

e-Protection Review

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

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Key statistics:

- NHS RTT median wait England August 2011: 8.1 weeks (See Page 13)
- e-Protection Review Long Term Protection Sales Index: 120.3 (Quarter 2, 2011, compared to base 100 in Quarter 1, 2000).
- e-Protection Review Employment Index: 107.017 (To end August 2011, compared to January 2000, see Page 13).

Half of advisers not addressing DRA removal protection needs

Over half (54%) of financial advisers say they have yet to make any alterations concerning planning for clients' protection and retirement provision, despite the abolition of the default retirement age (DRA) according to a poll by **Avelo**.

The survey of more than 150 Avelo Exchange users found that while 46% had already adjusted their clients' projected retirement age, 44% of protection policies still ran to age 60-64, with 42% running to between age 65 and 69.

This is despite the effective abolition of DRA for most people from 1 October 2011. Previously, an employer could force an employee to retire from their employment when they hit age 65. While some people are happy to retire as soon as they can, many can no longer afford to do so, while others are happier working. Economic factors include poor investment returns in recent years, coupled with very low interest rates. The combination for those not in a final salary pension scheme has meant a smaller pension fund buying an annuity that gives a lower (income) return.

Indeed, those who retired within the past decade or two probably did so in a retirement 'golden age'. They enjoyed strong growth in their pension fund, with higher annuity rates not reflecting the improvements in life expectancy older people are now enjoying. Moreover, lower inflation meant that the real value of their retirement pension could be much better protected than that of the previous generation. Subsequent generations are unlikely to be able to invest so little to get so much when they retire.

Working longer will have significant effects on the protection insurance sector. Generally, more health problems can be expected at older ages than at younger ages. So, in the individual or personal sector, premium rates can increase sharply when someone hits age 60, while many critical illness benefits stop at age 65 or before and joining a plan is often restricted to those below 60 or even younger.

In the employee benefits sector, many firms will find their claims increase disproportionately as their workforce ages. One option would be to change or restrict benefits for older workers but that could be regarded as age discrimination. Instead, many firms have already begun to question their approach to employee benefits (*Continued on Page 2*).

Quotes of the month:

'Hospitals: change the title of your A&E departments to A'n'E for a more informal-sounding emergency health service'. The satirical Viz Top Tip column in The Sunday Times Ingear section, 23 October.

"For the majority of people, retiring at 65 is no longer viable from a financial perspective." Paul Yates, strategy and product development director, Avelo, 21 October.

"The [critical illness insurance] definitions are not really meant to be for the consumer. They are for dealing with the medical specialist at point of claim. It is very important we are clear about what is covered and what is not." Nick Kirwan, assistant director of life and protection, ABI, speaking at the critical illness summit on 14 September.



(Continued from Page 1) While few employers want to be seen to take away employee benefits, many are prepared to make changes to their schemes.

For example, a firm might restrict benefits to all employees or move to a flexible benefits (flex) arrangement, so that, while employees can get more choice as to the benefits they have, employers can restrict their spend and, in effect, pass most or all of the greater cost of providing cover onto their employees.

A bigger concern is fewer firms wanting to add new employee benefits. As the economy relies on new firms coming through, the danger is that too many decide not to get 'locked-in' to a high cost employee benefits package. Or, a flex scheme may be chosen, with the result that premium income from such schemes grows slower each year than it otherwise might do.

Overall economic benefits should improve

It is easy to be critical of anti-age discriminate rules looking purely from an industry perspective though. Liz Field, CEO of the **Financial Skills Partnership (FSP)** puts the changes into a wider context: "In these difficult economic times, older workers can add resilience to a business' workforce, offering a vital blend of hard-soft skills that allow them to react in a more productive manner to economic crises." The challenge for the industry therefore is to manage its solutions to maximize the potential, while minimising the downsides. For example, that could include:

1. Developing new product solutions to appeal to older people who are now more likely to be working than retired. Such people may have good disposable income (their mortgage may be paid off or small while their children will be grown up and no longer financially dependent on them) and be more aware of the need for protection than some younger people.

2. Ensuring that rehabilitation and other services take account of the needs of older people. In the income protection area, for example, someone in their 60s may have less incentive to return to work than a younger person whose career trajectory is still upward.

3. Looking to see whether existing age cut-offs e.g. in critical illness insurance, are necessary or whether they could be increased.

4. There may be more scope for cross-generational solutions. For example, typically on private medical insurance and health cash plans, children are covered only until age 18 or until they finish full-time education (capped at age 25). One alternative may be to continue cover for children to say age 30 or even older, and to allow both gen-

erations to fund the product. So, initially mum or dad could pay 100%, then children pay 10% when they start work, rising to 50% or more as they can afford it (and/or as their income exceeds that of their parents).

5. Funding solutions could include the greater use of home equity, perhaps funding single premium solutions or providing a drip feed to fund a regular contribution plan.

6. One way to minimise claims is to give greater encouragement to people to take action to improve their health and to minimise the risk of a health claim (the two are not necessarily the same). The pioneer here has been **PruHealth** and **PruProtect** with their Vitality schemes. However, much of that is targeted at younger people. The challenge will be to increase the appeal to older people and to get their full engagement. Invariably financial incentives will be necessary but so too will be having the hard data to justify why people should take a more proactive approach to their health.

7. Will new product types emerge? That looks less likely, although there is scope to move away from the traditional silo approach to product design. So, for example, there is scope to merge income protection with PMI and health cash plans, given that in some cases benefits overlap.

8. Intermediaries will need both more training and motivation to take advantage of the ongoing changes in employment and also to provide a more proactive servicing approach. At present, too many advisers still sell a

product and then do not keep its suitability under review despite receiving renewal commission that is designed to fund that.

9. Underwriting will need to be reviewed. Many older people fear intrusive underwriting will not only increase their premiums but that it may lead to them finding out about a health issue they had previously been unaware of. That can be a positive, but the growth of 'grey' guaranteed acceptance whole of life policies in recent years illustrates the value of low underwriting solutions.

10. Providers will need to keep product features and benefits under review and to

look to make changes to reflect changing workplace needs and attitudes.

11. One knock-on effect may be that older workers can influence positively younger workers when it comes to protection needs. Workplace representatives and advocates were a mainstay of health cash plans in the past and could be so again in future, although regulatory issues may make remunerating such people difficult or impossible.

One thing is certain—the abolition of DRA will cause a few short-term issues for providers, not least of which is that claims costs could rise as workforces age, with knock-on effects on premium and demand. The challenge will be to take advantage of the new emerging opportunities to more than offset that.

What the law and the Government says

The law on equality is largely set out in the *Equality Act 2010*, which itself builds on earlier anti-discrimination legislation and is also gradually evolving. The **DirectGov** website (www.directgov.uk) includes some advice to workers on their rights, including:

'Age discrimination at work is unlawful in almost all types of employment. All employees and workers of any age are protected from age discrimination including partners of firms, contract workers and anyone in vocational training.

All aspects of your employment (or prospective employment) are protected from age discrimination, including your:

- recruitment
- employment terms and conditions
- promotions and transfers
- training
- dismissals.

In some cases different treatment of a worker or employee because of their age can be justified. For example making special provisions for younger or older workers in order to protect their safety and welfare.'

Bupa moves to open referral

Market leading PMI (private medical insurance) provider **Bupa** surprised the market on 21 October in an e-mail to intermediaries announcing that, from January 2012, it was moving to an open referral system for its Corporate Select PMI customers.

Open referral means that a patient's GP (general practitioner) refers them to a hospital specialist or consultant but not to a named individual doctor. Traditionally, GPs refer to a named consultant. However patients take it on trust that their GP is referring them to the right person for the right reason.

In some cases, the patient's own preference will be uppermost (e.g. if the patient has already been seen by a particular doctor and has great trust in them or perhaps has researched suitable consultants online). In other cases, the GP will use their specialist local or medical knowledge or will themselves have researched which specialist is most appropriate for that patient's treatment.

But there is concern too that a GP could refer to a known colleague regardless of their suitability or that personal relationships could be a factor in the referral. The stereotype is that the GP refers a patient simply to their golfing partner consultant friends.

The **Office of Fair Trading (OFT)** recently raised concerns that patients were suffering in the current private healthcare market due to a lack of information about the cost and quality of care in different hospitals and with different consultants.

A presentation accompanying Bupa's e-mail said that open referral was developed to tackle: '...high variation in clinical practice between many specialists,' and that '...most GP referrals are made without using any data on quality or value of specialist'. It also referred to: '...unsustainable cost inflation for employers,' and requests from patients for '...some sort of guidance around who they should see'.

Bupa is not alone in taking such an approach. The US-led managed care system, now used by some providers in the UK in some form too, relies on the medical insurer choosing not just the hospital and specialist but, in some cases, determining the medical protocol too. **Cigna** for example is a leader in having introduced the managed care concept into the UK, while **Simplyhealth** uses open referrals on some of its PMI plans and has done so successfully for some time.

The chief concern is whether the medical insurer will always put the customer's interests first, or whether it may choose a hospital or consultant, or even a specific treatment, based on price rather than quality.

