

e-Protection Review

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

Reform of sickness absence system proposed by Frost/Black report

A raft of reforms aimed at improving the services provided to employers and employees to help workers back to work if illness or disability strikes have been recommended by the long awaited report into sickness absence by Dame Carol Black and David Frost CBE.

The report starts with the premise that work is good for health and, in many cases, can aide recovery. Yet, each year around 11m employees take sick leave and while most people return to work, around 300,000 go on to claim health-related benefits. This costs the taxpayer £13bn a year and the whole country some £15bn in lost economic output.

Among the report's 11 main recommendations are:

1. The Government should fund a new Independent Assessment Service (IAS). This would provide an in-depth assessment of an individual's physical and/or mental function and give advice on how an individual could be supported to get back to work. The service would kick in around four weeks after absence begins.

2. Fit note guidance should avoid judgments based on job-specific assessments.

3. Knowledge and awareness among healthcare professionals should be improved.

4. Employer expenditure on helping employees back to work should get tax relief.

5. Tax relief on EAPs (employee assistance programmes) should be maintained.

6. A new job brokering service should be introduced to help long term sick employees find new work before they fall onto the benefits system.

The report, which focuses on the low paid, also includes a number of detailed recommendations to improve administrative processes and to further research how employees get into the benefits system having had no sick pay from their employer.

The review found that a significant minority of people could work, but not in their current job. Currently, this group gets very little help unless they leave work completely. Too many claimants are also directed towards Employment and Support Allowance (ESA) but subsequently fail to obtain the benefit because they do not qualify for it. The assessment phase of ESA should therefore be scrapped and would save taxpayers £100m a year.

The report aims to create 'a swifter and more sensible journey from work to a period of support and back to work again for the vast majority of (Continued on Page 2).

Quotes of the month:

"The NHS faces a perfect storm over the next 20 years." Harpal Kumar, CEO of Cancer Research UK, talking about the expected rise in cancer cases, 1 November.

'The short to medium term road to economic recovery now looks fraught with pitfalls and confidence is fragile. The message that there will be more challenges ahead is getting through to all.' Swiss Re The Insurance Report 2011, November 2011.

"The UK market has been declining in the past few years but that is turning for protection. The momentum will continue and turn for the positive." Herschel Mayers, CEO, PruProtect, November 2011.

Have a Happy Christmas and a great and prosperous New Year—from all the team at Protection Review.



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Key statistics:

- NHS RTT median wait England September 2011: 8.8 weeks (See Page 11)
- e-Protection Review Long Term Protection Sales Index: 123.3 (Quarter 3, 2011, compared to base 100 in Quarter 1, 2000).
- e-Protection Review Employment Index: 106.906 (To end September 2011, compared to January 2000, see Page 11).

(Continued from Page 1) people who can return to work’.

The report’s authors believe that a reformed system could save £400m a year for employers and up to £300m a year for the State, and boost economic output by up to £1.4bn. The report follows Dame Carol Black’s 2008 report *Working for a Healthier Tomorrow*.

People with long term health problems (who make up a quarter of the employed population) have only a 59% employment rate, compared to 77% for those without a health condition. For those with a mental health problem the rate is even lower—20-35% depending on the condition. A growing population (and especially a growing retired population) makes it imperative that those of working age are given every opportunity to contribute to the UK’s workforce. In the past, too many people have simply been written off as unproductive members of society by a system that appeared to recognise what people could not do rather than what they could.

The introduction of the Fit Note to replace the previous Sick Note has helped changed attitudes and pioneers such as researchers Waddell and Burton and **Cardiff University’s** Professor Sir Mansel Aylward (keynote speaker at the 2010 Protection Review Conference) have helped change attitudes in those in the medical profession.

Even so, too many GPs and other doctors have seen themselves as their patient’s advocate and supported time off work when, with the right support and help, the patient could be doing productive work that would not only benefit them financially but also generally be better for their health.

‘The doctors have told me I’ll never work again’ was almost a badge of honour for many who saw themselves as brave victims of illness or disability.

The reality however is that for only a small number of people (5-10%), work may contribute to poor health. Many of the rest will however need help to get back to work and that is where the system typically lets them down.

For example, someone may need to return to the workplace gradually, or may need to work part-time or require changes in their working environment. Such help may be beyond a GPs expertise and in any event few GPs have the time to provide such help. Employers too may take a short-term view and fail to see such help as an investment. Instead, it may be easier and sometimes cheaper to simply ‘let someone go’ and look to replace them.

The insurance sector—and particularly income protection providers—have increasingly provided more services to help people back to work. These include EAPs and

financial and other support for rehabilitation services and other therapies. Third party services by organisations such as **Red Arc Assured** have also supported people, while some IP insurers have even paid for private medical treatment where that would facilitate a return to work and the individual is not covered by private medical insurance.

The report suggests that currently around 140m working days are lost every year to sickness absence (less than the 190m days suggested by the annual **CBI** survey, which the report suggests may reflect the survey bias towards larger firms). Even though the long term trend has been downwards (from seven days per employee in 1993 to around five days now) thanks largely to better interventions, the figure is still too high.

The Government’s new Fit Note came into force in 2010 and, although generally well received, is now in need of further change if it is to achieve its full potential. In particular, an estimated 85% of those off sick for a week or more are currently being certified as entirely incapable of work. That does not reflect the reality and is further example of how the medical profession is still reluctant to engage in getting people back to work as well as it might.

The report also recognises the complex nature of sickness absence in smaller firms and recommends that record keeping obligations under Statutory Sick Pay (SSP) and the Percentage Threshold Scheme (PTS), which com-

pensates firms for higher than average sickness absence (and so may provide a perverse incentive), should both be abolished.

