inflammatory bowel disease is an umbrella term that includes Crohn's disease and ulcerative colitis. Venous thromboembolism (VTE), which includes deep vein thrombosis (DVT), pulmonary embolism (PE), and superior sagittal sinus thrombosis (SSST), affects around two in every 1000 people in developed countries annually.

The authors compared the number of new cases of VTE arising in around 50,000 children and adults with inflammatory bowel disease and more than 477,000 members of the general public. The study period spanned 1980 to 2007 and took account of known VTE risk factors, such as a broken bone, cancer, surgery and pregnancy.

The results showed that the risk of VTE was twice as high in those with inflammatory bowel disease as it was in the general public.

VTE is more common in older people, irrespective of whether they have inflammatory bowel disease or not, but the risk of VTE in patients with inflammatory bowel disease was highest in younger age groups, when compared with the general public. In those aged 20 or younger, the likelihood of a pulmonary embolism, which can be fatal, was low, but it was six times as common among those with inflammatory bowel disease as it was among the general public in this age group.

Even after taking account of concurrent cardiovascular disease, diabetes, congestive heart failure, the use of hormone replacement therapy or antipsychotic drugs, all of which are known to heighten the likelihood of VTE, the risk still remained up to 80% higher.

The findings suggest that inflammatory bowel disease may be an independent risk factor for clot formation, say the authors.

Thromoboembolic risk among Danish children and adults with inflammatory bowel diseases: a population based nationwide study. See: doi 10.1136/gut.2010.228585.

Alcohol in moderation protects against heart disease

People who drink alcohol in moderation are 14-25% less likely to develop heart disease compared to those who drink no alcohol at all, finds research led by Professor William Ghali from the **University of Calgary**, published on *bmj.com* on 22 February.

A paper led by Dr Susan Brien found that moderate consumption of alcohol (up to one drink or 15 g alcohol per day for women and up to two drinks or 30 g alcohol per day for men) is good for health. They say moderate amounts of alcohol significantly increase the levels of 'good' cholesterol circulating in the body and this has a protective effect against heart disease.

Brien and colleagues argue that their study strengthens the case that there is a causal link between alcohol consumption and reduced heart disease.

Professor William Ghali says his team's research is the most comprehensive to date. Ghali and colleagues reviewed 84 studies of alcohol consumption and heart disease. They compared alcohol drinkers with non-drinkers and their outcomes in relation to heart disease, death from heart disease, incidences of stroke and death from having a stroke.

Brien and colleagues reviewed 63 studies and investigated alcohol consumption with known physical markers for heart disease such as cholesterol, levels of inflammation, fat cells and the condition of blood vessels. They also assessed the impact of the type of alcohol consumed (wine, beer and spirits).

Brien's research concludes that it is the alcohol content that provides the health benefits not the type of alcoholic beverage (wine, beer or spirits) that is drunk.

Professor Ghali concludes that the debate between the impact of alcohol on heart disease should now centre "on how to integrate this evidence into clinical practice and public health messages".

Comment: *This new research back up previous studies, which show that regular alcohol intake—in moderation—is good for the health. This latest study helps explain why, and the levels that count as 'moderate'.*

NHS dentistry funds and private dentistry market share slow

Laing & Buisson report that spending on NHS dentistry accounted for 58% of the total £5.7bn UK primary care dentistry market in 2009/10 but warns that spending on NHS dentistry is likely to slow down as the Government reins in the funding available.

Spending on NHS dentistry has climbed 4% a year in real terms since 2006. The private dentistry market has grown more modestly and is thought to have peaked at £2.5bn in the UK in 2007/08 just before the recession.

For the first time, private dentistry fell by an estimated 7% in real terms over 2008/09 and 2009/10 as patients cut back or returned to the NHS.

Spending on private dentistry continued to dip in 2009/10 to an estimated 2.4bn. *Dentistry UK Market Report 2011* is available from Laing & Buisson price: £650 (hard copy). Tel: 020 7833 9123.

