

e-Protection Review

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

Fall in group IP premiums hides better 2010 as PMI rises 4.9% too

The long term group risk market enjoyed a generally stronger 2010, although overall in-force premiums fell on the back of a fall in group income protection (GIP) premiums, according to **Swiss Re's Group Watch 2011** report, published on 18 April. And, figures from the **ABI (Association of British Insurers)** show that premiums for all PMI (private medical insurance) grew by 4.9% last year, broadly in line with inflation, with again the corporate market growing although the personal market continued to shrink.

Overall, Swiss Re recorded in-force group risk premiums down by 1.5%, at £1,485,845,166. However, that masked an increase in group life premiums (up 2.3% to £918.3m) and group critical illness (GIC—up 3.9% to break through the £50m a year barrier for the first time). This compared to a rise of 6.6% in 2009 for GCI and a fall of 5.1% for group life.

Both those rises however were more than compensated for by a fall in GIP premiums. Following a 12.5% fall in 2009, they again fell in 2010—by 9.9%—to £517.3m.

The newer GCI market is enjoying record premium income, albeit it does so starting from a much lower base, and the post 2007 recession resulted in a slowdown in the progress it had previously been making. Both group life and GIP peaked in 2008, in premium terms, with group life now 2.8% below 2008's £945.2m peak and GIP down 20.3% on its 2008 peak of £648.9m.

Swiss Re attributes the figures to continued competitive pricing, driven by a lack of genuinely new to market business and pressure from clients for cost-cutting measures. It says competition for business among intermediaries and product providers was intense, with little expectation that rates would harden soon. Employers were also reviewing their advisers more frequently and in some cases were prepared to take on more work themselves if that could cut their costs overall.

One reason for GIPs' premium income fall is the trend away from 'to retirement' benefits towards limited payment terms. Although only three quarters (77.6%) of product providers could provide the data, 1 in 10 schemes they ran (10.1%) now has limited term benefits, up from 7.1% in 2009 and 6.7% in 2008.

This is one reason why, in terms of lives covered, the overall (Continued on Page 2).

Quotes of the month:

"We believe this decision signals the end of years of poor complaint handling and will trigger a dramatic improvement in the way customers are treated when complaining". FSA, 20 April, commenting on the High Court's rejection of the BBA's judicial review on PPI (see Page 5).

"Waiting times [in Northern Ireland] have gone from bad to abysmal." Dr Brian Patterson, at BMA Northern Ireland annual family doctors conference, 10 April.

"Introducing a group life assurance policy alongside auto-enrolment [NEST] would involve a relatively small additional cost compared with the pension contributions that employers will have to make." Katharine Moxham, GRiD, 11 April.



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Key statistics:

- NHS RTT median wait England February 2011: 9.0 weeks (See Page 13)
- e-Protection Review Long Term Protection Sales Index: 109.97 (Quarter 4, 2010, compared to base 100 in Quarter 1, 2000).
- e-Protection Review Employment Index: 107.469 (To end February, compared to January 2000, see Page 13).

(Continued from Page 1) picture is much more positive.

Swiss Re's report found that group lives assured were up 6.5% to 7.856m for group life, by 0.8% to 1.792m for GIP and by 10.5% to 0.306m for GCI. Overall, the number of group lives insured rose from 9.433m in 2009 to 9.954m in 2010—a 5.5% increase (although this will hide some overlap, as some employees will have more than one type of cover).

Sums insured were up too. In-force life cover (death benefits) rose by 7%, GIP by 1.6% and GCI by 7.6%.

Table 1 below shows how the death benefits market has developed since 2005:

Group life (death benefits)

Year	Premiums	Schemes	Lives
2005	£816.9m	42,929	7.318m
2006	£863.4m	42,641	7.258m
2007	£910.8m	41,622	7.417m
2008	£945.2m	42,366	7.674m
2009	£897.3m	42,244	7.379m
2010	£918.3m	48,071	7.856m

In addition, £55.0m of in-force premiums was written through flexible benefits schemes—up 7.6% on 2009. In-force sums assured for lump sum death benefits were up 9.2% to £678,189,147,376. In-force pensions benefits were down 0.4% to

£6,061,505,493 per annum. Using a factor of 30 to convert that to a lump sum equivalent gives total death benefits at the end of 2010 of £860bn—up 7% from 2009's £804bn.

It is interesting to note that the number of in-force death benefits schemes rose in 2010 by 13.8% to over 48,000 schemes.

Of the 44 respondents in the group death benefits market, Swiss Re found that 28 expected the group life market to increase in size in 2011 and 2012.

Group long term disability (income protection)

Year	Premiums	Schemes	Lives
2005	£587.4m	19,505	1.684m
2006	£612.1m	19,065	1.731m
2007	£640.9m	18,859	1.724m
2008	£648.9m	18,619	1.767m
2009	£568.0m	17,796	1.777m
2010	£517.3	17,576	1.792m

The above table shows the GIP market since 2005. It shows that, while the number of schemes has gradually fallen since 2005, as has premium income, the number of lives insured

has actually risen. In addition, £36.9m of in-force premiums was written through flexible benefits schemes—down 3.1% on 2008. In force annual benefits were up 1.4% on 2009 to a total of £48.371bn.

The GCI market has seen big percentage increases in recent years, although it remains a much smaller market than the other two group risk products:

Group critical illness cover

Year	Premiums	Schemes	Lives
2005	£28.2m	1,816	0.269m
2006	£34.8m	1,884	0.230m
2007	£37.2m	1,972	0.264m
2008	£45.4m	2,077	0.289m
2009	£48.4m	2,073	0.277m
2010	£50.3m	2,209	0.306m

In addition, premiums through flex was up 12.2% to £23.6m. Flex made up 52.6% of all GCI in-force premiums, 7.1% of GIP and 6.0% of group death benefits.

Source (all): *Group Watch 2011*, Swiss Re, 18 April 2011.

Report co-author Ron Wheatcroft commented:

“The results reflect the very competitive marketplace with pressure on employer costs feeding through to greater competition for intermediaries and product providers. Despite a modest reduction, the number of schemes in force

held up well.” He added: “Survey respondents frequently pointed to the important role for group risk schemes in the move away from State provision to greater self-responsibility.”

Both comments are conclusions we would agree with. Our discussions with intermediaries and product producers have indicated that the marketplace is now very competitive and that many more quotes are being produced. Employers want to ensure that they are getting best value, are looking more at alternatives and that includes their advisers.

The dearth of ‘new’ new business or virgin schemes also means that many inter-

mediaries are fighting to take over existing schemes from an established adviser. That is creating some disquiet as not every adviser is operating as ethically as they should—at least so it appears if you speak to an adviser or insurer that has just lost a piece of business.

It is also one reason why the **AMII/BIBA (Association of Medical Insurance Intermediaries/ British Insurance Brokers Association)** PMI group has introduced new industry standard forms to make it clear whether a broker is being asked just to provide a quote or to take on servicing rights too (which has commission implications for old and new broker).

It is interesting to compare and contrast the group risk market with the PMI market. This market is monitored

Protection Review conference—themes announced

Places are filling fast for this year's *Protection Review Conference*, which is being held at The Landmark, Marylebone, London, on Thursday 23 June.

The conference is spilt into four main themes following an opening address from **NMG's** Jonathan Gunby, which sets the background. Each section is led by a leading speaker, followed by a panel Q and A, so ensuring every delegate gets the maximum possible value from the day:

- Session 1: *Improving the messages. What practical lessons have we learned from advertising, communications and social media?* Louise Colley explains **Aviva's** highly successful TV protection ad.

- Session 2: *The changing role of the employer in providing protection.* Led by **Canada Life's** Paul Avis and **GRiD's** Katharine Moxham.

- Session 3: *Delivering results—why distribution and technology will be key going forward.* Led by leading analyst Ned Cazalet.

- Session 4: *Politics and protection.* Guest speaker: TBC.

The conference's closing key note address, on *The Health of the Nation*, is from Dr Bill Gunnyeon, Chief Medical Officer at the **Department for Work and Pensions**. Book and pay by end of May to qualify for the Early Bird rate and pay just £450+VAT to attend. Over 100 delegates have already registered. See www.protectionreview.co.uk for more.

by both the ABI and by **Laing & Buisson** and the first data on last year has now been produced by the ABI.

The ABI's data shows that gross earned premiums across the PMI market grew by 4.9% in 2010 to £3.614bn but, subscribers fell 1.1% to 3.327m and the number of people covered by PMI fell by 1.6% to 5.841m. In addition, some 1.137m people were covered by healthcare trusts (some 635,000 subscribers). The number of people covered rose by 3.9% and subscribers rose by 3.3%.

The tables below show how the PMI and healthcare trust markets have changed since 2002:

Table 1. UK healthcare trusts 2002-2010 000s

Year	Subscribers	People covered
2002	404	704
2003	444	786
2004	510	910
2005	538	960
2006	585	1,021
2007	623	1,136
2008	622	1,111
2009	615	1,094
2010	635	1,137

One reason for the growth of healthcare trusts is that employers have full flexibility to include the benefits they wish in the scheme, while contributions do not attract Insurance Premium Tax (IPT). As IPT went up from 5% to 6% in January 2011, it is likely that healthcare trusts will continue to grow in 2011 at the expense of group PMI.