Controversially, the report suggests that for 10-20% of people off work, a change of employer (particularly if the health condition is stress-related) may be the best solution.

Disappointingly, there is little mention of insurance in the main report. However, its Appendix A does examine an insurance-based approach to reducing sickness absence.

This notes ‘while those on higher incomes potentially have much to gain from IP insurance, the overall use of insurance to improve return

to work appears to be a more limited solution.’

It adds that the insurance market for IP is well established but: ‘we do not think there is a strong case for the State to drive greater coverage.’

Part of the reason is that adding IP would increase employer wage bills by 1.5-5%, compared to around 1% for meeting SSP and occupational sick pay costs. Partly too, IP would affect the private sector but not the public.

IP covers around 11% of employees at a cost of around 1.5% of an employer’s wage bill, a figure that could be higher in areas with low penetration currently.

The 112 page report *Health at work—an independent review of sickness absence* is published by **TSO** and can be downloaded from the www.dwp.gov.uk website.

Who are Dame Carol Black and David Frost CBE?

Professor Dame Carol Black DBE, MD, FRCP, MACP, FMedSci, is the UK National Director for Health and Work, Chairman of the Nuffield Trust, Chairman of the Governance Board of the new Centre for Workforce Intelligence, President of the British Lung Foundation, and Pro-Chancellor of the University of Bristol.

She is a past-president of the Royal College of Physicians and past chairman of the Academy of Medical Royal Colleges. The Centre she established at the Royal Free Hospital, London is internationally renowned in the field of connective tissue diseases. Since the early-1990s, Dame Carol has worked at board level in a number of organisations, including the Royal Free Hospital Hampstead NHS Trust, the Health Foundation, the NHS Institute for Innovation and Improvement, and the Imperial College Healthcare Charity, and recently chaired the UK Health Honours Committee. In 2008 she produced the *Working for a Healthier Tomorrow* report for the Government. Dame Carol was the guest speaker at the 2011 Protection Review dinner in London.

David Frost was Director General of the British Chambers of Commerce from January 2003 to September 2011. Prior to this he was Chief Executive of Coventry and Warwickshire Chamber of Commerce and Business Link. He was awarded the CBE in 2011.

Industry needs to do more to raise profile of protection insurance: Swiss Re Insurance Report

The savings and protection insurance industries need to do more to put their products higher on consumers' agenda and improve access, according to **Swiss Re's** 2011 *Insurance Report*, which was launched on 15 November.

The 80 page report is based on research among 1,000 UK consumers and over 500 employers, along with interviews with leading industry figures.

Subtitled *Facing life's responsibilities*, the report argues that closing the well-established protection and savings gaps will require more than just the application of pure logic and reason.

In its conclusions it says: 'To help consumers close their personal gaps successfully we will need to employ a better understanding of all consumer types. We will need to apply strong retail selling techniques, skilfully use the principles of behavioural economics and make the most of encouragement or endorsement from government. Furthermore, we will need to increase confidence and trust sufficiently, so that consumers are prepared to make a short term financial sacrifice because they are aware that this is the right thing to do.'

Swiss Re dubbed today's seemingly never-ending circle of economic uncertainty as being an O-shaped recession. Asking about later life, it found 32% of consumers said they 'can't afford to put anything away at the moment', compared to 10% in 2009.

Consumers' biggest worries or concerns for the future by age group were: at age 21-35: losing income (42% of respondents); at age 35-55: maintaining living standard when retired (44%); at age 56-70: being unable to afford long term care (47%).

Although not now published every year (the previous report came out in December 2009), Swiss Re's Insurance Reports are always thought-provoking and well-researched. This year's report talks of consumers being pulled in various directions—the Government needs them to reduce debt but also to spend. As a result, consumer attitudes are cautious and the purchase of financial products is either far down the 'to do list' or not there at all.

Yet many people are now beginning to realise that there may be no hiding from their responsibilities in the longer term. The report says: 'The winds of change are blowing in a favourable direction. We need to harness the opportunity by responding to consumer requests to simplify products, erase jargon, improve processes, deliver on promises and engage at a time and a place which suits the consumer—using media and in a language that the consumer understands.'

For more see www.swissre.com.

Comment: *There is one example where the industry has developed a solution that appears to meet consumers' needs (and worries) recently and that is guaranteed acceptance whole of life products. Setting aside the poor value such policies can provide over the very long term, they are simple (no underwriting or jargon), easy to buy and often sold through daytime TV ads, perhaps with celebrity endorsement too. £1 a week employer-paid health cash plans also meet many of these requirements. Now, more is needed elsewhere too.*

CII launches prot qualification

The **CII (Chartered Insurance Institute)** has unveiled a new qualification for advisers in the health and protection insurance sector.

Launched at the **AMII (Association of Medical Insurance Intermediaries)** autumn conference in early November, the new qualification is expected to be launched in the first quarter of 2012. The *Cert CII (Health and Protection)* designation has a compulsory element, IF1 which covers the fundamentals of insurance. Candidates then have to pass two exams from a menu of four:

- IF7: Healthcare Insurance Products (which AMII worked with the CII on developing).
- P64: Private Medical Insurance Practice. This new diploma level exam will replace the existing diploma level 790 unit.
- R05: Financial Protection.
- GR1: Group risk (which **GRiD** worked with the CII on developing).

The new qualification is below the Level 4 qualifications that IFAs will have to pass from 2013, but fills an important gap. Until now, health and protection insurance has often fallen uncomfortably between the CII's general insurance and financial services exams and qualifications.