In another L&B report, public sector outsourcing drove growth of the independent mental health and specialist care sector during the past year, pushing the total value of independent supply to a new record high of £7.7bn. However, the Government's public spending cuts will present a major challenge to providers of these services, with the next three years set to see forced fee decreases, smaller referral volumes and tighter profit margins according to the fifth edition of *Mental Health and Specialist Care Services UK Market Report.*

Breast cancer risk rising

Cancer Research UK, using data from the **Office for National Statistics** and UK cancer registries, has calculated that the lifetime risk of a woman in the UK developing breast cancer has risen from one in nine to one in eight, *BMJ* 2011; 342: d808 reported on 4 February.

Incidence rose from 42,400 in 1999 to 47,700 in 2008—a 3.5% rise. The biggest rise was in women aged 50 to 69 (6% in ten years) although there was a slight fall among women aged 25 to 49 (0.5%).

The charity suggests several explanations. The breast screening age range was extended in 2004 and so more women are now attending breast screening clinics.

An estimated 11% of breast cancers in the UK are due to alcohol consumption and 7% to obesity. Hormone replacement therapy can increase the risk of developing the disease and is a lifetime risk, and we are living longer. Maintaining a healthy weight, following a healthy diet and plenty of exercise are shown to reduce the risk of developing the disease and today almost two in every three women survive their disease for more than 20 years and more than three-quarters survive for at least ten years.

Medical briefs:

• **BMI The Ridgeway Hospital** in Swindon has announced a £3.2m development programme to include a third operating theatre, extension to the main hospital reception, a refurbishment of the existing pharmacy and new consultation rooms.

• **Circle** has agreed a £50m deal with **BP's** pension fund for the development of its second new build hospital, which will be called **Circle Reading**.

• Scottish research published online in the *Journal of Neurology, Neurosurgery and Psychiatry* has shown that head injuries, especially in young adults, can reduce the chances of an individual's survival up to 13 years after the trauma. Of the 757 people (out of 2000 studied) who had sustained a head injury requiring hospital admission, 40% were dead within 13 years compared to around 24% of the controls.

• A study of 7,403 adults from London and Leicester found 4.1% of gay people had experienced a depressive episode in the past week compared to 2.1% of heterosexuals and 8.6% of gay people reported self-harming compared with 4.6% of heterosexuals. See: *British* Journal *of Psychiatry* (2011) 198: 143-148.

• A US study involving data from 200,000 cases shows that trauma patients who used drugs or alcohol before their injury were more likely to develop complications in hospital, reported the *Journal of Trauma Management & Outcomes* (2011) 5:3. Infection was a significant risk for both alcohol and drug related trauma patients and those who tested positive for drugs were at significant risk of developing vascular problems.

• According to a study in the *Annals of Oncology* (doi: 10.1093/ annonc/mdq 774), nearly 1.3m people in Europe will die from cancer in 2011. Its estimates show a fall in the overall number of deaths from cancer since 2007 in European men (down 7%) and European women (down 6%) but a rising incidence of lung cancer in women.

• Exercising in the office, using portable pedal machines can counteract the harmful effects of sedentary desk jobs. The authors claim that just 23 minutes a day can boost health. See *http://press/psprings.co.uk/bjsm/february/bjsm79574.pdf*)

What is a Cochrane Review?

Cochrane Reviews are internationally recognised as the highest standard in evidence-based healthcare. A Cochrane Review is a systematic scientific review of primary research in human healthcare and health policy and each one addresses a clearly formulated question e.g. are statins effective for preventing cardiovascular disease? All existing research that meets certain criteria is searched for and collated, and then assessed using stringent guidelines, to establish whether there is conclusive evidence about a specific treatment. Reviews are then updated regularly to ensure they remain relevant.

A paper by Scottish researcher Professor Archie Cochrane (1909-1988) in 1972 (*Effectiveness and Efficiency: random reflections on health science)* first drew attention to the collective ignorance about the effects of healthcare. The Cochrane Collaboration was established in 1993 and is an international network of researchers. Each review is published in the online Cochrane Library and it is estimated that at least 10,000 Cochrane Reviews will be needed to cover all healthcare interventions that have already been investigated in controlled trials. There are currently over 4,000 Cochrane Reviews in the Cochrane Library plus around 2,000 protocols. For more see *www.cochrane.org*.

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2% threshold for statins?

The case for prescribing statins to people with atherosclerotic cardiovascular disease is strong but the case for using them for those without existing cardiovascular disease is less clear and was highlighted in a recent Cochrane systematic review, *BMJ* 2011; 342: d1048 reported on 16 Feb.