Table 2. UK PMI 2002-2010. No of subscribers 000s

Year	Corporate	Personal	Total
2002	2,282	1,124	3,406
2003	2,264	1,091	3,355
2004	2,223	1,052	3,274
2005	2,254	1,012	3,266
2006	2,345	1,030	3,375
2007	2,377	1,024	3,401
2008	2,522	1,021	3,543
2009	2,395	970	3,365
2010	2,368	958	3,327

Table 3. UK PMI 2002-2010. People covered 000s

Year	Corporate	Personal	Total
2002	4,304	1,887	6,191
2003	4,207	1,826	6,033
2004	4,084	1,736	5,820
2005	4,125	1,695	5,820
2006	4,188	1,691	5,879
2007	4,341	1,663	6,004
2008	4,571	1,653	6,224
2009	4,384	1,554	5,938
2010	4,305	1,536	5,841

It is clear from Tables 2 and 3 that the personal market continues to decline and has done so each year. This creates two problems—first, the average age of customers is likely to be increasing. Second, people who are claiming are likely to keep their policies going, while those who have never or only rarely claimed are seeing significant premium increases each year (PMI inflation plus because they are one year older and risk and claims experience

and so premiums rise with age), so may be more likely to lapse cover. One criticism of the sector is that it has not been successful in attracting large numbers of younger PMI customers. Unless that trend can be reversed, the personal PMI sector looks set to continue to decline.

Table 4. UK PMI 2002-2010. Gross earned premiums

Year	Corporate £m	Personal £m	Total £m
2002	1,341	1,369	2,710
2003	1,394	1,422	2,815
2004	1,433	1,422	2,855
2005	1,493	1,449	2,942
2006	1,561	1,509	3,071
2007	1,696	1,545	3,241
2008	1,831	1,637	3,468
2009	1,838	1,606	3,444
2010	1,982	1,632	3,614

Table 5. UK PMI 2002-2010. Underwriting results

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

Source (all PMI stats): ABI, 12 April 2011

Tables 4 and 5 show total gross earned premiums by type and underwriting results respectively. From tables 2 and 4 we can deduce that average PMI premiums per subscriber (in effect, per individual policy) in 2010 were:

- Corporate: £837
- Personal: £1,704

The significantly higher (more than double) personal premium reflecting both an older average age (many people buy a personal PMI plan when they retire, having previously had PMI cover as an employee) plus the greater buying power and reduced costs of corporate schemes. The type and extent of cover will also vary.

As with the group risk market, the PMI sector also has an important role to play with regard to State reforms. PMI can take some of the demand pressure off the NHS, while also giving a UK benchmark against which the NHS can measure itself.

However, the considerable cost of PMI and the fact that premiums for each insured person usually rise faster than general inflation is pricing out at least some potential customers. Comparisons can be made with long term protection products (the average annualised premium for an individual IP policy was around £430 by comparison, using ABI data), although personal PMI often covers more than one person and averages at 1.6 lives per subscriber, making a direct comparison harder.

Overall, 2010 was a tough year for group risks and for company paid PMI but turned out rather better than many had feared and both markets look reasonably well placed to build on that going forward.

More parents helping older children

One in four (24%) parents with adult children has given or loaned money to them, according to **Scottish Widows' Savings and Investment Report 2011**.

Where they have done so, the mean sum was £16,000. Nearly half (47%) expected to do so again in future and, on average, expected to lend or give their children £20,000. Two thirds (68%) had dipped into savings or investments to fund the payments.

Comment: *Some economists suggest that today's young adult children could be the first in generations to expect to be financially worse off than their parents.*

For today's parents with older children, the 'Bank of mum and dad' phenomenon gives rise to a need for life cover to ensure that such payments can still be made if mum or dad is no longer alive, or to help create or supplement mum and dad's existing estate (not every parent can afford to help their children when they are alive but life cover enables them to leave them a legacy).

The trend also highlights an opportunity for parents to fund health insurance (PMI and/or HCP) for their adult but still financially dependent children—if junior needs hospital treatment the bank of mum and dad may increasingly be asked to help financially anyway. As PMI cover is often significantly cheaper for young adults than for their parents, this could be a valuable gift to give. Yet, few intermediaries or providers are currently focusing on this market.

Business financial strength up

The latest *Business Insolvency Index*, for March, from **Experian**, the global information services company, has revealed that British businesses finished the last fiscal year stronger than they started it.

The average financial strength score, an indication of how likely a firm is to fail in the next 12 months, improved from 80.99 going into April 2010 to 81.58 by the end of March 2011. During the last fiscal year, the average annual financial strength score was 81.14 – an improvement on FY09/10 when it was 80.83.

In March the monthly insolvency rate was 0.11% – the same as that recorded in March 2010. For the fiscal year as a whole, the insolvency rate fell to 1% from 1.20% for financial year 2009/10.

Exeter Family Friendly improves Health Cover for Me

Exeter Family Friendly has introduced a range of excess options to replace its previous co-payment approach on its Health Cover for Me PMI product.

The excess options are £100, £250, £500 and £1,000 per person per year. The change comes on top of the introduction of a range of underwriting options and price cuts of up to 12.5% in 2010.

Head of intermediary sales, Mike O'Brien said: "[Intermediaries] have told us they don't like the co-payment approach of premium control; their customers don't understand it and as a result they don't feel comfortable recommending it. As an insurer, it is our job to listen and to make the changes that make a difference."

Groupama helps brokers sell PA

Groupama Insurance has come up with five questions brokers can use to help sell PA (personal accident) cover to businesses. The five are:

1. You might have financial protection if you lost your machinery or computer network in a fire, but aren't the staff you rely on to operate them just as critical to your business?

2. Do employees travel together to work or on business trips? Could you deal with the sudden absence of a number of your key staff if there was an accident?

3. Are you heavily reliant on a number of key individuals because you have cut staff numbers? How would you manage if one of your key staff had an accident while on holiday overseas?

4. Are you contracted to make salary payments when an employee is absent due to an accident? Could you afford to take someone on to cover their absence?

5. Did you know PA cover can start from just £25 a month [occupational cover for 20 employees providing £20K death/disability cover and £200 per week temporary disability benefit on its PA plan] and can cover as many or as few employees as you choose with the same flexibility in the level of cover?

Comment: *Useful questions—but PA only covers accidents, even though sickness is more likely.*

Women fail to protect financially

The majority of women (53%) say that protection products are an added expense they cannot afford, according to research commissioned by **Bright Grey**.

Its *Women and Protection* report found that while women have increasing financial responsibility in the household, many are still failing to safeguard their financial security. 59% had no life insurance in place, and 84% had no critical illness cover.

Worryingly, 1 in 6 women (17%) said they did not envisage themselves or their family ever needing financial protection. And, 12% said they were saving money for an emergency instead of taking out a protection product.

One in nine (11%) said they would consider taking out a product if they knew more about the products available and what they covered them for.

Proposition director Roger Edwards said: "It is worrying to see that a large number of women have overlooked a key element of their financial planning, leaving them and their families financially exposed."

The research was carried out by **Optimum Research** online in January with 2,010 adults.

And, research by **Confused.com** has found that mums would rather change a dirty nappy than sort out life insurance cover. However, they preferred that to cleaning hair out of a plug hole, going to the dentist, doing two weeks of laundry or having a smear test.

The main excuses for having no protection insurance were not understanding it (30% of respondents), not having time to sort it out (30%) and believing it was an unnecessary cost (36%).

The survey also found that the number of mums without protection insurance ranged from 37% in East Anglia to 62% in London.

High Court rejects BBA appeal

On 20 April the **High Court** rejected the **British Bankers Association's (BBA's)** challenge to the **FSA (Financial Services Authority)** and **FOS (Financial Ombudsman Service)** approach to complaints about payment protection insurance (PPI). The judicial reviews was launched last October.

The BBA sought to challenge a FSA Policy Statement that included amendments to regulatory rules and guidance about how PPI complaints should be handled and the basis on which they should be decided, and an Open Letter identifying what the FSA had identified as common sales failings. The BBA further sought to challenge the manner in which the FOS determined complaints on PPI sales.

The BBA advanced three main challenge grounds:

- **Ground 1.** The lawfulness of the Policy Statement, on the basis that general statements of the conduct required of financial services providers (known as 'the Principles') gave rise to obligations owed by firms to customers that could lead to compensation being payable for their breach in circumstances where such Principles are not actionable in law.

- **Ground 2.** It was unlawful for the FSA to provide in its Policy Statement that a customer might be entitled to redress by reference to the Principles which conflicted with or augmented its own specific regulatory rules. And so the FOS was acting unlawfully in publishing and maintaining guidance on its website which stated that the Principles would be taken into account in its decisions as to whether compensation would be 'fair and reasonable'.

- **Ground 3.** This was advanced by an interested party (**Nemo Personal Finance Ltd**) and adopted by the BBA. The argument was that the Financial Services and Markets Act 2000 (FSMA) provided a specific statutory procedure in S.404 for dealing with concerns about widespread misselling of financial product. The Policy Statement was therefore unlawful as it did not comply with S.404.