In future the industry will have a common exam that can meet all requirements, whether the individual is a generalist or specialises in PMI (when they may sit IF7 and P64), or group risk (GR1 and whichever of the other exams they feel is most appropriate) while an IFA may sit IF7 and R05. Candidates can then use their passes in all of the exams towards higher qualifications, taking them up to Associateship and Fellowship qualifications and Chartered Title status of the CII or its financial services arm the **PFS (Personal Finance Society)**.

Protection Review is involved in the new exams. Andy Couchman authored IF7 and has been commissioned to write the new P64 coursebook and Peter Le Beau authored R05. Both are also Fellows of the CII and Chartered Insurance Practitioners.

However, disappointment has been expressed that there was not more consultation before the qualification was launched and some have questioned whether a full Level 4 protection qualification would be even better.

New ABI PMI SoBP launched

The **ABI (Association of British Insurers)** has launched a new *Statement of Best Practice for Sales of Individual and Group Private Medical Insurance*.

The new SoBP replaces one launched in October 2007 and introduces new safeguards and best practice. It follows publication of a draft SoBP in April this year, which itself followed on from consumer research commissioned by the ABI.

The latest SoBP runs to 25 pages and is dated September 2011. It starts with a reminder to insurers of their obligations in law and is then followed by setting out the principles that apply. Common definitions and a template for setting out key information on PMI are followed by applicant requirements to disclose and their rights and roles and responsibilities on group schemes.

For more see www.abi.org.uk.

FSA and OFT's PPI guidance

The **FSA (Financial Services Authority)** and **OFT (Office of Fair Trading)** are jointly consulting on guidance for firms on payment protection insurance (PPI), aimed at avoiding past problems recurring in a new generation of products.

The draft guidance stresses that firms should ensure that product features reflect the needs of the consumers they are targeting. The four key areas of concern are:

- Firms not properly identifying the target market for the protection product.
- The protection not reflecting the needs of the identified consumers.
- The benefit of a successful claim not matching the needs of the claimant.
- Product features or pricing structures creating barriers to comparing products, exiting a policy or switching cover.

Consultation closes on 13 January. For more see www.fsa.gov.uk.

Comment: *This is good in theory but the rules are open to interpretation and could lead to stifling innovation. For example, is adding a service based USP (unique selling proposition) a consumer benefit or an attempt to make product comparison harder? It depends on your viewpoint...*

I in 3 won't pay for IP:ABI

One in three people (29%) would not pay to have income protection cover through their employer and, of those who would pay, most would not pay more than £5 a week, according to the **ABI's** latest consumer survey (for details see www.abi.org.uk). Only 14% would be prepared to pay more for the cover.

A worrying 43% believed their employer would continue to pay them in full or in part if they were off sick for at least six months. And 40% felt they could be off work for longer than three months without their job being at risk. That was partly because 82% said they had never been off work for three months or more.

When it came to advice, 46% of 2,561 adults polled felt it was essential when taking out a mortgage, 44% when taking out stocks and shares ISAs, and 39% when taking out a pension compared to just 18% believing it important for life insurance. Only 2% thought it important for car insurance and 3% for savings accounts.

Almost half (48%) of those polled wanted simple financial products with standard benefits and 36% wanted easier to understand terms but only 15% were keen on very comprehensive cover with few exceptions but a likely higher price. Consumers' greatest concern when buying was not being able to work out which products provided the best value for money.

I in 4 sickness absent in poverty

One in four (28%) people ill or injured people fall into poverty and a third are living in poverty within a year, according to research by the **Institute of Social and Economic Research (ISER)** commissioned by **Unum**.

The survey of 10,000 individuals in 5,500 house-

holds also found that people off work ill are less likely to return to work than people made unemployed. Only 24% of people re-enter the workplace after 12 months off work ill or disabled, compared to 50% of those unemployed.

On average people saw a 25% drop in household income, compared to a 28% drop for those unemployed. One in ten (10%) faced problems with paying for their housing and there was a 60% probability of stopping saving.

15% left work within a year because of their spouse leaving work for health reasons (compared to 3% if the spouse became unemployed). Of those who continued working, 28% reduced their work hours within a year, rising to 37% within two years.

Separate research by **Bupa** found that over half of HR managers say that employee absenteeism puts additional stress on employees who are left to 'hold the fort'. A poll of 100 HR managers also found that 31% were unaware of what workplace health schemes were available.

And, poor workforce health accounts for more than a 25% reduction in productivity, while presenteeism costs businesses three times more than sickness absence, according to **Legal & General**.

Businesses need education

More needs to be done to educate businesses on the need for protection, according to **Scottish Widows**. It found that 63% of small family-run businesses would not survive the loss of a key member of staff due to ill health.

Its *Scottish Widows Business Protection Report*, which polled over 500 UK businesses, found that only 6% of UK businesses have life cover for a key person and only 4% protection to cover a critical illness. Yet, 60% said they did not need a protection policy in place.

Analyst **Defaqto** has published a new guide to the business protection market, highlighting the areas of support advisers should consider when assessing potential provider partners.

SMEs look towards PMI: Jelf

24% of SME firms are more likely to support private medical insurance (PMI) as a result of changes to the NHS, according to a survey by **Jelf**.

The poll also found that 70% were likely to maintain their current level of employee benefits and 11% were likely to provide group income protection as a result of welfare reforms.

Almost half (48%) of firms expected to add voluntary (i.e. employee paid but employer facilitated) employee benefits as a result of State health and welfare changes.

Half of insurers offer HIV cover

Half of the UK's major life insurers now offer cover for people with HIV, according to **Unusual Risks**.

Aviva, Bright Grey, LV=, Prudential, Scottish Provident and **Zurich** all offered some form of HIV life cover but only three of the six offered pre-sale quotations. Pru took longest to complete an application on average (26 weeks) but the overall average was eight weeks, compared to around five weeks for someone without HIV.