The medical profession, understandably, also tends to resent what it sees as an attack on its own standards and its relationships with its patients. Bupa, as the market leader, has a track record of run-ins with the profession when it seeks to make changes, almost regardless of its reasons for doing so.

Intermediaries too have been critical of the Bupa move. The story was broken by *Health Insurance* magazine on 24 October and even a day later it reported that many intermediaries were still unaware of the forthcoming change. It may be that the move prefaces a growing debate about how much influence insurers should have.

Bright Grey CI White Paper

Bright Grey and **Scottish Provident** have produced a White Paper based on suggestions from panel members at a summit conference it held on the *Future of Critical Illness* on 14 September in London, hosted by **Lansons**.

The key calls to action include:

- Educate consumers about the value of taking out critical illness (CI) insurance cover.
- Simplifying conditions and explaining the likelihood of being able to make a claim under them.
- Increasing communications with charities such as

Macmillan Cancer Charity.

- Making greater use of social media.
- Produce a centralised protection information website, perhaps hosted by the **ABI**.
- Sell smaller sum insured CI add-ons alongside life insurance policies.

To read or download the White Paper see www.uncovered-uk.com.

Comment: *This is a good initiative and anything that takes CI cover forward is to be applauded. The risk is that this is seen as a Bright Grey/Scottish Provident initiative only, when it was actually much more than that. It was also disappointing that the role of CI cover alongside such as private medical insurance was not part of the White Paper. However, the key question now is how best to take this initiative forward.*

PMI cancer terms still unclear

There remains considerable confusion over the eligibility, level and duration of cover for some cancer therapies under private medical insurance (PMI) plans according to a new report from **Mercer**. That is despite considerable attempts by the insurance industry to make cancer policies more transparent.

Mercer's Covering Cancer Report, in association with **Oliver Wyman** and **HCA International**, is based on analysis of 11 PMI providers' cancer cover.

The report says that because PMI providers reserve the right to exercise discretion regarding certain claims, some sufferers feel that claims are declined unfairly. This is becoming a bigger problem because new cancer therapies falling outside traditional provider classifications are entering the market.

Some charities, for example, argue that treatment intended to slow the spread of the disease is 'active treatment' so should be covered by PMI providers. Providers also have to set their written rules at a given point in time and then determine their stance in respect of new treatments as they become available, which can result in delays and declinations for customers.

Some providers offered companies options about the extent to which cancer is covered, but the majority of firms offered a 'default' option provided by the insurer such as treatment with biological therapies limited to a year. Most providers still did not offer palliative care or treatment for terminal cancer and grey areas included reconstructive surgery, stem cell implantation and treatment with Cyberknife. Better definition of the transition from private to NHS care was also needed.

See www.mercer.com for more.

Simplyhealth to acquire Groupama Healthcare

On 3 August, **Simplyhealth** announced that it had reached agreement to purchase the UK healthcare business of **Groupama Insurances**, subject to the required regulatory approvals, for an undisclosed sum.

Simplyhealth CEO Des Benjamin commented: "For the past ten years, Simplyhealth has been looking to add more value and choice to customers through growing a diverse range of products and services. An essential element of this strategy has been achieved through mergers and acquisitions with health providers that share similar values to us.

By acquiring Groupama Healthcare, an award winning business, we have the opportunity to build greater presence in the small to medium business sector and grow market share. Following the completion of this latest acquisition we will join the UK's top five health insurance providers (source: Datamonitor 2010)."

On 25 October, Simplyhealth announced that the takeover was taking longer than anticipated, due to 'the number of companies working on similar transactions at this time'. It therefore expected that the formal takeover would not now complete this year.

The detail of how Groupama's healthcare business will be aligned with the rest of Simplyhealth has not been resolved yet and, in the meantime, both organisations are effectively continuing, with both Groupama's Santé and Simplyhealth's Preferential plans remaining available for both new business quotes and renewals.

Comment: *This acquisition adds a useful presence, especially in the PMI SME sector, for Simplyhealth. In addition, Groupama has a very strong reputation for good service too.*

The main downside looks to be the disappearance of yet another PMI provider. However, the huge presence in the sector of Bupa and AXA PPP healthcare, who between them have over 65% of the market, means both that mid-sized providers probably need acquisitions to achieve significant market presence but also that some providers will be too small to achieve reasonable profitability and return on capital which we assume was the situation for Groupama which, despite its huge presence in France and well-regarded products, probably only had a 1% PMI market share in the UK.

The delay in proceedings is odd, but means that all sides now have longer to work out how best to drive the combined business forward. Each has its own approach to the market and its own unique features, so it will be interesting to see which ideas ultimately are actively taken forward.

ABI to split into two

The **Association of British Insurers (ABI)** is restructuring into two divisions, which will mirror the forthcoming new regulatory regime it announced in October.

Current director of life and savings Maggie Craig will head the new financial conduct and consumer strategy division. Director of investment affairs Hugh Savill will become director of prudential regulation and taxation.

Director general Otto Thoresen will take responsibility for investment affairs 'for the immediate future'.

Further details are expected in due course.

80,000 turn to local authorities

More than 80,000 elderly people each year who pay for private care run out of money and have to turn to local authorities for funding, according to research by **Key Retirement Solutions**.

The research also found that just one in five people say they can afford the £35,000 cap on lifetime individual contributions suggested by the recent **Dilnot Commission** report on LTC funding.

Only 2% had made financial preparations for the eventuality of suffering ill-health in retirement.

Carewise launched in West Sussex

Carewise, a groundbreaking new care funding advice service for older people paying for long term care has been launched in West Sussex by Lord David Lipsey.

The information and advice service has been put together by **West Sussex County Council Adults' Services**, their **Trading Standards** department, **Age UK West Sussex**, **The West Sussex Forum** and the **Society of Later Life Advisers (SOLLA)**.

In the county, annual residential home fees average £30K, care homes with nursing £40K (with some costing up to £80K) and home care charges range from £13.50 to £20 an hour. 61% of care home residents fund their own care. Yet only 5.9% of older people going into care homes take specialist independent financial advice.

Carewise has approved a panel of local care funding advisers (all SOLLA members) who are also subject to CRB checks and have completed Safeguarding Adults at Risk training and are approved under the Trading Standards. 'Buy with Confidence' scheme.

For more see www.westsussex.gov.uk/carewise.

Comment: *This is an excellent model for how local authorities, financial advisers and other interested parties can work together to ensure people get the help and advice they need when considering care options.*

West Sussex says that 5,100 people in the county self-fund and that it funds nearly 400 self-funders whose assets have fallen below £23,250. Around 175 self-funders a year ask the council for help when their assets fall below the threshold. This costs West Sussex £5.91m a year (an average of £14,850 per care home resident).

38% found fit to work by WCA

More people are being assessed for the higher rate of Employment and Support Allowance (ESA), but a significant minority (38%) are being found fit for work under the Government's Work Capability Assessment (WCA), Employment Minister Chris Grayling announced on 26 October.

Latest figures covering the period 30 October 2008 to 28 February 2011 show 7% of those undergoing the WCA were put into the support group; 17% into the work-related activity group; 38% assessed as being fit for work; 36% closed their claim before assessment, and 2% of assessments were still in progress.

Comment: *ESA is proving to be a tougher benefit to get than its predecessors (and much tougher than claiming under most income protection policies). Just 1 in 4 claimants (24%) undergoing the WCA are being paid benefit.*

The Syndicate launched

The **Syndicate**, a new and innovative consumer research partnership between **Protection Review** and **Hannover Life Re (UK)** was launched on 11 October, with the revelation that when considering financial matters, men and women now share the decision-making process.

Where one party does not take the lead, 41% of both men and women say they consider themselves active in contributing to decisions in the household when selecting financial products.

However, there were significant regional differences, with 52% of women in the North East being the main decision maker, compared to just 37% of men.

The Syndicate has been formed to provide a fresh new way for firms across the life and health insurance sector to access research to help them drive their business. It comprises two waves of research, with the first focusing on gender and lifestyle. The consumer research is carried out by leading market research organisation **ICM**. ICM carried out a telephone omnibus consisting of 1,000 interviews per wave in September 2011.

The Syndicate offers three major benefits compared to conventional single party consumer research:

1. The research is considerably cheaper. Members' all-in initial fee is just £1,999 +VAT for 12 months and that includes a free question, responses to which are only available to that member, and attendance at the conference.

2. Full results are only provided to members and include expert analysis and interpretation by leading industry names regarding individual questions and themes.

3. An annual workshop (the first to be held in January 2012) enables members to further explore the findings.

Initial members include **Zurich**, **Friends Life**, **Exeter Family Friendly** and **The Finance IT Net-Work**.

Traditionally, consumer market research tends to be used to gain publicity, to justify a particular approach or action or to genuinely find out about consumer behaviour. However, it can be expensive, hard to interpret and no matter how good the commissioner is, the results are often disappointing.

The Syndicate aims to eliminate these drawbacks in a very cost-effective way that will, over time, also add up to a unique understanding of changing consumer behaviour.

Individual marketeers can then use the communal information and the results of their own unique question to better manage their messages and strategies, all for considerably less each year than commissioning just one small consumer survey.