The authors conclude that the benefits of statins outweigh the harm if the risk of cardiovascular events exceeds 2% a year. Statins should also be considered for diabetic men at least by age 50 and diabetic women by age 60.

Men over 55 with multiple risk factors and women aged 65 and above should receive statin, while in elderly people, a relatively low dose of statin may be sufficient.

Dogs sniff out cancer

Dogs can sniff out bowel cancer in breath and stool samples with a high degree of accuracy, and are not confused by samples from smokers or those with other gut problems, which suggests that chemical compounds associated with certain cancers circulate throughout the body an article in *Gut* in January reported.

A trained Labrador successfully identified those who did or did not have bowel cancer from 33 out of 36 breath tests (95% accuracy) and 37 out of 38 stool samples (98% accuracy). The highest detection rate was among those with early stage disease, whereas a faecal occult blood test only detects one in ten early stage cases. Using dogs to screen may be impractical and expensive, but a sensor could be developed to detect the specific compounds.

Obesity a killer in its own right?

Increase in weight is known to be associated with risk factors for coronary heart disease such as diabetes, high blood pressure and cholesterol but now a research team from the **University of Glasgow** has published research that suggests that obesity is a killer in its own right.

The team followed 6,000 middle aged men for 15 years and found the risk of death was significantly higher in men who were obese, even after adjusting for other risk factors. Inflammation is a strong factor in fatal cardiovascular disease and obesity is increasingly being recognised as an inflammatory state which might partly explain its link to heart disease. The findings were published in the journal *Heart* in February.

Researchers closer to predicting prostate cancer aggressiveness

Researchers at **Queen Mary, University of London** have found that men with the highest levels of expression of a set of 31 genes associated with cell cycle progression (CCP) were three times as likely to have recurrent prostate cancer than those with the lowest levels, *BMJ* 2011; 342: d1031 reported on 14 February.

In the UK men studied, the CCP score was the most important variable for predicting time to death from prostate cancer with a doubling of CCP score being associated with a tripling of risk.

UK alcohol-related deaths down

The **Office for National Statistics** has published the 2000 to 2009 figures for alcohol-related deaths in the UK, England and Wales and the data shows:

- 8,664 alcohol-related deaths in the UK in 2009 (down from 9,031 in 2008).
- Two thirds of those deaths were male (5,690 deaths: or 17.4 per 100,000 population).
- In 2000-09 period, the highest death rates were in the 55-74 male and female age group.
- The lowest alcohol-related death rates were among people aged under 35.

Worldwide, alcohol causes an estimated 2.5m deaths every year; a ratio of four in 100 deaths worldwide, *BMJ* 2011; 342: d1032 reported on 14 February.

Alcohol has a significant causal role in 60 different kinds of diseases and contributes to about 200 other diseases. The **World Health Organization's (WHO's)** report, *Global Status Report on Alcohol* says that 3.8% of all deaths in 2004 could be attributed to alcohol (6.2% of deaths of men and 1.1% of women).

The highest proportion of alcohol attributable mortality is in Russia and neighbouring nations, but rapidly emerging economies such as Brazil and China also have a high proportion of alcohol related deaths.

Political

Unemployment figures mixed

Unemployment in the three month period October to December 2010 fell from 2.498m to 2.492m, according to the latest *Labour market statistics*, released by the **ONS** on 16 February 2011.

During the same period, employment rose from 29.089m to 29.121m. 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, rose from 106.976 to 107.094. 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 went from 1.4566m in December to 1.4597m in January 2011. The latest unemployment rate remains at 7.9%, or 4.5% for JSA claimants.

Earnings in the three month period to end December fell from 2.1% to 1.8% on a year before.

On 15 February the ONS announced that in January the Retail Prices Index (RPI) was up from 4.8% to 5.1% compared to a year before, while the Government's preferred Consumer Prices Index (CPI) was up from 3.7% to 4.0%. This compared to an inflation target of 2.0%.

Comment: *This was an unexpectedly benign set of unemployment figures, although many job cuts in the pipeline (especially in the previously largely untouched public sector) have yet to show in the stats.*

Inflation continued its upward trend though, albeit not matched by earnings. Indeed earnings growth has slowed.