Cancer survival up sixfold

People diagnosed with cancer are now living, on average, six times longer than was the case 40 years ago, according to a new study of cancer survival by leading cancer charity **Macmillan Cancer Support** (see also Page 16).

Median survival has grown from one year to six, with 11 of the 20 cancers studied having median survival of over five years. However, progress has been 'extremely patchy', with nine cancers exhibiting median survival times of three years or less, little improved since the 1970s.

The biggest improvements have been in colon cancer, with a 17-fold increase in median survival from around seven months to over ten years. But lung and brain cancer median survival times have barely risen, from 11 to 20 weeks and from 13 to 28 weeks respectively, and for pancreatic cancer it has increased from nine to 12 weeks.

Median survival time is the time between diagnosis and when relative survival is at 50% i.e. half those diagnosed have survived (or died).

In a separate report, the **ONS** has published one and five year relative survival for adults (aged 15-99) in England diagnosed with the 21 most common cancers in 2005-09 and followed up in 2010. It found highest five year survival rates for breast cancer (females, at 85.1%) and prostate (males, 81.4%). But five year survival was below 20% for cancers of the brain, lung, oesophagus, pancreas and stomach in both sexes.

For more see www.macmillan.org.uk and *Cancer survival in England—Patients diagnosed 2005-2009 and followed up in 2010* which can be downloaded from www.ons.gov.uk.

GIPs pay out quarter of a billion

Group income protection (GIP) insurers paid out £292.3m in claims in 2010 according to new figures from **GRiD (Group Risk Development)**.

Some 13,500 claims were paid, at an average of £21,500 (just £2,500 less than UK average earnings). This is the first time such cross-industry research has been compiled. New claims represented £82.3m of GIP claims.

GRiD's Katharine Moxham said: "GIP provides cover which is often more generous in the event of a claim than the Government's Employment and Support Allowance (ESA), and it can provide access to protection cover that people may not be able to achieve on their own."

Comment: *We support publication of claims data and it is great to see GRiD's results, which should help get the message across that GIP is so much better than relying on whatever the State determines it can afford to pay and to whom.*

Bupa and hospitals at war

Bupa looks to be taking a hard line on trying to reduce claims costs on its private medical insurance (PMI) policies.

Following on from its move to open referrals on some of its group plans, it is now assessing the value of individual private hospitals, refusing business to some.

MD of Bupa Healthcare, Dr Natalie-Jane Macdonald was quoted in *IFAonline* as saying: "Hospital groups are charging medical inflation plus what they need to maintain their margins. We are challenging them in their assumed business model of uniform price for hospitals with a vari-

ance in care and in markets." She added: "We have watched as the hospital groups buy up smaller hospitals and introduce all-in-one negotiating. These hospital groups are not at capacity and are not value. They are not asking how they can compete; enough is enough."

The moves have come under attack from the hospitals themselves. *Health Insurance* reported (10 November) Dr Jean-Jacques de Gorter, clinical director at **Spire Healthcare** as saying the open referral decision was "...couching a decision to reduce their costs in terms of quality issues."

Then, on 24 November, *IFAonline* reported that **BMI Healthcare** had sent a letter to patients using 12 of its hospitals Bupa had targeted as too expensive saying the move was: 'Part of an ongoing Bupa initiative to direct patients to healthcare facilities who charge the lowest price, rather than offering patients the best quality hospitals and consultants.' Bupa said statements in the letter were 'misleading, defamatory and false'.

Comment: *Bupa is certainly playing hardball on costs, but it is wrong to see this as a purely cost-saving exercise. Such a public spat (and especially involving patients who are, by definition, ill and potentially vulnerable) is also damaging, not just to the parties concerned, but also to the reputation of PMI.*

For the sake of the industry, we hope that the issue can be resolved, but Bupa's sheer buying power (it still has a market share of over 40%) means that the stakes are high for all.

Simplyhealth: time for reform

A crumbling NHS and a PMI (private medical insurance) sector with a good reputation mean that now is the best chance to reform the structure of the country's healthcare system in the past 50 years **Simplyhealth** CEO Des Benjamin told **AMiI** delegates at its autumn conference on November 16.

But, *IFAonline* reported he warned: "Hospital groups are highly leveraged, with vacancy rates that are too high, insurers are making no margin on product and are quite uncertain what to cover and what not to cover." The reason was that the system is wrong and: "In the next few years the system has its best opportunity for 50 years to change; the best opportunity to get rid of the silliness which is the NHS and PMI divided and never the twain shall meet."

He also warned of more consolidation in the market and that Simplyhealth, which has a capitalisation of £250m, was pushing towards a market share of 10%.

Claims processes 'outdated'

Outdated claims processes need a radical overhaul, according to a new report from **SelectX** and claims expert Karin Lloyd, published on 24 November.

Combining the power of technology in business and healthcare with the 'connectedness' of modern society creates the opportunity to raise levels of service to those found in other industries and to address key issues such as costs, brand enhancement and regulatory compliance.

Life and disability claims: strategies for a technology-enabled world is available from www.selectx.co.uk and builds on a survey of 120 insurers in key markets worldwide.

Help us research mobile apps

There are a lot of developments in mobile applications at the moment and, following on from **L&G's** recent launch of its protection app, **Protection Review** has teamed up with **LifeQuote** to undertake research into what advisers want from mobile protection apps. It's a really quick (two minutes max) survey, and once you have completed the survey you will be entered into a draw to win a £50 iTunes voucher.

To enter the survey see <http://freeonlinesurveys.com/rendersurvey.asp?sid=7avhuijv8pjil2969205>. We will publish the results later and look forward to your feedback on what is really needed in this area. Thanks for your help.