Ronnie Bowes, head of marketing at Hannover Life Re (UK) said: "This new collaboration represents a partnership that brings together consumer focused companies. In today's challenging economic climate, we believe that innovative associations and consumer insight will play an increasingly significant role in ensuring we deliver products and services that consumers expect."

Protection Review co-chairman Peter Le Beau added: "We are delighted that The Syndicate will be able to provide new and topical consumer insights for some of the leading players in protection. We have high hopes that it will be a major addition to the knowledge base of our industry." See www.protectionreview.co.uk for more or contact jo@lebeauvisage.co.uk to find out how to join.

13% have key person insurance

Although 77% of businesses can identify at least one person whose loss through death, critical or serious illness would seriously impact the profitability or survival of the business, only 13% of those actually insure the risk according to **Scottish Widows Business Protection Report 2011**.

More than half of firms (60%) say they would not survive the loss of a key person (including 80% of sole traders, 63% of family businesses and 49% of partnerships). 26% of partnerships and 27% of companies say they would spread the workload to cope, even though this is perhaps a naïve approach.

The research also found that 59% of businesses had public liability insurance, 51% contents, 48% buildings and 27% office equipment insurance but only 6% covered the death of a key person and just 4% their critical illnesses. The report notes that 'more people insure their photocopier against breakdown than they do a key person on death or critical illness'.

Two thirds (66%) of businesses say they have no liabilities but this may be because their perception of debt has shifted and they no longer see overdrafts, stock on credit or mortgages as liabilities but just as part and parcel of running a business. Three quarters (75%) of businesses had no sought any advice on business protection, while 10% had consulted an IFA, 8% their bank, 6% their accountant, 2% their lawyer and 1% their family.

Scottish Widows concludes that firms need to understand the risks they face. That can be achieved by including the role of business protection insurance in their risk assessments, reviewing their governance arrangements and having regular financial reviews.

Cigna acquires FirstAssist

Medical insurer **Cigna International** has agreed a deal to buy protection and travel insurance provider **FirstAssist** with the aim of growing its UK presence.

The deal values FirstAssist at £71m and is subject to regulatory approval. FirstAssist grew as an MBO from **Royal and Sun Alliance** and originally included RSA's private medical insurance business before that was sold off to **Standard Life Healthcare**.

First Assist was previously owned by **Barclays Private Equity** and has nearly three million policyholders in the UK and employs around 480 people.

Comment: *This looks to be another good acquisition. Cigna is much better known on the global stage than in the UK and adding FirstAssist should help it expand its UK presence, while also giving FirstAssist a strong and stable parent.*

Ageas launches product labels

Ageas Protect has launched a product labelling system for protection products.

The system follows that used on food and, for each main product feature shows a green tick if the feature is included (or partially included), an amber box if optional and a red cross box if not included. So, for example its Real Life Cover plan includes green ticks for death, terminal illness, long term sickness and TPD. Specified CIs are a green partial benefit and unemployment an amber option.

Briefs:

- Esther McVey, Parliamentary Private Secretary to Employment Minister Chris Grayling told a **Legal & General** roundtable event that: "...we're looking at aids to assist businesses and if that [removing tax disincentives] is the best way forward then I guess that's the best way to go", *IFAonline* reported on 19 October.

- Up to one and a half million households may not have enough life cover to pay off their mortgage if either partner dies, according to **Gocompare**. A survey of 3,000 people found only one in four adults say they have sufficient life cover to clear their mortgage and other debts and provide an income for their survivors. Cost and apathy were the main reasons people did not have cover.

- A steering group has been formed to develop a suite of simple financial products (including protection). The group is chaired by Carol Sergeant (former chief risk officer at **Lloyds Banking Group**) and will report back to Financial Secretary to the Treasury Mark Hoban by July 2012. A summary of responses to earlier consultation is at www.hm-treasury.gov.uk/consult_simple_financial_products.htm.

- The **CII** and **PFS** have introduced a free legal advice helpline for their Chartered members. The service is provided by **Legal Assistance Direct** and can advise on most issues (except on employment law, criminal matters and, not surprisingly, anything to do with the CII itself). The number for members only is 0845 676 9572.

- Nearly half (47%) of people now exercise at least once a week and 38% don't drink at all during the week, according to the 2011 **Aviva Health of the Workplace** report. Only 19% now eat unhealthily to help cope with stress (down from 34% last year) and only 11% say they smoke more. 47% of employers say the recession has made them realise the importance of looking after staff health and wellbeing and 63% say health has a direct effect on productivity. A third (35%) want to further improve staff motivation and morale and a fifth to improve staff wellbeing. 18% plan to increase spending on health-related benefits. Over half (54%) said they would invest more in health-related benefits if they could see a tangible ROI (return on investment).

- Nearly 30% of employers are placing greater emphasis on promoting access to health and wellbeing initiatives compared to last year, according to the 2011 **Chartered Institute of Personnel and Development (CIPD)/Simplyhealth** Absence Management survey. 46% already had a health and wellbeing strategy in place.

- **Legal & General** has set up an exclusive deal with **Lifetime Legal Services** to provide a one stop legal shop for its business protection customers. It includes a fixed price menu of services and enables firms (and their advisers) to ensure that issues such as agreements, trusts and legal documents can be prepared without having to rely on a firm's own third party legal advisers.

- **Aviva** has introduced a free employee assistance programme for its group income protection customers. Previously a paid for add-on, the EAP gives access to face-to-face counselling and 24/7 GP, bereavement and stress counselling and legal advice helplines.

- Life expectancy in the UK from 2004-06 to 2008-10 was highest in Kensington & Chelsea where it increased

for males from 83.0 to 85.1 years and from 87.1 to 89.8 years for females, the **ONS** reported on 19 October. It was lowest in Glasgow City where, in 2008-10 it was just 71.6 years for males and 78.0 years for females.

- The **Income Protection Task Force** has announced that it has abandoned its quest to introduce a quality standard for IP products. The main reason, according to Richard Walsh (who with Karin Lloyd carried out a feasibility study), writing for *IFAonline* on 12 October, was that such a standard would not lead to people buying IP. However, the work carried out is expected to have a positive influence on future product design.

- **Leeds Metropolitan University** launched the **Institute for Health & Wellbeing** on 12 October. The institute will undertake research into the health status of individuals and communities and investigate issues including men's health, healthy communities, health promotion and nutrition and childhood obesity.

- **Bupa** has introduced a new cancer option 'NHS Cancer Cover Plus' under its Corporate Select PMI scheme. The option provides employees with diagnostic tests and consultations until a cancer diagnosis is confirmed. Then if treatment can be provided by the NHS it is, with additional telephone support from the Bupa Oncology Support Team. If not, the treatment can be funded privately. The option fits between Bupa's comprehensive cancer guarantee and having no cover for cancer.

- **HC-One**, a new care company taking over around a third of the **Southern Cross** care homes, comes into being on 1 November.

- Over 29.5m (48%) Brits has no will, yet one in five (22%) expect to leave over £10,000 in savings when they die, according to **Unbiased.co.uk**. 10% of those without a will believe their estate will go to the right people automatically. 84% of 18-34 year olds have no will, or 65% of those aged 35-54 and a still high 35% of those over 55.

- The insurance industry does not co-ordinate its efforts and fails to express its messages clearly, Jonathan Evans MP, chair of the **All Party Parliamentary Group on Insurance and Financial Services (APPGIFS)** told the *Cover Forum* on 10 October.

- **Unum** has become the second income protection insurer (after **Aviva**) to promote IP through TV ads.

- Protection complaints to the **Financial Ombudsman Service (FOS)** rose sharply in the July to September 2011 quarter with term complaints up 77% to 344, PMI and dental complaints up 58% to 150 and whole life up 52% to 596. One off or start of a trend?

- The **Health Authority Abu Dhabi (HAAD)** has warned all residents of the Emirate to maintain an up-to-date health insurance policy, or else face a stiff penalty. Employers or sponsors must provide some form of health insurance to all employees and their family members, including an employee's spouse and cover for up to three children aged under 18.

- Surgeon William Stewart Halsted (see page 10) suffered from compulsive perfectionism, which is perhaps one reason he became such a good, if painstaking, surgeon. By way of example, he had his shoes shipped to him from Paris (France, not Texas) and sent his shirts there to be laundered too. Do you know anyone in the industry with similar odd habits? If so, do let us know.

Pick of the month

We review this month products from more than four corners of the protection market.

ASDA's Instant Life Cover brings guaranteed acceptance life cover to younger lives, and is an interesting solution that is bound to be copied by others.

Cigna has launched a new modular international PMI plan, while UK Healthcare has introduced a new health cash plan and Aviva has updated its already successful CI plan. But our pick of the month is Exeter Family Friendly for taking IP an important step or two further.

ASDA Instant Life Cover

ASDA Instant Life Cover, underwritten by **Ageas Protect**, is a guaranteed acceptance term assurance policy for UK residents aged 17 to 50 at outset and provides cover up to 65th birthday only.

No health questions are asked at outset and terms are dependent on age, gender, smoker status and premium level chosen only. Three premiums levels are available—£5, £10 or £15 a month—and no customer can pay more than £15 a month (although they could, say, have a £10 a month plan now and add a £5 a month plan later on).