A key issue going forward will be interest rates, with the Official Bank Rate remaining at its all time low of 0.5% for at least another month. Many pundits expect an increase soon, although rates are likely to remain low.

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Hospital RTT waiting times fall

The median Referral to Treatment (RTT) wait for NHS hospital admission in England fell from 8.3 weeks in November 2010 to 7.9 weeks in December, according to a **Department of Health** Statistical Press Notice released on 17 February 2011.

For non-admitted patients the median wait fell from 4.2 weeks in November to 4.1 weeks in December.

The 95th percentile time wait for patients entering an RTT pathway fell from 21.0 weeks to 20.9 for admitted patients and from 15.7 weeks to 15.3 weeks for non-admitted patients.

North-south mortality divide up

Researchers from the **University of Manchester** and **Manchester City Council** have compared deaths rates between the north and the south of England over four decades and found that since 1965, there has been a 20% higher chance of dying early (under age 75) in the north of England than in the south the *BMJ* has reported.

This north-south divide decreased significantly from the early 80s to the late 90s, but this was followed by a steep rise from 2000 to 2008, despite Government targets for reducing geographical health inequalities.

The mortality trend was most significant among the 20-34 age group, which saw a sharp rise (22%) in northern excess deaths from 1996 to 2008. An accompanying editorial says the north-south health divide is now at its widest for 40 years and warns that 'the north is being decimated at the rate of a major city every decade'. The editorial also warns Government spending cuts will also hit hardest in the north and could make the health divide even wider.

See: *www.bmj.com/cgi/doi/10.1136/bmj.d508*.

BMA calls for action to tackle rising obesity

The **Liberal Democrats** have revealed figures that show that the number of people dying as a result of obesity has gone up by 40% since 2004. Commenting on the figures on 15 February, Dr Dean Marshall, Chairman of the **BMA's Scottish General Practitioners Committee** said that currently one third of children are overweight or obese.

In Scotland, over 40 people a day are diagnosed with diabetes, mostly Type 2 diabetes, which is closely linked to obesity. The increase in childhood obesity means there will be more cases of heart disease and osteoarthritis in the future. For the briefing paper *Priorities for Health: Tackling childhood obesity, see press.scotland@bma.org.uk*.

Elderly inpatient care is poor

A key finding of a report on the perioperative care of older people is that only 38% of elderly patients received care that was regarded as good by assessors from the **National Confidential Enquiry into Patient Outcome and Death**, *BMJ* 2011; 342: d373 reported on 3 February.

The report described an observational study of more than 800 patients over the age of 80 who died within 30 days of a variety of surgical procedures. Around 20% of NHS sites and 46% of private hospitals did not have on-site specialist medical support for the care of older people and most (87%) did not have a policy for appropriate medical pre-assessment.

Geriatricians are needed for complex referrals and to teach and reinforce good practice the enquiry said. The report makes recommendations on a range of issues including nutrition; assessment and management of frailty and comorbidity; medication review and pain management; assessment of capacity, and perioperative monitoring of blood pressure, body temperature and fluid balance.

Comment: *Many elderly people receive poor care. Could this be an opportunity for health insurers to offer guarantees of better quality care perhaps in the form of more regular appraisal of facilities?*

Political briefs:

• This year's Budget will be on Wednesday 23 March, **HM Treasury** has announced.

• The threshold above which individuals have to pay for their own long-term care costs in England is to be frozen at £23,250 in 2011/12, the **Department of Health** confirmed in February.

• In the quarter ending 31 December 2010, there were 89.5m UDAs (units of dental activity) in England. This was an increase of 0.4m (0.5%) on the previous quarter, the DH announced on 9 February.

• An online survey conducted by the **Royal College of Nursing** shows only 7% of nurses believe their organisation has the right number of staff to deliver good quality of care to patients, it was announced in February. 80% said they did not have enough staff to deliver good quality care and 46% said their trust had vacancies that had been unfilled for more than six months.

• On 17 February, the **DWP** announced a review of the sickness absence system, jointly chaired by David Frost (DG of the Chambers of Commerce) and Dame Carol Black.