The Hon Mr Justice Ouseley rejected Ground 1 and said that S.150 of the FSMA cannot render the Principles irrelevant to the FOS's duty and that the Principles can be relied on by the FSA and FOS. He also rejected Ground 2, saying the BBA's analysis was 'the wrong way round' as the Principles form the overarching framework for FSA regulation as an 'ever present substrata' to which the specific rules are added and do not supplant or contradict. He also accepted that the FSA and FOS had not changed their approach and commented the Policy Statement had made explicit that the FSA and FOS do not interpret or apply the specific rules as an exhaustive statement of the firms' obligations in the areas to which the specific rules operate.

On Ground 3 he ruled that S.404 did not exclude the FSA from taking the actions it did, although it could have used S.404 to achieve more or less the same end.

Given other concerns about the FOS (see below), it is interesting to report (line 77 of the judgement) Mr Justice Ouseley's comment: "Indeed, it is my view that it would be a breach of statutory duty for the Ombudsman to reach a view on a case without taking the Principles into account in deciding what would be fair and reasonable and what redress to afford. Even if no Principles had been produced by the FSA, the FOS would find it hard to fulfil its particular statutory duty without having regard to the sort of high level principles which find

expression in the Principles, whoever formulated them. They are of the essence of what is fair and reasonable, subject to the argument about their relationship to specific rules."

In response to the judgement, the BBA said that it was disappointed with the judgement and would now need to consider its next steps 'including whether it would be appropriate to apply for permission to appeal'. Until then, banks' processing of PPI complaints remains on hold.

It is estimated that the ruling could cost banks up to £4.5bn in compensation payments to customers.

To read the full judgement see: www.bailii.org/ew/cases/EWHC/Admin/2011/1999.html.

Comment: Sir Duncan Ouseley's judgement is an important one—although the BBA may yet appeal, given the cost of complying with it (some banks have a habit of delaying costly actions if they can...). His comments suggest that it is the principles of regulation that overarch any specific rules—a fact that all firms will need to take into account, not just those handling PPI complaints.

Trade bodies call for FOS curbs

Seven financial services trade bodies have jointly written to the Financial Secretary to the Treasury, Mark Hoban, calling for the powers of the FOS to be curbed, *Money Marketing* reported on 21 April.

The bodies are: **Association of British Insurers; British Bankers Association; Building Societies Association; Council of Mortgage Lenders; Association of Financial Mutuals**, and **UK Cards Association**.

The firms are concerned that current rules allow the FOS to go beyond its core function and take on roles that should be carried out by regulators, industry initiatives and market competition. Instead, they argue that the FOS's role should be clearly defined in statute to provide greater clarity that firms will not be hit by retrospective interpretations of the rules.

The seven make six proposals in their letter:

- The FOS's role and relationship with the Financial Conduct Authority to be clearly set out in statute to give firms confidence that if they comply with FCA regulations they will not face retrospective interpretations of the rules.

- For the FOS to be removed from the process of determining regulatory issues with wider implications to stop the ombudsman straying into regulatory functions.

- For consideration to be given to claim management companies (CMCs) being regulated by the FCA rather than the Ministry of Justice and to CMCs contributing to funding the ombudsman.

- For the FOS's right to prevent firms taking test cases to court when important or novel points of law are in evidence to be removed.

- For the FCA to undertake regular reviews of the FOS's operations, policies and procedures but not compromise the ombudsman's operational independence.

- That the FOS be required to consult with stakeholders before issuing policy notes or guidance.

Comment: Elements of the industry and the Ombudsman (in current and previous forms) have been at loggerheads since Ombudsmen first appeared. Firms want clarity; the FOS wants fairness. Somewhere in between is the right balance, but any change could be seen to be 'consumer bashing'.

News briefs:

- **Royal London** is to take over **Royal Liver**, subject to the approval of 75% of the latter's members at an AGM to be held in May.

- Half of hospital consultants have been challenged by PMI insurers over their fees and one in ten (11%) threatened with being 'derecognised' according to doctors' trade body the **BMA**. But it believes demand for PMI could increase as a result of NHS reforms.

- **NEST** (the National Employment Savings Trust) could have positive knock-on effects on the group risk market, according to research by group risk trade body **GRiD**. It surveyed 500 UK businesses and found 49% of firms with no current group risk benefits would consider introducing them once NEST is introduced. A similar outcome resulted when Australia went down the compulsory pension route some time ago.

- **Ageas Protect** and **Legal & General** have tied for top spot in the **F&TRC e-Excellence** research report on protection provider e-commerce systems. The F&TRC Protection Forum has also drafted a statement of good practice on consumer signature collection for online apps and is now looking at tele-underwriting and adviser remuneration processes and options.

- New guidance on the forthcoming Bribery Act, which is much more 'common sense' than some had feared has been published by the **Ministry of Justice**. For details see www.justice.gov.uk.

- **L&G** says it has cut GPR rates on income protection sales from 19% in 2008 to 9% in 2010 by using tele-underwriting, online underwriting and consequent higher medical limits.

- 51% of adults do not have a will, according to research for **Standard Life**. By age group, 60% of 35-44 years olds have no will, 38% of 45-54s, 32% of 55-64s and 22% of those aged 65+. Half (56%) of those without a will say they just haven't got round to doing it yet. Only 4% said it was too expensive. Of those with a will, 30% had not reviewed it within the past 3-10 years.

- **Cigna** recently celebrated 21 years of offering managed care PMI in the UK. It says for every £1 its clients spend on care management, they save an average of £3.17.

- 52% of employees would be tempted to switch jobs for a better benefits package, according to research for **Canada Life**.

- On 6 April the **FSA** proposed changing its definition of a Holloway income protection policy. It plans to have four criteria that must be met. The aim is for Holloway plans to avoid being affected by RDR but without creating a back door route to less regulated investment sales.

- One key to RDR reforms working will be for consumers to have access to simplified advice, according to Helen White, acting director of life and savings at the **ABI**. Its research found that consumers would be willing to pay up to £300 for financial advice—below the current average cost of £670. The ABI has also supported the Treasury's simplified products proposal.

- 61% of employers say their primary concern when an employee is on long-term sick leave is their health and wellbeing, although 23% were anxious about the pressure this absence put on other employees' workloads, according

to research for **Aviva**.

- On 5 April, **ABI** announced that insurers' Concordat and Moratorium on the use of predictive genetic test results has been extended to 2017. The only approved test remains that for Huntington's disease and only 3% of life applications exceed the agreement's £½m cover limit.

- Only 45% of the 15.2m Brits who have people dependent financially on them have any form of life cover, only 21% critical illness cover and only 14% income protection according to **Scottish Provident's** latest *Financial Safety Net* report published on 15 April. On average, people spend 39% of their income (average £26,510pa) on supporting their dependents it says.

- Only 56% of companies offering employee benefits use a broker, but 90% of those who do think it is money well spent, according to research by **Denplan**. Cost was cited as a reason not to by 30% of employers, with 21% not understanding the benefit of using a broker.

- **Exeter Family Friendly** reports that it paid over 95% of all its IP claims in 2010. Musculoskeletal injuries (excluding backs) made up 25.56% of its IP claims, followed by operations (13.73%) and fractures (12.57%).

- **IMG Europe** has launched a new redesigned website at www.imgeurope.co.uk.

- The cost of funerals has soared by 48% between 2007 and 2010, with many councils imposing cost increases significantly ahead of inflation, according to the **Dying Matter Coalition**.

- From 1 June, **Simplyhealth** is increasing premiums on its Simply Cash Plan products. Premiums for individuals are up by around 4.6% from our calculations but optical and dental maximum benefits are up too.

- **Friends Life** will use **Bupa Health Assurance's** online and back office platforms as it amalgamates its **Friends Provident, Axa UK Life** and Bupa brands under the new Friends Life brand.

- UK families are under-prepared for the worst case scenario, according to **Nationwide**, with 47% of parents having no life cover, and mums having less cover than dads. 76% have no critical illness cover (78% of mums) and 83% no income protection. 38% said they had no protection at all. Yet, 62% of parents have buildings insurance and 18% mobile phone insurance.

- **Legal & General** paid 93% of its income protection claims in 2010. Of those claims rejected, 2% were due to non-disclosure and 5% because the claim did not meet all the terms of the policy. The top three causes of claim were musculoskeletal, mental illness and cancer.

- **Scottish Provident** paid 90% of its CI claims in 2010, rejecting just 3% for non-disclosure.

- **L&G** has also reported that its research found that 50% of GPs see 'a few times a year' patients who have been dismissed from their job during an illness.

- Does the ECJ ruling on gender (see last month's e-PR) affect group plans or only individual? The test case was around the former, so group risks may not be affected. We'll let you know once we have a definitive answer.

- Corrections. **PruProtect's** low start option—Accelerator—is not available on its Education Cover plan (see review last month, Page 8). The option is however available on its whole life, income protection and serious illness cover plans.