Unlike guaranteed acceptance plans for older people, this plan does pay out on death as soon as the plan is in force (rather than there being, typically, a two year period when only accidental death claims are paid in full).

However, the plan will not pay out if the customer has or has had a specified serious medical condition and then dies of that condition. The specified conditions are heart conditions, cancer, HIV or AIDS and a stroke or terminal illness. In addition suicide is excluded for the first 12 months, military deaths from injuries while on active service outside the UK and diabetes (if death is from a heart attack or stroke) are also exclusions. Other exclusions are non-disclosure of smoker status and 'a history of alcohol or drug abuse' (that means having attended or being advised to attend any related treatment programme).

An exclusion only applies where death is from that cause e.g. if you have cancer but the cause of death is a heart attack, the plan will still pay out.

A standard trust is not available. Instead, customers are advised to contact a lawyer. There is however a three page download all about trusts. Advice is not available, but customers can talk to a trained person about the policy by phoning 0800 169 1722 from 8am to 8pm (10-4 on weekends). There is also a two month non-forfeiture period if a payment is missed.

A male non-smoker age 30 could have £27,441 sum insured for £5 a month, £74,627 for £10 a month and £121,812 for £15 a month.

Comment: *Guaranteed acceptance whole of life plans for the 50+ age group have proved to be a big success in recent years and this plan takes the concept down to younger ages. In doing so, the plan has become term to age 65, just three premium levels are available and the death benefit can be paid on death as soon as the plan is taken out, unless the cause of death is from one of the defined exclusions.*

Will this concept become as popular as grey whole of life has? That remains to be seen—but it will be interesting to

monitor this plan's progress to see how much appetite younger people have for simple products and ease of buying. It's disappointing that no trust wording is available, but then too many advised plans don't use a trust either.

Product design points: *Asking no medical questions at all risks customers (or, rather, their survivors) not understanding why a policy has not paid out on death, so clear communication of the benefits and caveats is essential and the folks at Ageas have done a good job in making things as clear as possible to customers.*

On grey (funeral) plans, typically the death benefit is only paid on accidental death within the first (usually) two years. Here, there is no need for such a wide-ranging waiting period. Instead, you pretty much have to have been diagnosed with a serious condition in order for there to be an exclusion on death.

That does mean some element of selection—someone who fears they may have cancer could apply for cover today and then make an appointment to see their doctor tomorrow. Most people in that situation won't do so of course, but actuaries and underwriters lose a lot of sleep worrying about those who will do so.

Unlike grey plans, this product can pay out serious sums of money too—over £120,000 for a man aged 30 paying £15 a month. It does seem odd to take gender into account still, when that will be outlawed in little less than a year's time, although such a change can easily be introduced when necessary or when the market generally moves to unisex rates.

*Will this type of cover be more expensive than fully underwritten life cover? Yes, of course (our ASDA customer could pop down the road to **Sainsbury's** and have £223,787 of underwritten cover for his £15 a month and add waiver of premium for another 30p a month too). But the ease of buying (we are an impatient society and waiting to be accepted or even to know if we will be accepted and how much we will really have to pay is at best uncomfortable) could attract many people who, at present, are buying no life cover at all.*

Indeed, one option for IFAs could be to encourage clients to take out this type of cover now while waiting for their fully underwritten plan to be accepted. Then once (if?) accepted, the client could cancel the ASDA cover. Moreover, the client would have a clear indication of the value of underwriting, while setting up the cover in trust would further reinforce the IFA sale.

Plus points: *Easy to buy, instant simple cover, with no waiting period and cover that can last up to retirement (although, in practice, looking to retire at 65 looks to be a tad optimistic for many 30 somethings).*

Not so plus points: *More expensive than underwritten life cover (if you are accepted at standard rates). Some risk of anti-selection for the underwriter. No standard trust wording. Limited choice (on premiums and term especially). No advice.*

Website: www.asdafinance.com.

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

Aviva Critical Illness Insurance

Aviva has introduced a number of changes to its existing CI plan from 17 October. The key changes are:

- For two early forms of cancer—low grade prostate cancer and ductal carcinoma in situ (an early form of breast cancer)—customers receive a partial payment of 20% of the sum insured, up to a maximum of £20,000. For both, Aviva covers all forms of recognised surgical treat-

-ments, including partial mastectomy, segmentectomy and lumpectomy—an important distinction, as some other insurers only cover full mastectomy, Aviva says. If one of these partial claims is made, the policy still continues.

- Enhancements have been made to a number of condition definitions and in total, 12 such definitions are now 'ABI plus' (i.e. a broader definition than the model approved by the **Association of British Insurers**). This includes, for the first time, multiple sclerosis (MS), where Aviva now requires just three months of continuous symptoms, compared to six months for the ABI standard.

Comment: *Aviva is the latest of many to look again at its CI conditions with a view to widening cover and so benefiting its customers. It has also decided to offer partial payments, and this is fast becoming a key element of CI cover for many providers. Do the revisions move the market on materially? No, but they are welcome nevertheless.*

Product design points: *CI development has tended to take place in a number of phases. In the very early days all CI plans only covered a handful of conditions and there was no commonality on definition wordings between insurers. Now, insurers are increasingly following the PruProtect model of paying for some serious as well as critical conditions, albeit at a lower benefit level.*

There is also a 'race' to extend standard ABI definitions and, in its response to this, Aviva has cut what is in effect its 'waiting period' on MS claims from six to three months.

All these developments benefit consumers (as does publishing claims stats, which increases trust and transparency if communicated well). However, they also make life harder for advisers and for customers who understandably want to know 'which is best, and why?'

We still feel though that the next phase for CI must be a little more radical if the product is to resume the success it enjoyed just a few years ago—or even to improve on that.

Plus points: *Partial payments and improved definitions build on an already well-established plan.*

Not so plus points: *Does not materially move the market on.*

Website: www.aviva.co.uk

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

Cigna Global Health Options

Cigna's Global Health Options is a modular international private medical insurance (IPMI) plan. It is built around a core product, which Cigna calls International Medical Insurance. The core plan pays for in and day-patient treatment plus cancer treatment, maternity care and psychiatric care up to 90 days a year. Overall, the benefits are capped at £2m a year per insured person. The core plan also includes parental accommodation with children up to age 18, transplants (as a recipient), scans, home nursing and rehabilitation up to 30 days a year.

One or more of four benefit options can then be added to the core plan. The options are :

- International Medical Insurance Plus. This option covers all out-patient treatment up to £50,000 a year.

- International Emergency Evacuation. This option provides evacuation and repatriation cover and includes travel costs for a family member too.

- International Health and Wellbeing. This option

pays for screening, tests, examinations and counselling as well as providing other wellbeing benefits. Routine physical examinations are limited to £300 a year.

- International Vision and Dental. This option pays up to £3,500 a year. There are limits on some items.

Once cover levels have been chosen, a range of deductibles is then available to fine tune the price. So, for example, on the core plan the available Sterling deductibles are £250, £500, £1,000, £2,000 and £5,000.

The plans can be denominated in pounds Sterling, Euros or US Dollars and benefits can be paid in a wide range of other currencies too. Quotes can be obtained online and, as with other IPMI plans now, a lot of information is available through the website.

Comment: *Cigna is probably better known globally than it is in the UK, but this plan could help raise its profile with UK customers and intermediaries too. Its new IPMI plan is built round a strong core element, although there are limits on many of the add-on benefits and the core plan has a £2m annual benefit cap. Overall though, this is a strong offering, albeit with little that is particularly innovative on the surface.*

Product design points: *We've mentioned it before, but it's good to see another provider paying for parental accommodation with children up to age 18 rather than having a much younger cut off. Let's hope this now becomes the norm.*

Including maternity benefits in the core plan is an interesting idea. On the one hand, it is a valuable benefit to those who will have children during the plan's life. Making it available only as an add-on benefit could also result in some element of selection, so raising claims costs above what might otherwise be expected. On the other hand, including such a benefit inevitably has to be paid for by other policyholders who will not or cannot benefit and the cross-subsidy involved may be unattractive to them. The overall effect may be small—but small things matter on product design.

Plus points: *Well-known global player that is also well-established in the UK. Good basic product design, using a modular approach to allow tailoring of cover and cost.*

Not so plus points: *Despite its global size, Cigna is probably still under-known in the UK although this and other initiatives could see that perception change. Including maternity benefit in the core plan will mean some element of cross-subsidy for some. Not particularly innovative.*

Website: www.cignaglobal.com.

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

Exeter Family Friendly Income One

Exeter Family Friendly has taken the product formerly known as the Professional Income Protection Plan and now renamed it Income One. In the process, it has introduced a number of key changes. These include:

- There is no longer a premium rating for being female. Traditionally, on long term income protection plans, (although this has not been a feature of most short term annually renewable ASU type plans) females pay 50% or more than males of the same age. However, following the recent ECJ Test-Achats ruling (see e-PR 132, April 2011), that will be outlawed from 21 December 2012. Exeter has brought its response forward and this also brings

the plan into line with most PMI and ASU products so far as gender is concerned.