• A Government cancer awareness campaign, 'Be Clear on Cancer', was launched on 31 January for seven weeks. The campaign, which includes TV, radio and newspaper adverts is designed to make people aware of the signs of bowel cancer and encourage them to see their GP. More than 90% of people diagnosed with bowel cancer at an early stage survive for at least five years compared to only 6.6% of those diagnosed at a late stage.

• Higher smoking rates between the 1940s and 1960s in the US, coupled with rising obesity rates are the primary reasons why US citizens older than 50 do not live as long as citizens of other industrialised nations, *BMJ* 2011; 342: d574 reported on 27 January.

• Following industrial action by nursing unions, the government of New South Wales in Australia has offered to impose an equivalent nurse to patient ratio of 1:4 in most hospitals, *Nursing Times* reported on 8 February.

• A German draft bill suggests that patients who have to share a hospital room with more than two other patients should be offered a discount, *BMJ* 2011; 342: d1044 reported on 15 February.

• On 22 February the **TUC** reported that there were over 50,000 planned or potential job cuts across the

Majority are still fit for work

The **Department for Work and Pensions (DWP)** announced on 25 January that the majority of people applying for Employment and Support Allowance (ESA) have either been assessed as fit for work or have withdrawn their claim before completing a medical assessment.

For new ESA claimants from October 2008 to May 2010 the breakdown is:

- Support Group (those who cannot work now or in the foreseeable future and who need unconditional support) – 6%.
- Work Related Activity Group (for those who cannot work now but with the right help could work in the foreseeable future) – 16%.
- Fit For Work – 39%.
- Claim closed before assessment complete or assessment still in progress – 39%.

For the full statistics see www.dwp.gov.uk.

But, is the current method of assessment fit for purpose? A separate *BMJ* feature looked at the assessment role undertaken by healthcare professionals recruited by the firm that provides the DWP's medical reports, **Atos Healthcare** in Glasgow.

The **General Medical Council** says that doctors should adhere to the same professional conduct as they would in any other role but the *BMJ* article says there is evidence that GP advice that patients were not fit to work was disregarded.

In the DWP role, doctors are dealing with claimants rather than patients it says. Although that may be good news for the taxpayer as the percentage of claimants deemed fit for work has risen from 37% under the previous Incapacity Benefits system to 66% under the present system, there is an internet forum that suggests widespread dissatisfaction from people who have been assessed and there is an unease among healthcare professionals as to the ethics and fairness of the system. See: *BMJ* 2011; 342: d599.

Comment: *It is not surprising that GPs' views have not been accepted by the DWP's doctors. It is still common for GPs to look sympathetically at patients who have no job and to agree that they should be paid ESA. Also, some GPs may believe that a patient should not return to work, when a more specialist doctor might recommend the opposite.*

PFI contracts should be re-evaluated

Public health physician, Professor Allyson Pollock and colleagues have questioned the affordability of private finance initiative (PFI) contracts, suggesting they should be re-opened and evaluated.

Annual debt repayments of 1.49 to 2.4 times higher than the amount that would have been charged to the Government if it had borrowed the money itself, translate into a policy of one hospital for the price of two. The high cost of PFI debt charges (£42.79bn), NHS funding cuts and expected efficiency savings of £15-20bn by 2013-14, are leading to redundancies, service closures, reductions in access and quality of care for patients, according to the authors of the *BMJ* article.

Ministers launch independent review of long term sickness

On 17 February the Government announced an independent review of the sickness absence system in Great Britain.

Chaired by David Frost, director general of the **British Chambers of Commerce** and Dame Carol Black, National Director for Health and Work, the review 'will explore radical new ways on how the current system can be changed to help more people stay in work and reduce costs'.

At present, working age ill health costs the economy £100bn a year. Employers largely cover short term costs (through sick pay) with taxpayers picking up the tab for longer term absence Over 300,000 people leave work to claim sickness-related benefits each year.

The Cancer Drug Fund is not a fair allocation of NHS resources

In a letter to the *BMJ* (*BMJ* 2011; 342: d621, 1 February), lawyer Sarah Thornton claimed the proposed Cancer Drug Fund is an unfair allocation of NHS funds and is not extra funding, but money that should be equally distributed across the health service to those in equal need.

She added that cancer patients are no more important than other group of patients and the move will allow the Government to provide piecemeal funding in other areas of the NHS in the future.