National Friendly pulls out of PMI

National Friendly has withdrawn its Five Year Fixed Healthcare and Healthguard products for sale to new customers, *IFAOnline* reported on 5 April. Chief executive Richard Sear was quoted as saying: "With claims rising as a whole across the PMI market, we are no longer in a position where we can sustain this product at the existing levels of volume and value." The company's 50+ life product has also been withdrawn.

The moves effectively meant that the firm has withdrawn from the private medical insurance market, although it still markets its One Fund health cash plan and savings and investment plans.

National Friendly says it has a number of new products already under development, which will be launched over the coming months. It is not known whether these will take it back into the PMI market. The company had an innovative part insurance part savings account PMI concept but it is believed that claims exceeded its expectations and a few months ago it changed the basis of funding. One broker we spoke to criticised the firm for having offered high commission rates, which could have led to attracting some poor quality business too.

Westfield acquires PatientChoice

Westfield Health announced on 29 March that it is acquiring the business of **PatientChoice**, which administers, markets and sells health insurance products.

Since 2007, PatientChoice has administered Westfield Health's Surgery Choices product, providing an add-on module to its corporate paid health plans that covers policyholders for more than 60 surgical procedures normally classed by the NHS as non-urgent.

Westfield CEO Jill Davies said: "The acquisition of PatientChoice is an exciting development and a natural progression for Westfield Health... and further strengthens Westfield's commitment to delivering innovative and relevant health cover."

PatientChoice plans were underwritten by **Great Lakes Reinsurance**. It is understood Westfield will be taking over from 1 May.

Dilnot Commission publishes summary of LTC responses

The **Dilnot Commission (Commission on Funding of Care and Support)** published a *Summary of Responses to the Call for Evidence* in April. Over 250 responses were received (including from **Protection Review**—e-mail us if you would like a copy of our response).

The 24 page paper noted: "There was considerable support for a partnership funding model" but it added that "the safety net needed to continue" and "there was a strong call for people to be made aware of the need to plan for the future". It also said "More effective integration of health and social care services was felt to be essential".

The paper added: "It was felt that both local authorities and the **Financial Services Authority** could help to signpost people to financial advice".

On possible pre-funded insurance solutions respon-

dents cited anti-selection and the pricing of tail end risk as concerns on the supply side. "Given these supply side issues, the industry as a whole was not confident that it would be able to design pre-funded products which would be attractive to consumers." On the demand side, the big issues were people's lack of awareness, a lack of appropriate financial advice and a lack of demand because people expected their families to look after them.

The Commission is expected to publish its recommendations in July. See www.dilnotcommission.dh.gov.uk.

On 19 April, think tank **Strategic Society Centre** published *Delivering a National Care Fund*, in which it advocates a State-sponsored insurance scheme administered and funded by the financial services industry. Some 250,000 claims a year would be handled by the fund and the life industry would benefit by the number of annuities each year being written increasing by over 50%.

It proposes a £6,825 premium from retirees or £14 a month over a 40 year working life. Retirees who fail three or more activities of daily living would then receive an income of £150 a week for the rest of their life.

Analysts **Laing & Buisson** estimate that the average annual cost of a care home bed was £35,984 in 2010.

Benefits increase engagement

More than six out of seven employers (81%) agree that providing benefits increases how engaged employees feel at work, according to **Standard Life's Insights into Financial Responsibility** report, published in March.

Other findings included:

- 90% of employers believe benefits are important or very important to employees, compared to 64% of employees believing that.
- 87% of employers and 88% of employees believe that individuals are primarily responsible for their own financial security. 63% of employers disagreed or strongly disagreed that the Government is primarily responsible for individuals' financial responsibility. Both 22% of employers and employees believe that the employer is primarily responsible, but 59% of employers think they are responsible to some extent for employees' financial security.
- 66% of employees agreed that benefits increase motivation at work.
- 38% of employers expect their employees to spend more than ten years at their organisation. Just under 48% of employees expect to spend more than a decade with their employer.
- 56% of employers think it is more important now to provide support and security to their employees than it was five years ago.
- Only 40% of employers believe over half their employees take full advantage of the benefits available to them, although 30% had no idea of uptake. Only 25% of employees said they take full advantage of their benefits.
- 65% of employers think that employee communication has improved over the past five years, yet almost the same percentage (64%) of employees felt that nothing had changed or it had deteriorated.

The survey polled 250 employers and 1,000+ employees and was developed in conjunction with occupational psychologist Emily Hutchinson.

Pick of the month

Most of the products reviewed this month are back to basics or simple products.

AA has launched a guaranteed acceptance over 50s life plan, while Holloway Friendly offers a simple pure protection IP plan and WPA has updated its Providential plan, adding an NHS top-up prefix too.

Our top scoring plans are both IPMI products and, good as IMG Europe's new GlobalFusion plan is, our product of the month goes to Morgan Price International for its innovative solution to the problem of people cancelling cover because they cannot afford it.

AA 50 Plus Life Insurance

Automobile Association Insurance Services Ltd has launched a guaranteed acceptance whole of life plan for those 50 or over, underwritten by **Friends Provident Life Assurance**. The plan is available to UK residents aged 50-80 and premiums and acceptance are guaranteed (no medical questions or medicals). Premiums are payable until the life insured reaches age 90.

In the event of death in the first two years of the policy, the plan pays back 1.5 times the premiums paid only. After that, the full sum insured is payable on death. Minimum premium is £4.99 a month; maximum £49.99.

A male aged 60 paying £29.99 a month would get a sum insured of £6,209, a male aged 70 would get £3,419, and a male aged 80 would get £1,362. Premiums paid would exceed the sum insured payable after seventeen years three months, nine and a half years and four years nine months respectively.

As an incentive, customers get a £30 **Boots** voucher if they take out a policy (£40 if they are an AA member).

Plus points: *Low cost life cover with guaranteed acceptance. Premiums stop at age 90. The 150% return on death in the first two years can make this an attractive small savings account for those with a terminal illness—but perhaps not if they live significantly longer than that.*

Not so plus points: *As with all plans of this type, someone in good health may expect to live longer than the time by which premiums paid exceed the sum insured—if they then stop paying, the policy lapses without value. No trust option. Online quotes are all based on premiums that end in 99p.*

Contact: 0800 107 6641 or www.theaa.com/insurance.

Rating (max 5): Innovation: 2.5. Overall: 2.5.

Holloway Friendly Purely IP

Hollow Friendly (the UK's first Holloway society) has launched its Purely IP product as a simple long term income protection (IP) plan, with no investment element (unlike its Holloway style plans, which build up a cash value available at retirement).

The plan is available to UK residents aged 18-54 at outset and has a minimum term of ten years. Selected retirement age can be between ages 50 and 65. Key features of the plan include:

- Maximum benefit is the lower of £26,000 a year or 50% of income.
- Deferred periods of 4, 8, 13, 26 or 52 weeks.

- An own occupation disability definition is used for the first 104 weeks of claim. After that it changes to an own or reasonably suited definition.

- Escalation is linked to RPI (Retail Prices Index) to a maximum of 10% a year.

- Premiums are guaranteed but increase on 1 January each year in line with age. Premium rates do not change with occupation, gender or for smoking.

- Career break and terminal illness benefits (six months benefit, which must be claimed within one month of diagnosis. On payment of this benefit the plan terminates). Medical expenses benefit (this is a lump sum, paid at the company's discretion, that can be used towards the costs of a specified medical operation or treatment where that might lead to a shorter claim period).

- Exclusions are fairly standard.

- Commission is 140% initial for online applications (125% for paper) with 3% renewal commission and a commission clawback period of 36 months.

Plus points: *Simple low start pure protection cover. No ratings for gender, occupation or smoking.*

Not so plus points: *Premiums are not level, but increase each January. Relatively low maximum benefits. A claimant who claims the terminal illness benefit could be worse off if they do not die within six months—this looks to be asking them to play Russian roulette with their benefits...*

Contact: 01452 526238 or www.holloway.co.uk.

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

IMG Europe GlobalFusion International Medical Insurance

IMG Europe's latest international PMI (private medical insurance) plan is aimed at expatriate and eligible local individuals and families. Key features of the new plan include:

- Full UK FSA regulation.

- Four sub-plans to tailor cover—Silver, Gold, Gold Plus and Platinum.

- Optional cover can be added: Global Personal Accident Plan; Hospital Income Plan; Maternity; Terrorism, and Sports.

- Two cover areas: Area 2 (worldwide excluding USA; Canada; China; Hong Kong; Macau; Japan; Singapore and Taiwan) or Area 3 (worldwide).

- Family premium covers first two children aged between 14 days to age ten at no additional cost in year one and 50% discount in year two.

- Can be denominated in GB £s, Euros or US \$ and with monthly, quarterly or annual premiums.

- IMG Europe says premiums are significantly cheaper than the majority of the market.

- Single annual excess applies.

- Freedom to choose any healthcare provider but with access to two extensive provider networks.

- Medical concierge programme within the USA.

- Online customer portal that gives access to documents, claims status, obtaining pre-certification and details of over 17,000 healthcare providers worldwide.

- Easy to understand EU-style policy wording.

At extra cost, some pre-existing conditions can be covered if treatment free in the first two years of the pol-

-cy. There is an overall lifetime limit per insured person.