- Customers can now insure 65% of their income up to £60,000 a year. Previously the limit was 50%. Maximum benefit is cut from 65% to 45% of all income in excess of £60,000 a year.
- The list of acceptable occupations has been reviewed and increased. However, the plan continues to target lower risk occupations only.
- Customers can now 'fix' a proportion of their benefits. This new feature means that the fixed element of the income protection benefit is no longer subject to financial proof and testing when a claim is made. Up to 50% of income can be fixed. For example, someone earning £50,000 a year could have a maximum annual insured benefit of £32,500, of which £25,000 is fixed, regardless of their income, provided that the customer is still actively employed when the claim is made. Additional evidence of income may be required as soon as the policy starts in order to fix the income.

The plan offers waiting periods of back to day one (after three days off work), 1, 4, 8, 13, 26 and 52 weeks. There are no standard exclusions but personal exclusions may be applied when the plan is underwritten.

Premiums are not level, but instead rise every year, although the actual premium rates are guaranteed. Smokers pay 35% higher premiums than non-smokers.

Premium rates depend on starting age and finishing age as well as deferred period and smoking status. Applicants below age 55 can complete a full application form or instead a shorter form with a follow-up tele-interview. Age at entry must be between 16 and 59.

Comment: *The big new idea here is being able to fix an element of the insured benefit (or in some cases the whole benefit). Exeter has gone further though by being one of the first to offer unisex rates and by making other improvements to the plan too. It adds up to a very strong package, although some of the ideas will quickly be followed by others.*

Product design points: *One of the problem areas for IP has always been that it is effectively underwritten twice—once at outset (when income is not usually checked at all) and then when a claim is made (although it is may be only income and employment that are checked). If the customer's income has fallen—even temporarily—their benefit is likely to be cut back in proportion to their actual vs. declared income. Moreover, the fact that they have been effectively paying for cover they don't have, is simply ignored by the insurer (is that TCF?).*

Exeter's solution is to allow customers to fix up to half their income. Like many good ideas, it's brilliantly simple and builds on what the industry already does elsewhere—someone who has housekeeper's IP cover does not have to prove their income (they may not have any) when a claim is made.

The risk to the insurer increases but, modern proactive claims management effectively limits the risk. Is 50% the absolute limit? No, but going higher will require a friendly reinsurer and some increase in risk.

But, at a stroke, one of the major downsides of IP—the uncertainty a claim will be paid in full—disappears, or at least is reduced, although customers must still be working immediately before their illness or disability. One concern is that advisers may now move towards a maximum benefit of 50% rather than any higher figure available. Even if they do, that should create a

market for top-up cover—so hypothecating the risks.

Plus points: *Ability to fix income; unisex rates; max 65% benefit, and other improvements.*

Not so plus points: *Some smallprint on the ability to fix and unisex rates mean males pay (relatively) more relative to the actual risk. Premiums go up each year. Low risk occs only.*

Website: www.exeterfamily.co.uk.

Rating (max 5): Innovation: 4.7. Overall: 4.25.

UK Healthcare Corporate Health Cash Plan

UK Healthcare is part of the **Bolton & District Hospital Saturday Council**, which traces its roots back to 1813, making it one of the oldest health cash providers in the UK. As is usual, this plan's counselling helpline is provided by a third party provider (**Europ Assistance**) and the customer discounts by **Incorpore**.

The plan itself is a corporate health cash plan and it offers a choice of five benefit/premium levels, with premiums ranging from £1 to £7.50 a week (or £4.33 to £32.50 a month).

The main benefits at the lowest (Level 1, costing £1 a week) and highest (Level 5, costing £7.50 a week) levels of the plans are as follows:

Benefit	Level 1	Level 5
Dental	£60	£275
Dental accidents	£200	£1,000
Optical	£60	£275
Wellbeing (physiotherapy; osteopathy; chiropractic; acupuncture)	£150	£750
Specialist consultations	£200	£600
Health screening	£100	£300
Complementary therapies (homeopathy; reflexology; aromatherapy)	£50	£250
Chiroprody	£20	£200
Prescriptions maximum each year	1	5
Hospital in-patient per night up to 28 nights a year	£10	£50
Hospital parental stay up to 12 nights	£10	£50
Day case up to 5 days, per day	£10	£50

Plans include a confidential counselling helpline, and discounted gym membership (with discounts on spas, holidays, theme parks and other attractions also available) and up to 28 days a year worldwide cover.

Minimum group size is 50. Children's cover is included free, with children's benefits being set at half those of an adult. To join, employees must be aged 18 to 70 and all pre-existing conditions (PECs) are excluded. Cover levels can be changed up to once every two years only and premiums and benefits may be changed from time to time at UK Healthcare's discretion. A waiting period of up to 13 weeks can apply for non-company paid schemes.

Comment: *A solid set of benefits and a range of premiums from just £1 a week. There aren't many providers that can claim to be three times the age of the NHS and Welfare State either. However, is the package enough to differentiate UK Healthcare from other leading health cash plan providers?*

Product design points: *Offering cover from just £1 a week would seem daft to most product providers, but it has*

now become the norm for many health cash plans. So, are cash plans the **Poundland** of the protection insurance industry?

In short, no. Such low ticket prices are there to appeal to businesses (in fact, the majority of all businesses if you look at the numbers) who provide no insured health benefits at all for their employees. Even for £1 a week, plans still provide benefits that will pay out every year (in most cases, often more than once a year) and helplines alone help employers meet their duty of care. And what business cannot really afford an extra fifty quid a year or so to tick so many boxes?

The challenge for providers (and intermediaries) is to get firms to trade up from the minimum to a more profitable premium level. That's an area the protection industry as a whole does not have a great track record on. But, both cross selling and up-selling can be very valuable strategies, albeit they take time and effort, require skill and experience and a degree of dedication to get right. But, given how hard it is to attract new customers (in any business, not just protection insurance), every marketing tome will tell you that investing in keeping your existing customers pays better dividends than just focusing on attracting new ones.

If you want proof, just tell your mobile phone company you're thinking of switching provider and see how hard they try to keep you—and to sell you a 'better', more expensive, deal...

Plus points: Good range of low cost benefits. Very long-established provider, albeit now trading under a name that should have more national appeal and be easier to remember.

Not so plus points: PECs not covered; waiting periods (in some cases); minimum size 50 lives. The plan needs more to differentiate UK Healthcare above other good, well-established providers.

Website: www.ukhealthcare.co.uk.

Rating (max 5): Innovation: 2.5. Overall: 3.5.

Unum Classic Group Income Protection Foundation Cover

Unum's new plan is described as a foundation level of income protection cover and fits in with its new TV advertising campaign that promotes IP as a back-up plan.

This variant on Unum's existing Classic GIP is aimed at employers who either have not been able to consider GIP for their workforce due to cost or who have GIP, but only for the top tier of their workforce.

The plan offers up to 60% replacement income with no offset for State benefits. Benefit runs to retirement rather than having a limited payment term because, Unum says, 30-35% of its IP claimants cannot perform any suited

activity and will never return to work. It adds though that exposure to its rehabilitation programme will ensure that the majority of claimants can return to their own occupation within two years.

Policy Terminal Age is 65 or to State pension age. The plan uses Unum's 'Definition B'—that is, the plan pays out where the employee is unable to perform their current occupation for 24 months and a suitable and gainful occupation thereafter. In other words, the industry Blue Riband standard of 'own occupation' applies for the first two years only. After that, if the customer cannot return to their old job, they will be expected to take up a suitable job.

Arguably, that is a good compromise between wanting the most generous cover and the most affordable cost.

The plan also includes the option for Unum to pay the benefit to the employee direct (rather than to the employer) if a return to work is not possible, so allowing both parties to move forward once duty of care obligations have been met. Unum's vocational rehabilitation service is included on all plans to help employees back to work, as is the Unum LifeWorks 24/7 employee and employer assistance programme.

Comment: This is a useful addition to Unum's GIP range and offers an alternative to the normal 'budget' option of selecting a shorter benefit payment period. Helpfully, Unum has set out who this arrangement should most appeal to, but also offers other variants if this option does not suit for any reason.

Unum perhaps risks having too many GIP solutions but, in practice, looks to be avoiding that both by clear labelling and by giving helpful advice on which benefits to use when.

Product design points: The trend on IP has been towards short benefit payment terms (typically 2-5 years) but, as this plan shows, there is still a case to be made for having much longer benefit periods without breaking the bank.

Although a minority of IP claimants will still not be able to do suitable work (as they might see it) two years after they stopped working, increasingly, they will find themselves under pressure to do some work. Insured employees can also expect considerable help to rebuild their lives and this option is an interesting compromise between needing to keep costs low, while also maximising the potential long term benefits for those that need it most.

Plus points: Compromise option providing good rather than best long term protection. Adds to an already strong portfolio of GIP solutions from the market leader.

Not so plus points: The disability definition effectively worsens after a claim has been running for two years

Website: www.unum.co.uk.

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

What is the story of rubber gloves?

Forgive our deviation this month (sorry about the double entendre...) but we are indebted to freelance writer and author Wendy Moore for her fascinating article in the *BMJ* on 20 September about how rubber surgical gloves came into being. Here's a flavour, but see www.bmj.com for the full article.