Briefs:

- **LV=** has chosen **TCP's** SS/G Underwriting Engine to support its IFA protection proposition and is expected to launch towards the end of 2012.

- **PruProtect** has enhanced its quotes facility and made improvements to its Vitality and Vitality Plus programmes. It has also launched a Premium Saver reward for life, serious illness and income protection planholders.

- A new breed of rehabilitation only group risk products is one likely outcome of the Black/Frost review, according to **Legal & General**.

- A quarter of people who earn below average salaries would still be prepared to pay for private treatment, according to a survey for **Spire Healthcare**. 58% of low earners said they would be willing to sacrifice their annual holiday to pay for treatment or an operation. Over half of 2,000 people polled thought it was becoming more popular for normal people to opt for private treatment because of increasing waiting times at NHS hospitals. And, 4 in 10 believed the NHS would not be able to look after them in the future. Spire reports a 29% increase in self-pay over the past year.

- Two thirds (66%) of people living together do not have a will, according to **Confused.com**. A poll of 2,000 co-habiting couples also found that 50% had no life insurance. 66% of over 55s had a will, compared to just 24% of 18-24 year olds, but 55% of over 55 cohabiters had no life insurance cover. Despite that, 65% of couples had a mortgage (45% of which were in joint names) and 28% said they could not afford to pay for a funeral if their partner died.

- **Denplan** is celebrating a quarter of a century in business. Established in 1986, it now has more than 6,500 member dentists and 1.8m registered patients.

- **AXA PPP healthcare** has added an international PMI policy for individuals or groups who work at sea. The plan includes a ship to shore benefit to pay for the cost of getting from a ship to the most appropriate hospital or clinic.

- **Benenden Healthcare** and **Engage Mutual** have teamed up to offer the Benenden Over 50s Life Cover plan to Benenden's members aged 50-80.

- **Simplyhealth** has rebranded its cash plan for Gibraltar residents as the Simply Cash Plan for Gibraltar. Premiums remain the same but dental and optical cover is up and the complementary therapies reimbursement level is raised from 50% to 70% among other improvements.

- While all local councils provide help for people with critical care needs, that drops to 94% for people with substantial needs, 22% for those with moderate needs and just 6% for those with low needs, according to a poll of 41 local councils in England by **Prestige Nursing and Care**.

- **Now Health International** has signed a memorandum of understanding with **Minan Property and Casualty Insurance Company** of China. This will give Now Health a pan-China license to market international healthcare products.

- **Friends Life** is outsourcing the remaining half of its admin and IT to **Diligenta**. Some 1,900 roles will transfer across too.

- Relatives of elderly and disabled people are defrauding councils of over £2bn a year, of which only £185m was detected last year, the **Audit Commission** claimed on 9 November.

- **Legal & General** and **Barclays** have agreed a deal whereby L&G will provide all family and mortgage-linked protection cover on an advised basis to the bank's retail customers.

- 52% of workers would be unable to survive financially more than three months if they were off work ill, according to **Aviva**, and 30% said they would survive less than a month. 19% knew how much statutory sick pay they would get, but 26% thought they would get considerably more and 16% expected to get double the real figure.

- Solvency II will not actually come into effect for insurers until 1 January 2014 (a year after expected) the **FSA** has said. Applications for internal model approval are expected to start on 30 March 2012.

- **ALC Health** is transferring the underwriting of its international PMI plans to **AXA PPP International**.

- So is **Permanent Health Company** for its UK PMI and dental business, which will now be underwritten by **AXA PPP healthcare**. The move sparked fears of a potential takeover in the online trade press, which Permanent Health denied.

- **Now Health International** is allowing its IPMI customers to pay in one currency but take benefits in another, to best suit where they are having treatment.

- **Westfield Health** saw sales growth of 29% in the year to end March, and its market share rose to 13.5%. Assets rose 13.7% to over £83m. Corporate sales rose 76%. It also paid £1.2m to its charitable trust.

- Protection providers are failing to meet IFAs' service expectations in eight out of ten key service aspects, according to **Defaqto**. Only in treating customers fairly and staff competence did they meet intermediaries' needs.

- **AXA PPP healthcare** has posted no less than 33 new videos on its website to help members better understand how PMI actually works and delivers their healthcare. See Page 15 for more.

- This is the final paper edition of *e-Protection Review*. In future the newsletter will be free to all and published online ten times a year at www.protectionreview.co.uk on the 28th of each month (except December and August). We have one sponsorship opportunity still available (sorry, not open to insurers) to firms who want to be associated with the newsletter. Naturally, we will continue to develop the newsletter to meet your needs and do tell us what you like and what you would like to see more (or less!) of.

Pick of the month

We review three products this month and all merit interest, albeit they are very different offerings.

First, Legal & General has become the latest office to launch a relevant life policy. RLPs offer life cover with tax relief on premiums in a product that should be selling much more than it is.

Paycare has an interesting idea with up to three free add-ons on its HCP—which employers can choose from.

Top marks though to Friends Life for bringing together three providers—never an easy or quick task—and launching a protection proposition that includes many of the best elements of all three.

Friends LifeProtect+

Protect+ is a menu proposition that can include life, income protection, critical illness cover and business protection. The plan also brings together many of the best points of previous **Friends Provident**, **AXA** and **Bupa** protection plans. Key benefits of the new plan can broadly be divided into four parts and include:

- **Life cover.** The plan aims for flexibility and options include level, renewable, decreasing and mortgage protection term or a family income benefit. Premiums can be guaranteed or renewable and there are four indexation options plus optional fracture cover up to £2,100.

- **Income protection.** This features a guaranteed benefit of £15,600 a year, a hospitalisation benefit (with no exclusions), unique therapy and trauma benefits. There is also an innovative doctors' sick pay benefit and fracture cover plus a new way to use waiver of premium benefit that offers to speed up claims.