A male age 44 and a female 39 with children aged 5 and 8, with a £138 (\$250) annual excess would pay £1,276 a year for Area 2 Gold cover or £1,725 a year for Area 3 Gold cover. IMG Europe says the Gold level of cover is 'exceptionally competitive' and ideally suited to short-mid term expatriates. Under this version, cover is reduced after three years.

Plus points: *Comprehensive cover for short-mid term expats, offering a range of options. Competitively priced. Good online support and help.*

Not so plus points: *Lifetime and other benefit limits. Benefits under some versions reduced after three years. Some treatment has to be pre-certified. The number of options can make choosing the right level of cover quite complex. Cover ceases at age 75.*

Contact: 01444 46 55 50 or www.imgeurope.co.uk.

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

Morgan Price International Healthcare EssentialCare

Morgan Price International Healthcare has launched its EssentialCare expatriate health insurance plan as a simple and cost effective plan, especially for people who would otherwise opt out of having cover on cost grounds.

The plan offers a choice of three options, with all options having a single worldwide premium rate and cover:

- Level 1. An annually underwritten product with no automatic renewal or continuation of cover, with consequent lower pricing (the insurer can refuse to renew if say claims have been made, unlike under a conventional PMI plan where renewal is virtually automatic). A 30 year old could have Level 1 worldwide cover for an annual premium of £552. For a 50 year old the same cover would cost £1,212 for a year. Benefits are limited to £50,000 per person covered lifetime and per year.

- Levels 2 and 3 are more conventional products that are not re-underwritten at renewal, but both have lifetime benefit limits. Benefits are limited to £150,000 (Level 2) or £300,000 (Level 3) per person.

Residents of China, Hong Kong, Japan, USA and Canada have compulsory annual in-patient excesses, with two age points. In addition to the basic cover, customers can add on accidental death and dismemberment (including temporary total disability) cover; accidental death only cover, or evacuation and repatriation. Plans can be denominated in GB £s, Euros or US Dollars.

Most in-patient treatments are full refund, with most out-patient treatments individually limited. Emergency dental treatment is covered on Level 2 and 3 plans only, as is maternity and psychiatric (both the latter being subject to a 12 month initial waiting period).

Plus points: *Much lower cost than traditional IPMI, especially for Level 1 plans. A reasonable level of benefits, given the plan's positioning. Can be used to save a situation where otherwise a customer may choose not to have any IPMI cover at all when working abroad. For people looking to work no more than a year more outside the UK the plan could be ideal. A very innovative solution to the real problem of people cancelling cover when some good quality low cost cover would be much better than no cover at all.*

Not so plus points: *Intermediaries must take great care to ensure that customers understand the plan's limitations, and should explore other options before looking at this plan. Benefits are limited in a range of ways and Level 1 cover could mean being unable to get insurance in future if the customer has had to claim (depending on the type and number of claims).*

Contact: 01379 652794 or www.morgan-price.com.

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

WPA Providential

WPA has updated benefits on its Providential dental insurance policy, which has now gained an 'NHS top-up' prefix and is available both to individuals and to groups. For individuals, the plan offers two levels of cover:

- Level one (NHS only). Pays 100% of NHS treatment costs plus up to £500 for NHS or private dental emergencies, £10,000 for dental injuries or £10,000 for oral cancer treatment.

- Level two. This pays 75% of treatment costs, up to £250, plus up to £1,000 for NHS or private dental emergencies, £20,000 for dental injuries and £10,000 for oral cancer treatment.

There is an initial one month qualifying period for check-ups, hygienist and general treatment and three months for restorative treatments. Claims for dental injuries and oral cancer treatments must be made within 72 hours of the injury/diagnosis.

Both levels also pay £200 per day/night (max £2,000) for hospitalisation due to dental injuries or oral cancer, and both offer worldwide cover (for trips up to 35 days a year). The plan has a dental schedule setting out maxima for benefits e.g. the reimbursement limit for a single filling is £45 up to £95 for multiple fillings.

For ages 18-49 Level one cover costs £9.50 a month or £13.50 for Level two. In both cases, the first month's cover is free. A £1.50 surcharge applies if premiums are paid by credit card. Maximum age at entry is 64.

In the voluntary corporate sector, the plan is available to firms with 50 or more employees, from £8.55 per month per employee.

Plus points: *Relatively low cost, enabling choice of dentist and cover level. True insurance rather than a capitation plan (which can get more expensive if you need more treatment). Available to individuals or groups.*

Not so plus points: *Level two only pays a maximum of 75% of costs and limits are relatively low (except for dental emergencies and oral cancer treatment). Injury/cancer claims must be made within just three days.*

Contact: 0800 783 0 784 or www.wpa.org.uk.

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

Product design matters...

Reducing benefits after three years or taking away the traditional automatic renewal option are both extreme solutions to meet extreme needs. In both cases, they mean that the long term risk to the insurer is much reduced, and that can be passed on to customers in the form of lower premiums today. But, it does mean the customer taking on much of the long tail risk themselves—a potentially dangerous and expensive option—but worth it for some?

Medical briefs:

- A new tool to rule out dangerous heart disease in people with chest pains combines a clinical score, an electrocardiogram and a panel of three cardiac biomarkers measured at the bedside twice in two hours. Patients testing negative for all elements of the tool are at low risk and can be sent home. See: *BMJ* 2011; 342: d1979.

- Two studies on *bmj.com* on 20 April show emerging evidence that contraceptive pills containing a new type of progestogen hormone (drospirenone) carry up to a threefold increased risk of venous thromboembolism than pills containing an older progestogen (levonorgestrel). See: www.bmj.com/cgi/doi/10.1136/bmj.d1883.

- **University of Cambridge** researchers have found that closed loop insulin delivery, also known as an artificial pancreas, may improve overnight blood glucose control in adults with type 1 diabetes and reduce the risk of nocturnal hypoglycaemia which is a sudden drop in blood glucose levels at night. The number of people with type 1 diabetes is increasing at the rate of 3% per year, particularly in white northern European populations. See: www.bmj.com/cgi/doi/10.1136/bmj.d1855.

- Coronary artery bypass grafting (CABG) is a more invasive treatment but still better at relieving angina than the use of stents in percutaneous coronary intervention (PCI), but only just, *BMJ* 2011; 342: d1788 reported on 21 March. Those who had the less invasive PCI felt better faster, but scores were similar in both groups from six months onwards and CABG overtook PCI by 12 months on two of the many subscales examined. CABG still looked a bit better at relieving angina in the long run.

- Acute illness or trauma triggers overwhelming inflammatory response and one small trial (*JAMA* 2011; 305:1201-9) reports that patients given replacement hydrocortisone (a form of steroid) within 36 hours of multiple trauma were less likely to develop pneumonia in hospital than controls given a placebo, although six deaths occurred in the steroid group versus four in the placebo group. The authors have called for more trials.

- A trial from 40 countries has shown that giving the drug, tranexamic acid, reduced all cause mortality in patients who were bleeding or likely to bleed after major trauma. A new analysis of the data has also shown that the drug, if administered within an hour of major trauma, reduced deaths from bleeding by more than 30% compared with a placebo. See: *BMJ* 2011; 342: d1979.

- Care home operator **Southern Cross** has told landlords who own one third of the company's 752 homes

it will not pay the next quarter's rent, moving instead to monthly payments to give the company £10m of breathing space, the *Sunday Times* reported on 27 March. The troubled care home operator is expected to ask some landlords to take a 20% cut in rents or defer payments by up to two years and some may be offered shares instead of cash. The chain looks after 31,000 elderly people.

- A new infectious disease that has been active but undetected for some time has been discovered in China, *BMJ* 2011; 342: 1788 reported on 21 March. Around 170 cases of severe fever with thrombocytopenia syndrome (SFTS) have led to 21 deaths so far.

- Despite the focus on gun and knife crime, most urban trauma deaths arise from falls and traffic accidents. The **Royal London Hospital** research, reported in *Emergency Medicine Journal* (2011) 28: 305-309, shows of 4,243 trauma admissions between 2004 and 2008, falls and traffic accidents accounted for 79% of admissions but 87% of mortality. Stabbings and shootings accounted for 21% of admissions and 13% of mortality.

- London research reported in the *Archives of Internal Medicine* online reports that patients who stop smoking only a few weeks before surgery do not cut their risk of complications. The optimum period to quit before surgery is unknown. See: www.tinyurls.co.uk/V26787.

- The addition of information on working hours to a study that calculates people's risk of coronary heart disease improved the identification of people who later developed coronary heart disease (CHD) by 4.7%. Over a median follow-up of 12 years of 7,095 participants CHD was recorded in 192. Compared with those working 7-8 hours a day, those working more than 11 hours had a 1.67 (95% CI 1.10 to 2.55) increased risk of heart disease. See: *Annals of Internal Medicine* 2011; 154: 457-63.

- Spanish researchers found that 37% of 8,295 patients believed to have resistant hypertension were found not to have it after having their ambulatory blood pressure monitored for 24 hours and may actually be suffering from 'white coat' hypertension. See: www.tinyurls.co.uk/Q27384.