Ms Moore writes that Pasteur proved his germ theory in 1857 and Lister pioneered antiseptic procedures in 1865, but surgeons continued to operate with blood encrusted bare hands for more than another two decades.

US surgeon William Stewart Halsted (1852-1922) was an early adopter of Lister's antiseptic regime and an enthusiastic pioneer of anaesthesia. But his self-experimental zeal nearly finished his career when he became addicted to cocaine and spent a year in a sanatorium cured of his habit, but addicted to morphine for life. He was then offered the role of chief surgeon at the Johns Hopkins Medical School in Baltimore when it opened in 1889. When head nurse Caroline Hampton complained that the mercuric chloride she washed her hands with gave her a rash, Halsted persuaded the Goodyear Rubber Company to make her two pairs of thin rubber gloves. The grateful Miss Hampton married the perfectionist surgeon in 1890.

2 stage route to back treatment

UK researchers at **Keele University** have designed and tested a two stage process that aims to match patients with non-specific back pain with treatments, based on a randomised trial of 851 general practice patients.

Patients are first screened for low, medium or high risk of long term disability, with medium and high risk patients referred for standardised physiotherapy. The high risk group have extra psychological support and the low risk group are offered a single session with a physiotherapist that includes information, education and encouragement to return to work.

Using the initial risk assessment before treatment, patients improved more, took less days off work and the strategy saved money. Adults who were risk assessed before treatment improved by 4.3 on a score from 0 to 24, compared to an improvement of 3.3. points for a group treated in line with standard best practice.

Patients were assessed using the previously validated STarT Back screening tool.

For more see: *Lancet* 2011; doi: 10.1016/S0140-6736(11)60937-9.

Life expectancy in HIV up

More than 33m people worldwide are infected with HIV but data suggests that more than 80,000 people are currently living with HIV in the UK, with about 25% of those being unaware of their infection.

As far as life expectancy is concerned, a large cohort study of patients who started HIV treatment between 1996 and 2008 at some of the largest treatment centres in the UK suggests that between 1996-7 and 2006-8, life expectancy of a 20 year old infected with HIV increased from 30 to 46 years.

Decreases in life expectancy are greater in men than in women with researchers estimating that for an average 20 year old man, HIV decreases life expectancy by 18.1 years, while for women the figure is 11.4 years. Data from other countries suggests this may be explained by women starting HIV treatment earlier than men and also women are tested during pregnancy. High volume treatment centres, such as those used in the study, are associated with better outcomes. See: *BMJ* 2011; 343: d6015.

Ductal carcinoma in situ care

Ductal carcinoma in situ (DCIS) accounts for one in five new cases of breast cancer in the US each year and about two thirds of these are oestrogen receptor positive tumours, *BMJ* 2011; 343: d5344 reported on 19 September.

As knowledge of the disease has increased, oncologists have faced an increasingly complex task in diagnosing and treating the cancer the article says.

However, recently published data has extended the knowledge about the usefulness and relative importance of adding radiotherapy to segmental excision.

Adding radiotherapy reduced recurrence of invasive ipsilateral breast tumours by 52%.

Also, by adding tamoxifen to treatment with lumpectomy and radiation, the 15 year cumulative incidence of death was a significant 2.3% lower.

Half of ME patients stop work

A study from the **University of Bristol** has found that over half of patients attending specialist ME (myalgic encephalopathy) services had stopped work because of fatigue related symptoms. The cost in lost productivity represented by the 2,170 patients studied was £49.2m.

BMJ 2011; 343: d5905 reports the UK annual cost would be £102.2m, which far exceeds the NHS spend on the condition for the near 4,500 patients accessing specialist services. Researchers point out that most ME sufferers do not access specialist care.

An assessment of the financial and psychological effect on mothers of children with ME shows, an average £247 loss in monthly income and £206 increase in expenditure, with three quarters of mothers having mental health problems compared to 20% of the general population.

Revision rate double for metal on metal hip replacements

Revision rates for metal on metal hip replacements are double the revision rates for hip replacements using other materials (13.6% for metal on metal and 3.3% to 4.9% for other materials). For resurfacing, the latest revision rate is 11.8% at seven years on average, *BMJ* 2011; 343: d55977 reported on 21 September.

Failure rates varied with the brand used, with the now recalled articular surface replacement (ASR) total hip implant made by **DePuy** giving a 29% replacement rate for patients who received the device six years ago. Metal on metal hip replacements were used in only 5% of procedures since 2010, down from 15% in 2006 and 2007.

Annual mammography may improve breast cancer survival

Breast cancer reoccurs in about a quarter of the UK's 45,000 new cases of the disease each year and a study led by Fiona Gilbert at the **University of Aberdeen** found a strategy of mammography alone every 12-24 months seemed to carry the highest net benefits. At present there are more than 50 different regimens reported with different combinations of start, duration and discharge from surveillance mammography.

Mobile phones: no cancer link

A Danish study of 358,403 mobile phone subscribers over an 18 year period has found no evidence of a raised risk of brain tumours.

Overall, 10,729 central nervous system tumours occurred in the study period 1997-2007. When figures were restricted to people with longest mobile phone use (13 years or more), cancer rates were almost the same in long-term users and non-subscribers of mobile phones.

Researchers warn that a small to moderate increase in risk for subgroups of heavy users or after even longer induction periods than 10-15 years cannot be ruled out. See: www.bmj.com/cgi/doi/10.1136/bmj.d6387.

Comment: An important but not conclusive finding.

Medical briefs:

- An extended follow-up trial has revealed a significant association between vitamin E supplements and prostate cancer. Men who took the supplement for seven years were 17% more likely to develop the cancer researchers found. Around half of all US middle aged men take the supplement with a quarter taking the high dose tested in this trial. See: *JAMA* 2011; 306: 1549-56.

- The risk of serious magnetic interference from MRI scanners for patients with a pacemaker or implantable cardioverter defibrillator may be exaggerated. 438 adults fitted with these devices were put through a scanner, and none came to permanent harm. However it is not yet risk free and doctors should consider safer diagnostic options first. See: *Ann Intern Med* 2011; 155: 415-24.

- An updated version of the *British National Formulary* has been published. For details of *BNF62*, go to the website at <http://bnf.org>.

- A US study has found that just 1.25% of adults over 65 went home the same day after elective percutaneous intervention, although they were no more likely to be readmitted or die than those who stayed overnight. The authors have urged hospitals to consider same day discharge more often. See: *JAMA* 2011; 306: 1461-7.

- A Swedish study has found an overall 4% drop in risk of death for every extra week of gestational age at birth among 674,820 Swedish babies born between 1973 and 1979 who survived to their first birthday. Adults who were born preterm carried a higher risk of death from cardiovascular, respiratory and endocrine diseases and also congenital abnormalities. The legacy for public health is likely to get worse as preterm birth is rising (12% of the US total in 2008). See: *JAMA* 2011; 306: 1233-40.

- A new meta-analysis adds to growing evidence that depression is associated with a higher risk of stroke. Data from 28 cohorts of 317,540 men and women found that adults with depression are 45% more likely to have a stroke than those without depression. In the US that translates into 106 extra strokes a year for every 100,000 adults. Depression could be a modifiable risk factor for an estimated 4% of strokes. See: *JAMA* 2011; 306: 1241-9.

- A small study published online in the journal *Gut* has found two out of six suspicious bacteria species, *Neisseria elongata* and *Streptococcus mitis*, showed up significantly less often in the mouths of patients with pancreatic cancer and levels of *Granulicatella adjacens* were significantly higher than in healthy people. It is not known whether the presence of particular types of bacteria are a cause or effect of pancreatic cancers. See: <http://presssprings.co.uk/gut/october/gut300784.pdf>.

- Although the number of MRSA infections in European hospitals are declining, infections caused by resistant *Escherichia coli* (E coli), are going rapidly in the opposite direction and will soon overtake MRSA as leading cause of drug resistant bacteraemia. See: *BMJ* 2011; 343: d6657.

- The *Lancet* 2011; 378: 1388-95 reported 40% of 649 adult patients in one UK centre given neurosurgery for focal epilepsy since 1990 had no further seizures after surgery. A further 11% had simple partial seizures only.

- 625,000 women worldwide died of breast or cervical cancer in 2010, the *BMJ* reported on 21 September.

Political briefs:

- A panel of doctors and economists in India asked by the Indian government to come up with strategies to implement universal healthcare, have proposed free health services to be financed mainly through tax revenues, *BMJ* 2011; 343: d6774 reported on 19 October. It is thought an increased health spend to 3% of gross domestic product could largely be achieved through reallocation of priorities and resources. A basket of free health services; preventative and primary, secondary and tertiary, with a mix that is likely to vary between states is envisaged. Insurance and other contributory schemes introduced over the past four years appear not to be working as they still leave patients with high levels of out of pocket expenses.