Rise in number of healthcare assistants predicted

Skills for Health, the health sector skills council established in 2002, forecasts that there will be a major expansion in assistant practitioner roles and numbers over the next decade as the Government seeks to make economies in the NHS, *Nursing Times* reported on 8 February.

Howard Catton, director of policy development at the **Royal College of Nursing** warned that in the long run such measures to produce savings "could have a detrimental effect on the standard of patient care".

Comment: *This is an important finding, as it suggests some dumbing down of roles in the NHS is possible in future.*

Wilful neglect should be criminal

Ethicists writing in the *Journal of Medical Ethics* have suggested that the wilful neglect of a patient should become a criminal offence for doctors and nurses in the UK, as it is in France. This would boost accountability and act as a deterrent they argue.

At present, healthcare professionals only face prosecution if a serious error results in the death of a patient yet, a healthcare professional who persistently neglects a patient with no justification or excuse, need not fear criminal law. The question has been raised subsequent to the basic care and hygiene failures at the **Mid Staffordshire NHS Foundation Trust** which are thought to have contributed to the deaths of up to 1,200 patients. See: *http://press.psprings.co.uk/jme/January/jme38737.pdf.*

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AMII exposes PMI underwriting myths

Two recent press releases from PMI trade body AMII seek to expose the myth that medical insurance will not be available unless you are in perfect health. But could that apparently benign approach be set to change in future?

Reference to the medical pages in *e-PR*, or indeed to virtually any publication covering medical issues, frequently illustrates the adverse health effects related to our lifestyle choices—chief among which is now obesity.

And, if you take out any term, critical illness or income protection policy you are first likely to be asked a huge number of questions about your health (some life application forms run to over 30 A4 pages) and lifestyle choices and may well then find that unless your BMI (body mass index) meets prescribed limits, that cover is going to cost you more or, in extreme cases, you may not be offered cover at all.

Yet, private medical insurance (PMI) appears to be bucking that trend. A recent press release (10 February) from **AMII** (the **Association of Medical Insurance Intermediaries**) quotes executive committee member and treasurer Debbie Kleiner-Gaines as saying: "Unlike other forms of insurance, such as life cover, critical illness and income protection, private medical insurers generally do not penalise overweight people by charging higher premiums. If someone obese has not yet had any cause to visit their GP, they could get medical insurance with no personal exclusions. This is because currently applications for private medical insurance are assessed on an individual's personal medical conditions, and not on lifestyle factors such as weight, smoking and alcohol consumption."

So why is PMI so different? First, the PMI market is dominated by group (corporates and SMEs) business rather than individuals. Second, PMI is (usually) an annually renewable contract so, in theory, an insurer could refuse to offer cover on renewal—although that is rare and doing so is likely to damage an insurer's reputation very quickly.

There is another factor too. Many PMI policies cover not just one person, but a whole family. Take the same approach to underwriting as a life insurers does, and a PMI underwriter could find themselves having to wade through reams of answers from four or more people per application, some of whom would be young children (raising the issue of from what age can they reasonably be expected to answer such questions, and what happens if they non-disclose).

Tight margins and the desire to issue terms quickly (how many life insurers still remember that maxim…) also go against the idea of over-underwriting.

Experience rules the day for groups

In the group market, especially for corporate schemes, underwriting decisions are more pricing decisions, and a key factor there is the group's claims experience, rather than the health or claims record of any individual.

PMI claims are also not directly related to health. An overweight person may eventually suffer a heart attack or a chronic condition such as diabetes, but both are likely to be met by the NHS rather than through a PMI policy.

There is an alternative approach too. When it came into the market in 2004, **PruHealth** was unusual in that its marketing activity, and especially its Vitality programme, actively targeted people looking to improve or maintain their health and fitness, in the belief that such people exhibit lower claims experience. Not every PMI insurer subscribes to that theory (how many would insure a professional sportsperson for example) but PruHealth seems happy to continue with the basic philosophy.

If a health issue is discovered at underwriting stage that might affect claims experience, the traditional approach is to apply an exclusion for that or any related condition. Such exclusions may not be permanent—the customer can ask for the decision to be reviewed at any time and most insurers would look at such requests (although medical evidence may be at the customer's expense).