- US research in *Arthritis Care & Research* (2011) 63: 630-632, claims singing can reduce postoperative hypertension. A 76 year old woman failed to respond to aggressive drug treatment to lower her blood pressure before total knee replacement surgery, but it dropped dramatically from 240/120mmHg to 180/90mmHg after she sang some religious songs. Should health insurers provide song sheets for customers having operations? If so, what songs would you suggest? E-mail info@anycouchman.com and tell us!

What is SOLLA?

The **Society of Later Life Advisers (SOLLA)** was founded in 2008 as a not for profit organisation, to meet the need of consumers, advisers and those who provide financial products and services to the later life market. Its aim is to ensure that consumers are better informed about the financial issues of later life and can find an accredited adviser. Its main public role is to help people find a suitably qualified and experienced financial adviser

Founder members are **SVAR Fair**, **CAM (Care Asset Management)**, **Partnership**, **Care Aware** and **AXA Lifetime Care**. Joint chairmen are Tish Hannifan and Jane Finnerty. Lord Lipsey is Honorary President.

SOLLA operates a Later Life Adviser Accreditation (LLAA) Scheme, which has been developed by the standard-setting body the **Financial Skills Partnership (FSP)** in collaboration with the specialist financial services consultancy SVARFair. Advisers need to hold appropriate financial planning, equity release and long term care qualification, meet LLAA knowledge standards, be regarded as competent under their employer's T&C scheme, meet CPD requirements and have a supportive working environment. For more see www.societyoflaterlifeadvisers.co.uk.

Are preventative drugs good value?

Three recent studies have raised questions around statins. A Finnish paper challenges the view that preventative heart drugs such as statins or bisphosphonates (to prevent fractures) have the effectiveness in everyday situations compared to that seen in clinical trials. Using 2003 data on 7,411 hip fractures, it estimates giving bisphosphonates to all 1.86m Finnish citizens over 50 would only guarantee prevention of 343 fractures and would not be cost effective. See: www.bmj.com/cgi/doi/10.1136/bmj.d2175.

And, a small health survey by UK health supplement **Works with Water Nutraceuticals** found 47% of 105 people surveyed in March 2011 were worried about the health risks associated with taking statins, with 13% not worried and 40% not aware of the possible side effects, it said on 6 April.

Finally, a ten year Dutch study on low dose statin treatment daily versus no treatment on a hypothetical population of men and women aged 45 to 75 without a history of vascular disease or risk of stroke or heart attack has concluded that in daily practice, statin treatment for primary prevention of vascular seemed not to be cost effective despite the low cost of the drug. Adherence to statin treatment needed to be improved to enhance the cost effectiveness of the use of statins for primary prevention. See: *BMJ* 2011; 342: d1672.

Bowel cancer surgery death rates

Bowel cancer surgery death rates are higher than previously thought and vary significantly between hospital trusts, *BMJ* 2011; 342: d2379 reported on 12 April. The discrepancy between the rate of death within 30 days of surgery of 6.7% calculated from more than 160,000 operations carried out in England between 1998 and 2006 compares to the 4.7% figure from last year's UK national bowel cancer audit programme, with the new figure being 'notably higher'. The authors point out this may be because submission to the programme is voluntary. The picture is improving, however, with a mortality rate within 30 days of surgery of 6.8% in 1998 but 5.8% in 2006. Thirty day death rates from population studies in Scandinavia, Canada and the US range from 2.7% to 5.7%.

BMI predicts later heart disease

The risk of type 2 diabetes in young adulthood can be explained by body mass index (BMI) close to the diagnosis, but BMI in adolescence and young adulthood independently predicts coronary heart disease. A study of 37,674 healthy young men (mean age of 17 years at baseline) followed for 17 years revealed 1,173 new cases of type 2 diabetes and 327 cases of coronary heart disease. Increased BMI in adolescence predicted both diseases after adjustment for other factors but, when the models were further adjusted for BMI in adulthood, BMI in adolescence stopped predicting diabetes but was still predictive of heart disease.

The process lends support to the hypothesis that heart disease processes happen more gradually than those leading to diabetes. Of concern is the observation of increased cardiovascular risk with BMI values in adolescence that are currently considered normal.

WHO warns on noise pollution

A **World Health Organization** study has found environmental noise leads to a disease burden second only to air pollution *BMJ* 2011; 342: d2114 reported. Such noise accounts for over 1m healthy years of life lost annually to ill health, disability or early death in Western Europe.

One in three people experiences annoyance during the daytime and one in five has disturbed sleep because of noise from roads, railways and airports. This increases the risk of cardiovascular disease and high blood pressure. Noise levels above 55 decibels have detrimental effects on health. 1.8% of heart attacks in high income European countries are attributed to traffic noise levels over 60 decibels. A European commission proposed update of the *Vehicle Noise Directive* could set strict new noise standards.

In terms of disability-adjusted life years (DALYs), the report estimates that DALYs lost to environmental noise in western Europe are:

- 61,000 years for ischaemic heart disease.
- 45,000 years for cognitive impairment of children.
- 903,000 years for sleep disturbance.
- 22,000 years for tinnitus.
- 587,000 years for annoyance.

More nurses mean fewer deaths

Research in the *New England Journal of Medicine* has shown patient mortality risk increases by 2% for each shift worked that was substantially understaffed by registered nurses, *Nursing Times* reported on 29 March. Nurse shift data was compared with records for 198,000 patients in 43 wards at a large hospital and researchers looked at the number of nurses on each eight hour shift. The average exposure to understaffing was three shifts, meaning a patient's in-hospital mortality risk was about 6% higher than for patients on fully staffed wards.

Alcohol link to cancers

One in ten cancers (10%) in men and one in 33 (3%) in women in Western Europe are caused by former or current alcohol consumption, according to the *BMJ* (6 April). The *European Prospective Investigation into Cancer (EPIC)* focused on representative alcohol consumption data from France, Italy, Spain, the UK, The Netherlands, Greece, Germany and Denmark compiled by the **World Health Organization (WHO)**. 363,988 men and women, mostly aged between 35 and 70 at recruitment were followed for cancer since the mid 1990s.

The study calculated that in 2008 current and former alcohol consumption by men was responsible for 57,600 cases of cancer of the upper digestive tract, colorectum and liver in Denmark, Greece, Germany, Italy, Spain and the UK. Over half of these cases (33,000) were caused by drinking more than two alcoholic drinks a day.

Alcohol consumption in women in the eight countries caused about 21,000 cases of upper digestive tract, liver, colorectum and breast cancer, of which over 80% (17,400) was due to the consumption of more than one drink of beer, wine or spirits a day. See: www.bmj.com/cgi/doi/10.1136/bmj.d1584.

Call for integrated health and care

The **King's Fund** warned in April that a social care funding gap of £1.2bn could develop by 2014. The think tank's study, *Social care funding and the NHS: an impending crisis?*, describes how social care spending on the elderly over the past five years has increased by just 3% compared to spending on those with learning difficulties (20%) and those with physical disabilities (14%) over the same period.

The King's Fund makes recommendations including that there should be more integration of health and social care on all levels but warns against 'injecting additional resources into an unchanged system'. There should be a single strategic assessment of the funding needs of the NHS and social care it says.

In Scotland, the Scottish Labour Party has proposed merging health and social care for older people into a National Care Service, with a single dedicated budget.

1 in 4 delays dental treatment

The *2009 Adult Dental Health Survey*, which covers England, Wales and Northern Ireland, suggests that adults' dental health continues to improve but that 1 in 4 (26%) adults say the type of dental treatment they chose in the past was governed by cost, and 19% said they had delayed treatment for the same reason.

Overall, 50% of all adults with at least one natural tooth ('dentate') attended the dentist at least once every six months, 21% once a year and 6% once every two years. 61% of dentate adults said the reason they attended was for a regular check-up and 10% for an occasional check-up. 27% attended the dentist when they had trouble with their teeth and 2% said they never attended the dentist.

71% of dentate adults said they had received NHS care at their last completed course of dental treatment; 45% said they paid for this care and 25% said it was free. Private dental care was reported by 27%.

51% were classified as having low or no dental anxiety, 36% moderate dental anxiety and 12% extreme anxiety. See: www.ic.nhs.uk/pubs/dentalsurvey09.

Are trusts rationing operations?

An open letter to the *Guardian* from the **Federation of Surgical Speciality Associations (FSSA)**, claims that trusts are using lists of surgical procedures and interventions deemed to be of low clinical effectiveness to limit access to certain procedures, *BMJ* 2011; 342: d2553 reported on 20 April.

The list includes spinal, bariatric, dental, cancer and ear, nose and throat surgery and hip replacements. FSSA members are already working with the **Department of Health** to determine if any surgical procedures should be limited on the NHS but the letter says 'the only justification' for the lists is as a means of 'reducing expenditure at a time when the NHS faces a financial crisis'.

And a report from the **King's Fund** says more than two thirds of a panel of 26 financial directors drawn from acute, mental health and primary care trusts from all English regions said they may not meet their productivity targets for 2011-12. *BMJ* 2011; 342: d2612 reported on 20 April almost half (12) the panellists identified closing hospi-

tal wards and reducing services to deliver efficiency savings. *How is the NHS performing?* is at www.kingsfund.org.uk.