- Andrew Dilnot told a fringe meeting at the Conservative Party Conference that the Government has a "huge moral obligation" to include his long term care commission's recommendations on contributions to social care costs, *Money Marketing* reported on 6 October. The Dilnot Commission's report published in July called for a lifetime cap on an individual's contribution to social care costs, with a £35,000 recommended figure. It is thought to be far from certain the Government will include the proposals in a social care White Paper due to be published in the spring of next year. Mr Dilnot told the meeting it may be two years before any further progress is made in Parliament and that the issue was whether reform started under this or the next Government.

- Trade union **Unison** is taking legal action against the **Nursing and Midwifery Council (NMC)** over claims that nurses who strike could be in breach of its code of conduct, *Nursing Times* reported on 11 October. A day of action is planned on 30 November in protest at pension reform. NMC CEO and registrar Dickon Weir-Hughes said: "In considering how to respond to calls for industrial action, nurses and midwives must ensure that their actions do not jeopardise good standards of care."

- Online research in the *Journal of Clinical Pathology* says UK doctors will not put smoking as a cause of death on certificates for fear of stigmatising the deceased, leading to flaws in statistical data on the death toll from smoking. Yet UK doctors are willing to cite alcohol as a direct or contributory cause of death. The authors say this may be because alcohol use is more acceptable culturally in the UK. See: <http://presssprings.co.uk/jcp/october/jcp200299.pdf>.

- Half of all English NHS hospitals are failing to provide basic care to older people, the **Care Quality Commission** reported in October.

- The **Royal Marsden NHS Foundation Trust** has said that it plans to grow its private patient income by 20% this year. Last year £41.5m (26%) of its income came from private patients.

- A **BMA** survey of every GP in the UK conducted in April found that 88% of GPs said the intensity of their consultations and 84% the complexity of their consultations had increase in the last five years. Three quarters (75%) of GPs in England do not agree with the proposal to link practice income to the performance of their commissioning group. Seven in ten are concerned about conflicts of interest inherent in reforms and 85% do not believe practice boundaries should be abolished. See: www.bma.org.uk/gpnationalsurvey.

Unemployment continues up

Unemployment rose from 2.51m in May-July to 2.57m in June-August, according to the latest *Labour market statistics* bulletins, released by the **ONS** on 12 October. This is the highest figure since the three months to October 1994.

During June-August, employment fell from 29.169m to 29.10m. 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, fell from 107.271 to 107.017. 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 (JSA) claimants rose from 1.58m in August to 1.60m in September. The latest unemployment rate is now 8.1%. The unemployment rate for economically active 16-24 year olds rose 1.6% over the quarter to 21.3%. This compares to an inactivity rate of 23.3% for all 16-64 year olds. The unemployment rate for 16-24 year olds is the highest since comparable records began in 1992.

The number of people over 65 and in employment fell by 74,000 over the quarter to 822,000.

In the three months to August 2011 the number of people who had become redundant was 150,000, up by 6,000 over the previous quarter. Earnings in the three month period to end August (including bonuses) remained at 2.8% higher than a year before.

On 18 October the ONS announced that in September the Retail Prices Index (RPI) rose from 5.2% to 5.6% compared to a year before, while the Government's preferred Consumer Prices Index (CPI) was up from 4.5% to 5.2% in September. This compares to an annual inflation target of 2.0%.

Comment: *The disappointing trend continues.*

Hospital RTT waiting times fall

The median Referral to Treatment (RTT) wait for NHS hospital admission in England fell from 8.7 weeks in July to 8.1 weeks in August according to a **Department of Health** Statistical Press Notice released on 13 October. For non-admitted patients the median wait rose from 4.0 weeks to 4.1 weeks in August. The 95th percentile time wait for patients entering an RTT pathway rose from 22.4 weeks to 22.6 weeks for admitted patients and fell from 15.8 weeks to 15.7 weeks for non-admitted patients.

The number of admitted patients meeting the 18 week target fell from 90.6% to 90.4%.

ISTCs perform well says report

A study published on 18 October has shown that concerns over the quality of care given in independent sector treatment centres (ISTCs) are largely unfounded.

Patients undergoing surgery in ISTCs tended to be healthier than those treated in NHS centres, have less severe symptoms, were more affluent and had slightly better outcomes for joint replacement than those treated in NHS centres. There were no significant differences in outcomes after surgery for hernia repair and varicose veins. See: www.bmj.com/cgi/doi/10.1136/bmj.d6404.

GPs suggests private treatment

The **Haxby and Wiggington Health Centre**, a GP surgery in Yorkshire, is being questioned by its local primary care trust after it wrote to patients giving details of alternative providers of treatments no longer available on the NHS, *BMJ* 2011; 343: d6463 reported on 6 October.

The letters proposed patients consider having their procedures, such as skin tag removal, done privately by one of four local service providers, one of which was a company owned by the practice. Some bodies such as the **BMA** and the **Royal College of General Practitioners** have raised concerns about what they see as a blurring of the lines between NHS and private health care.

Hospitals forced to change

A report published on 14 September suggests that 40 NHS hospitals will have to change or close if the Government wishes to avoid a £5bn bail-out by 2013. Report author Professor Paul Corrigan's key points are that Government bail-outs should stop as they undermine the case for change. There should be better commissioning to keep patients out of acute hospitals when they can be treated elsewhere. Intensifying market pressures will force NHS modernisation and the Government must set out a failure regime for hospitals. *The hospital is dead, long live the hospital* is available at www.reform.co.uk.

Prioritising high risk surgery

Death rates for general surgery are up to three times those for cardiac surgery, where there has been a much greater focus on outcomes, says a new report from the **Royal College of Surgeons in England**. It recommends that hospitals prioritise high risk emergency cases over elective cases.

The report also recommends all general surgical patients should undergo risk assessment and tailored management. High risk patients should be under direct consultant supervision with routine admission to critical care after surgery. Post-operative care should be improved and hospitals should have routine audits of emergency cases to improve outcomes. *The Higher General Surgical Patient: Towards Improved Care for a Forgotten Group* is available from: www.rcseng.ac.uk/publications/docs/higher_risk_surgical_patient.

High cost of cancer treatment does not reflect benefits

A team of 37 specialists assembled by *The Lancet* says care of patients with cancer in rich countries has become 'a culture of excess', *Lancet Oncology* reported in September.

The commission said 'We overdiagnose, over-treat and overpromise', adding that expensive new drugs contribute only modest benefits while imposing huge cost burdens and that cancer surgery, with the increasing use of robot assisted surgery, is also going the same way. Drug companies refused to take part in the commission's work, with the reticence to take part coming from legal teams rather than clinicians it was reported.

ABI in-force long term protection business

One way long term insurance is different from short term (general) insurance is that while the latter focuses on the total amount of business on the books, the former's focus is on acquiring new business. The stats reflect that.

It can be difficult to know exactly how much long term protection business is actually in-force. However, the **ABI (Association of British Insurers)** publishes its own data and figures for 2010 are now available.

Table 1 shows how the number of term policies in-force has risen by 40.3% since 2001, while in-force premiums have risen by 307%. However, the 2001 premium figure looks to be suspiciously low. Even so, in-force premiums show a big increase over the past decade, despite a widespread fear that much new business has been churning of existing plans.

The percentage of mortgage-linked plans has however fallen from over half (51.5%) of the total in 2001 to less than two in five (39.7%) in 2010.

Despite the ABI's best endeavours, the figures may not be fully representative. For example, some product providers did not keep records of every policy that is mortgage-related, so we would expect some mortgage-linked cases not to be recorded as such and vice versa.

Table 1. Regular premium term assurance

Year	Policies 000s	Mortgage %	Prem income £m
2001	9,048	51.5	1,037
2002	9,991	53.5	2,672
2003	11,428	53.2	3,938
2004	11,778	52.6	3,798
2005	10,670	48.3	3,350
2006	11,734	43.2	3,712
2007	11,981	43.0	3,930
2008	12,123	43.6	4,042
2009	11,627	41.7	3,868
2010	12,698	39.7	4,223

Table 2 shows in-force whole of life policies. Only in the latest year has guaranteed acceptance (grey or funeral plans or over 50s plans) been recorded separately, so we would expect the proportion of policies in force in that segment to increase.

Table 2. Regular premium whole of life

Year	Policies 000s	Gtd accep %	Prem income £m
2001	5,301	-	1,580
2002	4,726	-	1,357
2003	4,650	-	1,351
2004	4,413	-	1,293
2005	4,332	-	1,341
2006	5,321	-	1,375
2007	4,665	-	1,357
2008	4,434	-	1,225
2009	5,493	-	1,138
2010	6,684	12.3%*	1,201

* Guaranteed acceptance whole life policies made up 12.3% of policies by volume, and by 11.1% of in-force premiums.

It is clear too that while whole of life policy numbers have shown a healthy trend, the same is not true for premium income, where premiums have fallen by 24% since 2001.

Guaranteed acceptance policies are typically written with much lower premiums than other whole life plans have, so we cannot expect any sharp increase in overall premiums any time soon.

Table 3 shows in-force regular premium income protection policies and this table goes back to 2000.

This figures show policy volumes having fallen by 6.7% since 2000, yet premiums have increased by 25.8% and in-force benefits by 27.4%.

The table shows a much more encouraging trend for IP than just looking at the new business figures alone. There, IP sales are shown as still being 4.9% lower (in the second quarter of 2011 in terms of new policies sold) than in the first quarter of 2000 and, in 2010 as a whole, IP sales were 38.9% lower than in the full year of 2000.