- **Critical illness cover, with or without life cover.** This includes 14 ABI+ definitions and eight partial benefit conditions. An advance payment up to £25,000 for heart surgery is included, along with child cover (including for congenital conditions). There are premium reductions for diabetes and diabetic risks. Fracture cover, intensive care benefit for children and a family income benefit option are also available.

- **Business protection.** High underwriting limits include up to £10m of life, £5m of CI and £2m own occupation total permanent disability, with the capacity to go higher. The plan can be written for key partners, shareholders and for loans.

All plans include access to the **Best Doctors** service and to the 24/7 **Bupa HealthLine**.

Comment: *Friends says it has included the best elements of the three businesses that now make up Friends Life, and that's a fair summary. Behind the bare product details, attention has also been given to support packages, including a signature-free online application package that even includes a suitable trust. Such things not only make life easier for IFAs (and their clients) but also improve the quality of the overall package (too few policies are written in trust in our view).*

Product design points: *Two points here. First, Friends Life has acted quickly to bring together three similar but not identical propositions. That is never easy (understatement of the month?), but it looks to have done a good job. At a time*

when the industry is still relatively slow to develop new products (in most cases) this task alone is worthy of praise.

The second issue is fracture cover. On one level this is little more than a gimmick—the sums payable are small and illness is generally a bigger worry than injury. However, on another level, such cover should appeal especially to younger people and if there is one thing the whole industry needs, it is more younger customers. They are tomorrow's profits, have the potential to be long-time income generators (and advocates) and the key is to not just keep them but to help and encourage them to upgrade their cover too. So, we're rather warming to the idea of fracture cover, especially as it also means customer contact in a positive way anytime someone breaks a bone on the football field or falling off their bike.

Plus points: *Powerful proposition from one of the industry's big hitters. Good product features backed up by good technical and marketing support. We like the idea of online trusts too and are warming to the inclusion of fracture cover.*

Not so plus points: *Evolution rather than revolution and we did lose two good players when the merger came about.*

There is not space to go into detail about all the possible cover options in Friends' new Protect+ proposition, but its claim to have taken the best elements of its constituent brands is not far from the mark.

Website: www.friendslife.co.uk.

Rating (max 5). Innovation: 4.5. Overall: 4.

Legal & General Relevant Life Policy

Relevant life policies are a relatively new phenomenon and, in essence, offer pension scheme tax reliefs to employees who want term life cover for as long as they are working.

Legal & General's plan pays a lump sum on death in service or if diagnosed with a terminal illness. Under the relevant legislation (and L&G has obtained a legal opinion on its core literature from William Massey QC so the plan should meet its objectives and is compliant with legislation), RLPs must provide a death benefit only to employees and cannot last beyond age 74.

So, this plan must be taken out by an employer for employees only (including company directors) but not to equity partners of a partnership or LLP (limited liability partnership), sole traders or anyone else who is not an employee. Similarly, only life (and terminal illness) cover is included—it is not possible to add critical illness cover for example. Maximum age at entry on this plan is 73.

Death in service benefits do not form part of an individual's £1.5m (2012/13 or £1.8m until next April) lifetime allowance. The plan is designed to be written in a discretionary trust (L&G's Relevant Life Plan Trust) at outset, with the employee's family and dependants as beneficiaries. L&G will write up to 25x remuneration at ages 17-29, falling to 10x remuneration at ages 60-73.

The maximum sum insured is £10m, with detailed financial information required for sums insured of £2.5m and above. Minimum term is one year and maximum term 40 years but the plan must end by age 75.

Accidental death up to £300,000 is covered up to 90 days from receipt of application form until the plan goes on risk. Those below age 45 can increase benefits with no further underwriting on promotion and in various other

situations. Benefits can be linked to inflation, as measured by the RPI (Retail Prices Index). Premiums are payable monthly or annually and are guaranteed.

A continuation option is included but must be exercised within 30 days of leaving. The new employer can then take over the RLP or the customer can have a new term assurance policy, subject to a declaration of good health.

Comment: RLPs are a very cost-effective way to buy term life cover but do have restrictions (e.g. they must be taken out by an employer and on the life of an employee). The 2011 Budget also provided that such plans could lose their tax advantages in future. That said, it is hard to see why an employee would now take out life fund based term assurance when an RLP can provide the same for less.

Product design issues: Are RLPs tax avoidance? The fiasco around pensions term assurance a few years ago (when the Government seemed happy to promote this tax-efficient way to buy life cover only to quickly stop it once the industry began to gear-up to sell it in volumes) will make many cautious. However (although the same could also be argued of PTAs) an RLP puts an employee in no different a situation to any other employee whose employer's pension scheme includes life cover as a death in service benefit.

L&G has been cautious by getting a top QC's legal opinion on its plan and (just as important) its literature and intermediaries will need to ensure they are aware of the rules to ensure they do not transgress them either.

The relevant legislation is in s. 393 B (4)(b) of the Income Tax (Earnings and Pensions) Act 2003.

We would like to see HMRC formally recognise the validity of RLPs and also for them to be available to employees even without their employer's involvement. Meantime, we expect to see more life offices go down this route as the tax benefits can make a big difference. L&G's own figures show a hypothetical example where a £1,000 a month premium into a conventional term assurance actually can cost £1,569.65 a month, when employee NICs (£34.48 at 2%) and income tax (£689.65 at 40%) and employers' NICs (£237.93 at 13.8%) and less corporation tax (£392.41 at 20%) are taken into account. This compares to a similar RLP, where £1,000 a month costs just £800 net (allowing for corporation tax relief of £200 at 20%).