But an **Audit Commission** briefing suggests the NHS could save £500m a year by cutting ineffective treatments, procedures where there are lower cost alternatives and procedures no longer deemed necessary, *BMJ* 2011; 342: d2438 reported on 13 April. The Commission cited tonsillectomy, heavy menstrual bleeding where there are alternatives to hysterectomy, wisdom teeth extraction and some cosmetic procedures such as orthodontics.

Political briefs:

- A *Nursing Times* survey reported on 29 March that when nurses were asked: do you enjoy working in the NHS? Only 17% said 'Yes' and 83% said 'No'.

- And, when asked: is your ward regularly understaffed?, 90% of nurses said 'Yes' to the *Nursing Times* survey reported on 5 April and only 10% said 'No'.

- Health Minister Lord Howe announced on 12 April that 62 dental practices will take part in a trial of a new NHS dental contract. Dentists will be paid for the quality of their treatment rather than the number of treatments. Three slightly different models will be trialled from this summer.

- Dr Peter Carter, head of the **Royal College of Nursing (RCN)**, has warned that cuts in NHS posts are "misguided" and "ill thought through" and could lead to a return of superbugs in hospitals, the *Evening Standard* reported on 8 April. The RCN said almost 27,000 NHS posts nationwide were earmarked for cuts to meet the £20bn savings target over the next four years.

- Bowel cancer is the third most common cancer in the UK, with more than 35,000 new cases a year. But research in *Gut* in April found that of 161,000 patients undergoing major bowel surgery between 1998 and 2006, 6.7% (10,704) died within 30 days of their operation. The figures are much higher than for many other countries.

- Surgical rates for cancer fall off steeply with age, according to *Major Surgical Resections England 2004-2006* published by the **National Cancer Intelligence Network** in March.

- A **King's Fund** report warns of a £1bn funding gap in social care by 2015. *Social care funding and the NHS: an impending crisis?* is available at www.kingsfund.org.uk.

- The **Nursing and Midwifery Council** reported in April a 60% rise in complaints about nurses and midwives since last year, with 833 new referrals compared to 530 in the same period in 2010.

- On 18 April the **Department of Health** confirmed funding for four local authority social care PFI (private finance initiatives) in England. The four are in Hammersmith, Hull, Leeds and Sandwell.

- The new Irish government plans to introduce a universal single tier health service by 2016, with access guaranteed to medical care based on clinical need rather than ability to pay.

- There were 5,446 breaches of the Mixed Sex Accommodation (MSA) guidelines in March, down from 7,583 in February, the DH reported on 21 April.

- There were 738 cases of MSSA infection in January, the DH reported on 6 April, up from 675 in February.

Hospital RTT waiting times down

The median Referral to Treatment (RTT) wait for NHS hospital admission in England fell from 9.1 weeks in January 2011 to 9.0 weeks in February according to a **Department of Health** Statistical Press Notice released on 14 April. For non-admitted patients the median wait fell from 4.8 weeks in January to 3.5 weeks in February. The 95th percentile time wait for patients entering an RTT pathway rose from 22.4 weeks to 22.8 for admitted patients but remained at 16.1 weeks for non-admitted patients.

The number of patients not meeting the 18 week target was 89.8% for admitted patients and 97.2% for non-admitted patients.

Employment up, inflation down

Unemployment in the three month period December 2010 to February 2011 fell from 2.529m to 2.480m, according to the latest *Labour market statistics*, released by the **ONS** on 13 April. During the same period, employment rose from 29.157m to 29.233m. 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 107.226 to 107.469. 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 rose from 1.4486m in February to 1.4505m in March. The latest unemployment rate is now 7.8%, or 4.5% for JSA claimants, with 23.2% of those of working age (16 to 64) recorded as 'inactive'. Earnings in the three month period to end February (including bonuses) fell from 2.3% to 2.0% higher than a year before.

On 12 April the ONS announced that in March the Retail Prices Index (RPI) was down from 5.5% to 5.3% up on a year before, while the Government's preferred Consumer Prices Index (CPI) was down from 4.4% to 4.0% up. This compares to an annual inflation target of 2.0%.

Government's 'listening pause'

On 6 April, the **Department of Health** announced a Government NHS listening exercise to address concerns over health service modernisation plans. Health Secretary Andrew Lansley said 6,500 GP practices and 90% of local authorities had signed up to improving patient services so far, but there was now the opportunity for a natural break in the passage of the Health and Social Care Bill to "pause, listen, reflect and improve," and to hear people's views and give them a say in shaping the future of the NHS. The public and patients can leave their own feedback by visiting www.dh.gov.uk/healthandcare.

In a *BMJ* interview (*BMJ* 2011; 342: d2221) **Health Select Committee** chairman Stephen Dorrell suggested there is less than meets the eye in the current furore over where the Government is taking the English NHS and that the process is more evolution than revolution and in effect a continuity of policy carried out over the last 20 years.

A report from the Committee published on 5 April suggests that commissioning needs broadening to include nurses, hospital doctors and social care and local community representatives and Mr Dorrell expressed concerns

about commissioning responsibility where consortiums are not ready to take it on.

As for NHS savings he said: "The service is used to increasing resources year by year. It hasn't achieved a 4% efficiency gain in any year of its history, and there's no example in the free world of a health service that has managed to do it four years in succession."

To concerns that the bill will open the door to privatisation, he said he didn't see a problem in including the independent sector adding: "Some private companies may be interested. But NHS managers are not getting very many calls from them at the moment."

Comment: *NHS reform is never easy (see Page 14) but the strength of opposition from many in the medical profession—the most trusted group in the UK—could result in either reform being delayed until after the next election, or else to it being rolled out in a series of pilots.*

Frontline jobs under threat

A **Royal College of Nursing (RCN)** investigation claims that trusts plan to shed 12% of their registered nursing workforce over the next four years with nearly 10,000 NHS posts in England to be axed by 2015. RCN chief executive and general secretary, Peter Carter said: "Our figures expose the myth that frontline staff and services are protected."

The College's 'Frontline First' campaign launched last year, reported on 12 April that 5,209 jobs (54% of the 9,650 posts at risk of being cut over the next few years) were clinical posts: doctors, consultants, nurses, midwives and health visitors. Of the 5,209 posts, 4,209 were nurses or healthcare assistants. However, David Nicholson, chief executive of the NHS disputed the figures, stating nursing numbers rose by 1,272 from September to December 2010 and by 2,677 since September 2009.

Earlier, *Nursing Times*, 29 March, reported a fall in nurse numbers for the first time in a decade. Data from the *NHS Workforce Census* showed the service employed 335,357 whole-time equivalent nurses on 30 September last year, 650 fewer than 12 months earlier. Although still higher than the 2008 total, it is the first year-on-year fall in more than a decade. The statistics show a fall of 2,487 in bank nurses, a 414 drop in practice nurses but an 881 increase in healthcare assistants.

Variation in surgical admissions

A report from the **King's Fund** on 14 April highlights the wide variation in surgical procedures in England, with some patients not getting the surgery they need while others may be having procedures from which they do not benefit, *BMJ* 2011; 342: d2380 reported on 13 April.

The report analysed 36 surgical procedures in 2009/10 and found a fourfold variation in admission for hip and knee replacements and a 300% variation in cataract operations between primary care trusts. Some of the variations were justified, but 'bad' variations should be discouraged by calling on care providers and commissioners to justify their decisions and also by engaging patients in key decisions and giving them the information to understand the risks and benefits of their treatment.

NHS reform—why so difficult?

By mid-April, Health Secretary Andrew Lansley must have been wondering whether it was such a good idea to take on his current role and to have the temerity to want to change the NHS at all, writes editor Andy Couchman.

If it wasn't bad enough that he was under attack from the **Lib Dems** (hold on, aren't they supposed to be a coalition partner?) and the **BMA**, now 98% of nurses thought he wasn't up to the job.

What must have seemed a shoe-in was now a shoe that was causing painful blisters with every step taken.

The irony is that the reform's fundamental premise—giving GPs power to control their patients' treatment and getting the private and third sectors to compete more with the NHS looks to make such a lot of sense.

So why is the Health Secretary under such attack?

Forgotten in the mists of time...

It is easy to forget that that dear old national treasure, the NHS, wasn't always regarded with the reverence it now seems to command from every quarter. Back in 1948, for example, just a few months before the NHS was due to come into existence on 5 July 1948, the **BMA** set up a £½m fighting fund to oppose the NHS. That, at a time when the country was almost bankrupt after a hugely expensive world war, was quite some achievement.

So, it is useful to try to dispel three NHS myths:

1. The NHS has no place for the private sector.
2. The NHS needs no reform. No one want it.
3. Doctors should not have to be accountants. And

the NHS must remain free at point of need for everyone and with no postcode lotteries.

1. The NHS has no place for the private sector

One of the ways the first Health Secretary, Aneurin Bevan, sought to placate doctors was by allowing GPs to be self-employed and to allow hospital doctors to continue to work in the private sector as well as in an NHS hospital. NHS hospitals too could also take paying private patients.