This suggests that IP has enjoyed stronger persistency levels than some other products have. However, there is an additional caveat to add on IP and that is that the numbers may include some short term ASU (accident, sickness and unemployment) policies too, as some of these are also recorded as being 'income protection'.

Table 3. Regular premium income protection

Year	Policies 000s	Prem inc £m	Benefits pa £m
2000	1,480	361	12,808
2001	1,537	378	14,050
2002	1,825	447	14,852
2003	1,488	456	13,597
2004	1,290	408	12,319
2005	1,414	473	14,183
2006	1,418	473	15,460
2007	1,365	483	15,294
2008	1,345	504	16,228
2009	1,223	426	15,277
2010	1,381	454	16,315

Given the various caveats, are these data worth noting? The answer to that is a firm 'yes'. In an industry where numbers dominate, every set of data has a value. Not least, we can try to discern trends or back up our pet theories by better understanding how our markets work.

Can we do better?

Given the importance of long term protection insurance to millions of families and businesses in the UK we have long argued (and will continue to do so!) for better quality data in order that every decision maker—whether an insurance giant CEO or a micro business intermediary—can make the best decisions for their business or organisation.

One key to getting better data is for every data producer to redouble its efforts to provide accurate data. The ABI team does an excellent job in our view, but its data is only as good as the raw input it receives from its insurer members.

So, if such work is part of your team's responsibilities, we would ask everyone to look again to ensure that their data is as correct as it can be—always.

Our thanks to the ABI, and we hope you find such analyses useful and our comments helpful.

People news

- **AMII.** New Executive Committee member Graeme Godfrey of **Best Go Private** has been appointed as broker liaison. Andrew Tripp continues as chairman at the PMI intermediary trade body.

- **BHSF.** Samantha Fennell has been appointed assistant company secretary and Shelley Tromans has joined as marketing manager.

- **Jelf Employee Benefits.** Claire Parrott has been appointed operations manager for its healthcare team. She was previously international claims manager at **William Russell** and before that, resources development manager at **Standard Life Healthcare**.

- **Lloyd's Channel Syndicate 2015** has appointed Ian Fordham as head of its accident and health division. He has over 40 years' experience in the London Market and will be joined in due course by another experienced underwriter as The Channel Syndicate (which has an initial stamp capacity of £75m) builds its portfolio.

- **NFU Mutual.** Current vice chairman Richard Percy takes over as chairman from Sir Don Curry from January 2012.

- **PMI Health Group.** Jane Knight has joined as account director, from **Jelf Employee Benefits**, as part of the group's expansion into large corporate markets in the South of England.

- **Simplyhealth.** Tim Brooke has been appointed a non-executive director. He is MD of global consulting firm **Protiviti Ltd**.

e-Protection Review T&C

Our regular training and competence (T&C) section now consists of five multiple choice questions that test your knowledge of what is happening in the health and protection insurance world. Each question can be answered from reading and understanding this issue of e-PR.

All you have to do is answer each question, check your answers against the newsletter (or log on to www.protectionreview.co.uk) and then record your answers. You can do this for yourself and also for those who work

for or with you if they read e-PR. This will enable you, over time, to build up additional evidence of your training and competence. This issue's questions are:

1. Which socio-economic group perceives itself in best health? a) Managerial/professional, b) Intermediate, c) Routine and manual or d) there are no differences.

2. What is the new default retirement age? a) 60, b) 65, c) 67 or d) there is none.

3. The latest medical research on mobile phones and brain tumours shows? a) a clear link, b) a possible link, c) some link for younger people or d) no link.

4. The leading cause of death of males aged 5-14 is? a) cancer, b) suicide, c) accidents or d) coronaries.

5. Scottish Widows says business are more likely to insure what than their key people? a) company cars, b) computers, c) photocopiers or d) mobile phones.

Protection Review news

- The second of our pilot generic protection training programmes for intermediaries took place at **Swiss Re's** offices in London on 13 October. Feedback from delegates was outstanding, with very high scores being recorded for the format and presentations. Initial sessions have been run by Kevin Carr, ably supported by leading IFAs and underwriters, and the real key is their independence and quality. We are now in discussion with insurers and reinsurers to build on the programme going forward.

- Don't forget next year's annual conference (daytime) and dinner (evening) and *Protection Review* book launch will again be at **The Landmark Hotel** in London's Marylebone on 11 July (don't worry, it doesn't clash with the Olympics).

- **The Syndicate**, our new and innovative research partnership with **Hannover Life Re (UK)** formally launched on 11 October and we are very excited by the results from the first wave of research. If you want to know the full story, you really have to join!

- At Protection Review we are passionate about protection—and that includes the whole market from PMI and cash plans, to life, CI, IP and long term care and a whole lot in between too.

For more news see www.protectionreview.co.uk.

About e-Protection Review

e-Protection Review is a subscriber-only PDF publication and is published ten times a year, on the 28th day of the month prior to that issue's date, every month except at the end of August and December. It is now free to download to those who register with www.protectionreview.co.uk.

A limited range of partnership opportunities now exist and to find out more, please contact Andy Couchman at Protection Review Limited, Bank House, Great Rissington, Cheltenham, Gloucestershire, GL54 2LP. Or phone 01451 821982, fax 01451 821972 or e-mail andy@andycouchman.com. Or contact Peter Le Beau on 07799 074020 or peter@lebeauvisage.co.uk. Or contact Kevin Carr on 07887 838811 or kevin@kevincarrconsulting.co.uk.

Leading causes of death by age group, England and Wales 2009

- Age 1-4 years. Congenital abnormalities: 73 deaths (combined males and females).
- Age 5-14. Suicide: 952 males and 249 females.
- Age 35-64. Males: coronary heart disease, 7,987 deaths. Females: breast cancer, 3,665 deaths.
- Age 65-79. Coronary heart disease. Males: 15,466 deaths. Females: 7,394 deaths.
- Age 80+. Coronary heart disease. Males: 17,894 deaths. Females: 21,405 deaths.

Comment: Around half a million people, representing less than 1% of the population, died in England and Wales in 2009. The vast majority (almost eight out of ten men and nearly nine out of ten women, dying at age 65 or above.

Source: *Leading causes of death in England and Wales, 2009*, Office for National Statistics, 20 October 2011.

Perceived General Health: by National Statistics Socio-Economic Classification (NS-SEC), April 2010 to March 2011, UK

Health	Man/prof	Interm	Routine
Very good	50.9%	44.5%	40.1%
Good	38.4%	40.9%	41.3%
Fair	8.8%	11.7%	14.2%
Bad	1.5%	2.5%	3.6%
Very bad	0.4%	0.5%	0.8%

Notes: Based on 213,998 respondents.

Comment: Overall, 80% of men and 78% of women perceive themselves to be in good health. However, while 51% of those working in managerial and professional occupations reported the highest level of good health, that figure fell to just 40% for those working in routine and manual occupations. The higher groups also reported the lowest levels of very bad health at just 1.5% compared to over double (3.6%) for the lowest group.

Geographically, people in Wales reported the lowest rate of perceived good health by country, at 75%, while those in the North East reported the poorest rate of good health by region at 74%, compared to 82% in the South East.

The reasons for the variances are complex but include not just relative poverty or even the nature of occupations but factors such as education, diet and lifestyle, smoking status and

family history. Unemployment is also a significant factor in perceived and actual good health. Attitude is a key factor, but one that itself is externally influenced and hard to change.

Both this and the following table are ONS experimental statistics, but we think very useful additions.

Source: *Integrated Household Survey April 2010 to March 2011: Experimental Statistics*, ONS, 28 September 2011.

Smoking Prevalence by Socio-Economic Classification (NS-SEC), April 2010-Mar 2011, UK

Group	Current	Ex-smkr	Never
Managerial/professional	14.9%	34.9%	50.2%
Intermediate	20.4%	32.4%	47.2%
Routine and manual	30.0%	28.9%	41.1%

Comment: Data based on 203,494 respondents. The results show that smoker status does vary by occupation group. It is interesting to note that, except for routine and manual occupations, there are now more ex-smokers than current smokers while, overall, a majority either do or have smoked. How does this compare to what your insurance application forms say?...

Source: *Integrated Household Survey April 2010 to March 2011: Experimental Statistics*, ONS, 28 September 2011.

Insurance Age Top 50 brokers in personal lines 2010

GWP band	Name (alphabetically)
£1bn+	Acromas
£750m-£999.99m	Swinton Group
£500m-£749.99m	The BGL Group
£250m-£499.99m	Hastings Insurance Services
	Kwik-fit Financial Services
	RIAS
£150m-£249.99m	Capita Insurance Distribution
	Endsleigh Insurance Services
£100m-£149.99m	Ageas Insurance Solutions
	Brightside Group
	Towergate Insurance

Key: GWP: gross written premiums. Note: excludes those groups that asked to be wholly or partly excluded or who did not supply details.

Source: *Top 50 Brokers in Personal Lines*, Insurance Age/Cornell Consulting, 2011, report sponsored by Marketstudy Group

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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