Increasingly, some insurers will now consider using personal underwriting to impose a rating, in the form of an increase to the normal premium, as an alternative to an exclusion—but not in all cases.

Other insurers offer an alternative approach by applying a rolling moratorium instead (some insurers apply a fixed two year moratorium, but a rolling moratorium is more common).

A moratorium may not be the best answer

But a moratorium is also not a perfect solution. Debbie Kleiner-Gaines again: "Moratorium underwriting is a quicker application process and a common form of underwriting used by UK private medical insurers. A policy taken out with moratorium underwriting will exclude any medical conditions for which there have been symptoms, treatment, advice or medication in the five years preceding the beginning of the insurance. After two continuous policy years without treatment, medication or advice, including check-ups, for the condition, it will then be covered under the policy, subject to the standard policy terms and conditions. There are some medical conditions and treatments that will always be excluded under a private medical insurance policy, as part of the general exclusions of the plan."

That is a good point. Someone with well controlled high blood pressure, for example, can often get cover under a fully underwritten scheme, whereas their regular annual check-up would preclude them from ever being covered for related conditions under a moratorium plan.

The post-NHS Bill opportunity

PMI underwriting is taking on a greater significance partly because the Government's new *Health and Social Care Bill* (see *e-PR* 130, Page 13) could lead to a resurgence of interest in PMI if concerns increase over any adverse effects on the NHS going forward. Even if the NHS remains just as effective overall as it is today (or even improves), there are bound to be winners and losers. The mere fact that the 367 page Bill (three times the size of the 1948 Act which set up the NHS) is drawing people's attention to the NHS's shortcomings means that PMI providers have a unique opportunity to look to attract more customers.

That is especially important as the personal PMI market has shrunk since the 1980s—partly because premiums continue to rise faster than inflation—while the company paid market also saw a shrinkage in subscriber numbers in 2009 (down 5%), due to the economic slowdown.

So, will PMI providers change their underwriting model to more accurately assess the risks they take on?

In practice, that seems unlikely, at least in the short term. One radical solution would be to link underwriting to a health screen, so as to provide more information to both provider and customer alike. While this would clearly give underwriters more information, it is likely to be unattractive to many customers—not least because any health problem discovered at outset could result in an exclusion or a rating being applied.

Seeking medical information from a GP or through a medical or paramedical would add significant costs and also impose a huge training strain on providers, whose underwriters have different skills to life underwriters.

Adopting some form of tele-underwriting or tele-interviewing could be more cost-effective, but again this would increase costs.

However, we would expect to see some changes. It is surprising that most PMI insurers do not take account of smoking status, while adding a few more health and lifestyle questions could give underwriters valuable information.

Some insurers might seek to actively target very low risks—as life insurers have done in recent years, effectively now quoting preferred life rates as their standard—on the basis that cutting claims costs can enable an insurer to offer much more competitive premium rates. However, the correlation between health and claims on PMI is not as clear cut as most actuaries would be comfortable with. PMI is also not so price competitive as say term cover, partly because the benefits mix is much more complex.

Overall, PMI underwriting may, to a life underwriter, look to be overly simplistic, but there are good reasons for that. Until that changes, the PMI underwriting model looks likely to continue broadly along the same lines. Revolution looks unlikely; evolution more likely.

People news

• **Baigrie Davies LifeSearch**. David Child has been appointed non-executive chairman.

• **Consumer Protection and Markets Authority** (**CPMA**). Martin Wheatley is chief executive designate for the new body, which takes over from the FSA from the end of 2012. From September 2011 he will become MD of the FSA's consumer and markets business. He is currently CEO of the **Securities and Futures Commission** in Hong Kong.

• **Friends Provident**. Colin Williams has been appointed director of corporate, with responsibility for its strategy on corporate benefits. He was previously distribution and marketing director.

• **LV=**. Iain Clark has joined as director of protection. He joins from **Legal & General**, where he was sales director for its IFA protection business.

• **National Dental Plan**. Andrew Bower has been appointed managing director. He has been with parent **Capita** since 2003. One of his first tasks is to launch a dental plan for Capita's 36,000 employees in March.

• **RGA Re**. Mark Johnson has joined as business development manager. He was previously UK sales manager of **Best Doctors** and, prior to that, with **Swiss Re Life & Health**.