BMA secretary, Dr Charles Hill, also the BBC's Radio Doctor, said in 1948: "Let us make sure that your doctor does not become the State's doctor."

Today, doctors still retain much more independence than most employees do. Your GP is likely to be a private profit making business and your hospital consultant may well make most of his or her income outside the NHS. Most pharmacists too are privately run, for profit businesses and some hospitals are now run as PFIs (private finance initiatives). OK, bad example—many PFI schemes have been poorly set up and are likely to end up costing taxpayers considerably more than perhaps they should.

This is not to knock doctors, or anyone in the medical profession. I have huge respect for the vast majority, who do an important and often thankless job with dedication that most of us simply couldn't imagine.

But, as an eminent ENT consultant told me many years ago: "My politics are right of centre but on health matters you'll find that I and most of my colleagues are very much left of centre."

But, the BMA should recognise that we have moved on from the 'them and us' mentality that did so much dam-

age to British industry a generation ago. The NHS is now and always has been reliant on both the private *and* public sectors to achieve its outcomes. The only issue is where any boundaries should be drawn.

2. The NHS needs no reform. No one want it

One simple statistic—a recent poll by *Nursing Times* found that 83% of nurses did not enjoy working in the NHS. Is that an organisation that needs no reform?

Of course, as human beings, we don't always welcome change. When your boss calls you in to tell you about the latest corporate reorganisation, doesn't at least part of you fear that any change will be bad for you personally. And, if you know some jobs will go, how often do you fear you may be one of those 'let go'.

No, fear of change is quite normal. And, with an institution as loved as the NHS is, the fear is that any change is bound to be damaging. That is why no political party mentioned NHS reform in the run up to last year's General Election. In the same way none of them proposed raising VAT rates...

Yet, the NHS must change. With an ageing population, constraints on spending (inevitable, following the 2007 banking collapse), an unwieldy 1.7m people to manage and inefficiency rife and people too often unaccountable, change is necessary. And, the process that has seen the NHS's power base slowly migrate from cash guzzling hospitals to 'frontline' GPs is both inevitable and desirable too.

The issue is not about should the NHS change (it must) or should more power be given to GPs (again, arguably necessary) but only about the detail, the timings, who does what, how they are accountable and how can we ensure 'good' changes are made and 'bad' changes avoided.

3. Doctors should not have to be accountants. The NHS must be free at point of need for everyone with no postcode lotteries

The NHS is not completely free at point of need. Since 1952, patients have had to pay for prescriptions, dental care (even if we can still find an NHS dentist), holiday vaccinations, eye tests and a raft of other costs (including hospital parking—but not in Scotland or Wales).

Mention of the four UK countries also highlights that already there are big differences between the health-care in each. In April, Scotland scrapped paid for prescriptions but already has much higher NHS resources per head than in say England. And, even in England, healthcare will vary from region to region, town to town and even hospital to hospital. One person's healthcare lottery is another's local choice being exercised.

Doctors may not want to be accountants but do we really want them to ignore the financial consequences of their decisions? Can we afford that?

The Lansley reforms are not perfect and much will depend on the detail that ends up in the Act and how that Act is implemented. The Government is now 'listening' and changes are inevitable or the Bill may be delayed or change piloted first before being rolled out (eventually) to all.

But let's not forget that whether it's nurses demanding the right to participate in local boards or doctors wanting more money for their new responsibilities, many of the complaints about reform are primarily political and financial. With a healthy fear of change thrown in too...

People news

• **ALC Health.** Joe Coker has been promoted to senior business development manager. His new role will include ALC Health's business in Hong Kong and South East Asia. Andrew Lindly has moved from client services to sales, providing support to international corporate clients and marketing functions.

• **Aviva.** Andy Curran joins as UK life retail and partnership director. He was previously intermediated distribution director at **Prudential** and will report to life distribution director Graham Boffey.

• **AXA PPP healthcare.** Elliott Hurst has joined as director of health consulting, reporting to sales and marketing director James Freeston. He was previously commercial director at **Roodlane Medical**.

• **Canada Life.** Sue Grene has been promoted to marketing manager.

• **Chase Templeton.** Duncan Deaves has been promoted to national sales director.

• **Engage Mutual.** Andrew Gosling has been appointed to its board as a non-executive director. Until his retirement in 2010 he was finance director at **Yorkshire Building Society**.

• **Fitbug Holdings.** Fergus Kee has been appointed executive chairman, replacing Allan Fisher who is stepping down to pursue other business interests but who remains a non-executive director. Fergus Kee was previously MD of **Bupa's** UK and North American division and CEO of **Bupa Insurance Ltd**.

• **Health Screen UK.** John Picken has been appointed MD. He was previously CEO at **Medisure** and a senior vice president at **Marsh**.

• **HSF Health Plan.** On the retirement of CEO Keith Bradley in May, current sales and marketing director Stephen Duff takes over as CEO of the health cash plan and its parent **Hospital Saturday Fund**.

• **Private Healthcare Company.** Daniel Keyte has been appointed senior sales adviser. He joins the company from **USAY Health**.

• **RGA.** Ken Hogg has been appointed chief actuary and financial officer at the global life reinsurer, joining on 1

June. He joins from the **FSA** where he led the work on insurance sector issues and was previously with **Aegon**, **AIG Life** and **MGM Advantage**.

• **Royal London.** Phil Loney has been appointed group chief executive, taking over from Mike Yardley. Phil Loney is currently MD, life pensions and investments at **Lloyds Banking Group**.

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. Name the chief medical officer at the Department for Work and Pensions.
2. Approximately how many people in France have long term care insurance?
3. Who in April promised to "pause, listen, reflect and improve"?
4. Which High Court judge rejected the BBA's challenge to the FSA and FOS in April?
5. What is 'the bank of mum and dad'?

Can you help us improve e-PR?

As part of our continuing strategy of making everything Protection Review does as effective as possible while offering best value for money too (yes, we know everyone says that, but we mean it!) we are looking over the coming weeks at how we can make e-Protection Review even better.

For example, what works best and what could be improved and how? What would you like to see added or dropped? Are we too opinionated, or not opinionated enough? How can we best help you and your business?

Just e-mail andy@andycouchman.com and tell us what you think. Thank you for your time; we appreciate it.

Subscribing to e-Protection Review

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Long term care insurance— international comparisons

Long term care insurance (LTCI) in the UK has not proved popular since it started in the early 1990s. However, LTCI has proved more popular in some other countries and is currently being considered by the **Dilnot Commission**, which is expected to publish its recommendations in July.

France

- 3m policyholders (2007).
- 45% individual, 55% group, but premium income is 90% individual.

- Banking networks have a 45% market share.
- Market grew by 15% on average from 2000-2007 but has slowed since then.

- Average annual premium €340 provides an indemnity cash benefit.

- Main market: 40-75 years olds as asset protection.

USA

- 6.5m policies in-force.
- Policies mainly reimburse the cost of care and cover all costs.

- Mainly sold by intermediaries.

Israel

- 3m policies in force (of total population 7m).
- Mainly group LTCI but individual also emerging.

Germany

- LTCI system implemented in 1995-6 as fifth pillar of social security system.

- 250 public funds cover 90% of the population, funded by payroll deduction.

- High income and public servants and self-employed usually opt for private insurance instead.

Japan

- Mandatory state system (from 2000) funded 50% from tax and 50% from insurance premiums.

- Prior to 2000, 2m policyholders had private insurance. This sector is now in run-off.

- Benefits usually only apply from age 65 and there is a 10% co-share.

Singapore

- Social LTCI launched in 2002.

- Tender process with insurers every five years.

There is random assignment to one of three insurers.

- Entry age 40-70. Premiums usually paid to age 65.

- More than 600,000 members. Few opted out.

South Korea

- Public LTCI system replaced private LTCI (which started in 2003) in 2008.

- Part of its NHS and costs 4.05% of NHS premium.

- 15% co-payment (homecare) or 20% (facilities).

Source: Scor Global Life, 2011.

Private dental costs

Treatment	Average cost
X-ray	£28
Scale and polish	£45
Small tooth filling non-white	£77
Large tooth filling non-white	£101
Sedated tooth removal	£142
Whitening	£304
Root canal	£377
Dentures full	£564
Implant	£1,272

Source: www.whatprice.co.uk/dentist, April 2011. Figures shown are averages based on inputs from website viewers.

UK gross disposable household income per head 2009

England	£15,545
Wales	£13,484
Scotland	£14,908
Northern Ireland	£13,520
UK	£15,333

Note: Gross disposable household income is defined as the amount of money left available within the household sector for spending or saving, after expenditure associated with income (e.g. taxes and NICs), property ownership (mortgage interest) and pensions contributions.

Source: *Regional Gross Disposable Household Income 2009*, ONS Statistical Bulletin, 30 March 2011.

UK company profitability Q4

- The net rate of return for private non-financial corporations in Q4 of 2010 was 12.2% and the annual rate for 2010 was 11.7% (up from 11.3% in 2009).

- Manufacturing co's: 10.4%; service co's: 14.8%.

Source: *Profitability of UK companies 4th quarter 2010*, ONS Statistical Bulletin, 6 April 2011.

Protection Review: financial services consultancy and communications solutions

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

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