Plus points: Simple life cover to age 75 effectively at discounted rates because of the tax relief on premiums.

Not so plus points: RLPs sound too good to be true and so some fear they could risk HMRC's wrath—although that would be perverse, given the fact that death in service is a standard benefit in many pension schemes. The important thing is that life cover should be in addition to 'true' (long term savings) pension contributions, not instead of them...

Website: www.legalandgeneral.com/advisercentre.

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

Paycare Additions

Wolverhampton based **Paycare** started life in 1874, making it one of the older health cash plans. Its new company paid health cash plan offers a choice of five cover levels. Maximum annual benefits for Level 1 and Level 5 plans being (100% of cost unless otherwise shown) are:

	Level 1	Level 5
Optical, 100% of cost up to	£65	£220

Dental charges, 100% of cost to	£65	£220
Specialist consultations and tests	£300	£600
Professional therapy (physiotherapy; osteopathy; chiropractic; acupuncture; homeopathy; hypnotherapy, and reflexology)	£180	£550
Chiropractic	£50	£150
Health screening	£100	£300

Benefits also cover dependent children and all plans include Paycare's 24/7 Employee Assistance Plan. There are three additional benefits available (but not for children or partners). These are:

- Personal accident cover up to £10,000 (under 70s only).
- Inoculation/vaccination cover up to £50 a year.
- Wellbeing/alternative therapies cover up to £50 a year.

Level 1 and 2 plans are entitled to one free Addition (chosen by the employer and then applied to all members), Levels 3 and 4 to two and Level 5 to all three.

Premiums range from £1.00 a week for Level 1 up to £5.00 a week for Level 3 plans. Partner cover can be added, but their premium is 25% higher. For example, adding a partner on Level 1 cover would cost an extra £1.25 a week on top of the employee's £1 a week.

Plans may be subject to an initial 13 week waiting period. Benefits are usually paid within 48 hours direct to the employee's bank account.

Comment: There are now a number of low cost employer paid HCPs in the market and Paycare adds itself to that growing list. What differentiates Paycare is the Additions concept—a simple idea that allows employers to include one or more extra benefits, depending on the premium level chosen.

However, there is a 13 week initial waiting period (although that may be waived in some cases we would expect) and the additions can only be chosen by the employer (not the employee) and will apply to all employees. To do otherwise might however complicate what should be a very simple as well as effective proposition.

Product design issues: Most extra benefits on protection products are either included 'free' or available only as an additional cost add-on. Paycare's Additions idea looks at this situation in a different way, and it's quite clever.

First, on all except the top level plans, it allows the employer to choose one or more additions from a range of three. But it also effectively encourages them to have a higher level product, because that can also mean getting more additions or getting all three.

The concept could be expanded further—a bigger list and maybe allowing the employee as well as (or instead of) the employer to choose which add-ons to have—for example.

And the concept could be applied to any form of protection insurance, not just to health cash plans.

Plus points: Simple low cost HCP benefits, from just £1 a week per employee. Additions allows employers to choose from a (small menu) on lower level plans or to get three useful add-on at higher levels—which also encourages firms to choose higher levels at outset.

Not so plus points: Initial 13 week waiting period usually. Partners pay 25% more for their cover. Only the employer can choose the addition(s) they want, not the employee.

Website: www.paycare.org.

Rating (max 5): Innovation: 4. Overall: 3.75.

Protection sales edge forward in Q3 but premiums flat

Long term protection insurance sales in the third quarter of 2011 were marginally ahead of those in the second quarter, according to the latest **ABI (Association of British Insurers)** new business statistics, which were released in November. However, sales of all regular premium accumulation and protection product sales decreased by 10.6% year-on-year in Q3 2011 indicating that in relative terms, long term protection did well in a difficult market. Compared to the second quarter of 2011, sales volumes were up 2.7%, with new annualised premiums up by 1.2%:

Table 1. Long term protection sales Q2 2011 vs. Q3 2011

	Sales 000s		Premiums £m	
	Q2	Q3	Q2	Q3
Whole life	144	142	31	31
Term—non-mortgage	251	261	91	93
Term—mortgage	146	151	53	54
Income protection	39	40	12	12
Standalone critical illness	4	4	2	2
Critical illness rider	163	169	68	68
Totals	747	767	257	260

Note: Figures in bold italics are different to last year's figures in *HCIR 130*, or the quarter 2 figures in *HCIR 137*, reflecting changes as the ABI updates figures where new information becomes available.

Looking at individual product types, term assurance sales rose, as did income protection and critical illness rider plans. Whole life sales were down marginally, although annualised premiums remained the same as in quarter two.

Of 142,000 whole life sales, 116,000 (82%) were guaranteed acceptance plans, although in premium terms, they only made up 61% of new whole life annualised premiums. Guaranteed acceptance figures have been falling, suggesting that the market may have reached a plateau.

Non-mortgage term was up 4% in sales terms but premiums were only up 2%. Mortgage term was up 3.4% on sales but also only up 2% on premiums. Critical illness rider plan sales were up 4% but premiums were unaltered.

Compared to quarter 3 of 2009, sales volumes were up 12.5%, with new annualised premiums up by 0.4%.

Table 2. Long term protection sales Q3 2010 vs. Q3 2011

	Sales 000s		Premiums £m	
	2010	2011	2010	2011
Whole life	121	142	30	31
Term—non-mortgage	248	261	89	93
Term—mortgage	168	151	60	54
Income protection	30	40	13	12
Standalone critical illness	5	4	3	2
Critical illness rider	138	169	69	68
Totals	710	767	264	260

Tables 1 and 2 both illustrate that new premiums are lagging behind sales—an indicator both of straitened economic times and of many products now being cheaper or people choosing less cover or cheaper variants. Indeed, it can be argued that the industry has been successful in attracting more customers but has failed to turn that into

increased revenues because of an over-focus on price rather than value. Whilst few would argue with that conclusion, there is little common agreement as yet as to what to do about it or whether that can be changed.