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. The ABI has recently launched a new SoBP for which product? A) CI, B) IP, or c) PMI?

2. Which leading protection IFA is launching a new comparison site for critical illness insurance?

3. Is the risk of breast cancer rising or falling?

4. Describe a typical rolling moratorium underwriting system as applied to a PMI policy.

5. Which State benefit is expected to replace the existing Disability Living Allowance?

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NHS workforce October 2010

As at October 2010, the NHS in England had a headcount of 1,216,235 (and a role count of 1,242,025—the difference being unfilled posts). As some posts are filled by more than one part-time person, the number of full time equivalent posts was 1,058,282. The headcount included:

• 630,863 professionally qualified clinical staff (51.9% of all staff).

• 37,869 hospital consultants (including directors of public health).

• 38,265 registrars.

• 14,052 other doctors in training.

• In addition, there were 2,910 locum doctors, of whom 1,946 were consultants.

• 353,678 qualified nursing, midwifery and health visiting staff, including 25,044 qualified midwives and 10,066 qualified health visitors.

• 74,554 qualified allied health professionals.

• 2,432 qualified therapeutic and 14,068 qualified diagnostic radiography staff.

• 32,044 qualified healthcare scientists.

• 18,553 qualified ambulance staff.

• 232,808 NHS infrastructure support staff, including 12,257 senior managers and 29,097 managers.

Source: *NHS Hospital Community Health Service (HCHS) monthly workforce statistics—October 2010, provisional, experimental statistics*. See *www.ic.nhs.uk*.

UK suicides 2000-09

Suicide rates in the UK for both males and females fell in the period 2000 to 2009:

• In 2009 there were 5,675 suicides in the UK, down from 5,706 in 2008.

• The male suicide rate is significantly higher than the female suicide rate—more than three times higher.

• The male suicide rate during 2000-09 was highest in 2000 at 19.9 per 1000,000. The rate declined to 16.8 in 2007 before rising in 2008 to 17.7, then falling again to 17.5 per 100,000 in 2009.

• The female suicide rate during 2000-09 was highest in 2000 at 6.2 per 1000,000. The rate declined to 5.0 in 2007 before rising in 2008 to 5.4, then falling again to 5.2 per 100,000 in 2009.

• The highest suicide rates are in men aged 15-44. In 2009 the rate was 18.0 per 100,000.

• By age group, the lowest male rate was 13.6 per 100,000 for males 75 and over in 2009. For men aged 45-74 it was 17.4 per 100,000.

• The highest rate for females in 2009 was in the 45-74 age group at 5.8 per 100,000.

• The lowest rate for females in 2009 was 4.7 per 100,000 females aged 75 and over and 4.9 per 100,000 for women aged 15-44.

Source: *Suicide rates in the United Kingdom, 2000-2009*, **ONS** Statistical Bulletin, 27 January 2011.

Comment: *Suicide rates have fallen significantly in recent years but still more than twice as many people die by suicide than in road traffic accidents.*

And, many more men than women take their own lives. Organisations such as the ***Samaritans*** *play an important role in helping people with suicidal thoughts, but could health and protection insurers do more to help too?*

Cancelled elective operations, quarter ended 31 Dec 2010

In the quarter ending 31 December 2010 in England:

• 16,785 elective hospital operations were cancelled at the last minute for no clinical reason (this was 1.0% of all elective activity).

• This was up from 15,675 cancelled operations in the same period of 2009.

• Of those cancelled operations, 521 (3.1%) were not subsequently treated within 28 days of a cancellation.

Source: *Statistical press notice: NHS cancelled operations—quarter ending 31 December 2010*, **DH**, 11 February.

Mixed sex accommodation

Since January, the **Department of Health** is now publishing information on the number of mixed-sex accommodation (MSA) breaches in English NHS hospitals.

Latest information (for January 2011) shows:

• 8,160 breaches of MSA guidance in the month.

• Only half (72) of the 144 Acute Trusts submitting data reported zero sleeping breaches.

Source: *Statistical press notice: Mixed-sex accommodation breach data—January 2011*, **DH**, 17 February.

Comment: *Mixed-sex wards can be very distressing for some patients and this initiative should see breaches fall quickly, even if complete privacy is still rare in the NHS.*

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