Protection sales index up again

After the peak of 129.9 for the first quarter of 2004, the *e-Protection Review Protection Sales Index* fell and, for many quarters was below 100, indicating lower sales than in the first quarter of 2000. However, in 2009 the index again rose over 100 and is now 23% higher than in Q1 of 2000 (our benchmark figure). Anything above 100 indicates an increase in sales, anything below, a decrease.

This index looks at numbers of policies rather than annualised premiums to take premium rate changes and increases or decreases in benefits out of the equation and is a broad proxy for activity and market penetration.

Table 3. Long term protection sales Q1 2000 vs. Q3 2011

	2000	2011	Index
Whole life	111	142	127.9
Term—non-mortgage	168	261	155.4
Term—mortgage	137	151	110.2
Income protection	41	40	97.6
Standalone critical illness	22	4	18.2
Critical illness rider	141	169	119.9
Totals (including LTCI)	622	767	123.3

We no longer regularly monitor long term care insurance sales as the numbers are so low but 311 policies of various types were sold in the quarter (95% single premium).

In terms of products, the clear winner since 2000 has been term assurance, despite sharp falls on the back of a subdued mortgage market since the 2008 credit crunch.

Term is now simpler to buy, cheaper (rates are around 50% lower than in 2000 for many ages) and with quotes and application online, indicating that simple products that consumers and intermediaries can understand easily will appeal to a market that is generally not (yet) well educated when it comes to financial matters.

Of the other products, whole of life has progressed, on the back of guaranteed acceptance policies (another vote for simpler products), and CI continues to recover on the back of a lot of work on rebuilding trust and future proofing. IP is recovering more strongly than we can recall happening before and is tantalisingly close to 2000 sales levels, albeit premium growth has been relatively poor as more people focus on budget solutions.

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

Table 4. Group protection sales 2010 and 2011 £m

Product	Q3 2010	Q2 2011	Q3 2011
Group life	35	42	35
Group critical illness	2	3	1
Group income protection	20	28	21

We are cautious of the group risk numbers and the third quarter of 2011, on the face of it, was again a poor quarter, almost exactly matching the same period of 2010. Certainly, rises in unemployment coupled with concerns over funding costs and the economy may again indicate tough times for this sector.

Better breast cancer outcomes

A meta-analysis reported in *Lancet* 2011; doi: 10.1016/S0140 6736(11)61629-2 claims postoperative radiotherapy substantially reduces the risk of recurrence in women having breast conserving surgery for early stage cancer (halved risk over ten years). Radiotherapy also reduced the risk of death from breast cancer by one sixth over 15 years.

Two new observational studies from the US on breast cancer screening also suggest best practice. The first (*Ann Intern Med* 2011; 155: 481-92) on how often a woman should be screened reports that those who have yearly mammograms for ten years have more false alarms (61.3% have at least one) and more unnecessary biopsies, than women screened every two years. Cancers detected through biennial screening were slightly more likely to be end stage than cancers detected by yearly screening but the weight of evidence was against yearly screening.

The second study (*Ann Intern Med* 2011; 155: 493-502) of more than 300,000 women looked at digital and film mammograms and suggests the two look broadly comparable, except for non-significant hints that digital screening is better (more sensitive) for those with extremely dense breasts or those with oestrogen receptor negative cancers. For younger women, digital mammography was less specific than film and was associated with significantly more recalls. More than 70% of mammography machines in the US are now digital and the switch from film may well reduce the overall efficiency of breast cancer screening.

New endoscopic technique improves tumour removal

A new endoscopic resection technique called endoscopic submucosal dissection (ESD), pioneered in Japan, can completely remove 95% of large early colorectal cancers with very low rates of complications reported.

The technique, reported to journalists in Stockholm during the United European Gastroenterology Week in October, involves the injection of a fluid underneath the tumour lesion to separate it from the deeper tissues and raise the area for removal with an endoscopic knife.

Using other surgical techniques, larger tumours have been more difficult to remove whole and piecemeal removal is associated with a 20% risk of tumour recurrence. ESD's main disadvantages are that it takes longer to perform and initial studies suggest it is associated with an increased risk of perforation.

Medical passport launched

Freespirit Enterprises has launched a medical passport, which it says can give the public responsibility for their own health and help inform healthcare professionals if the owner is taken ill away from home. Following problems with the NHS database scheme, the inventors say this small 64 page book (Price: £11.99) can help plug the information gap, as it is kept with the patient at all times. Patients can update their passport with health information and record conditions and medications and can also add notes about self-care. See www.freespirit-medical-passports.co.uk.

It's raining (32m) men

A report, *The State of Men's Health in Europe*, reveals that the male population across Europe is changing, with a predicted reduction of 24m men of working age (15-64) and an increase of 32m men aged over 65 across Europe by 2060. But, men are more likely to die prematurely than women and men in lower socio-economic groups have significantly poorer health than those in higher groups. This applies to every country within the EU 27.

Life expectancy for the EU 27 stands at 76.07 for men and 82.21 for women, with male life expectancy ranging from 80 years in Iceland and Lichtenstein to 66.3 years in Lithuania – a gap of 13.7 years. In 2007 there were over 630,000 male deaths between the ages of 15 and 64 (300,000 for females). Across the EU 27, deaths in the 15-64 age group account for 26% of total male deaths (13% for females) ranging from 44% in Lithuania to 18% in Sweden. Men's vulnerability to a wide range of conditions, such as cancers, is less well known. **Leeds Metropolitan University**, where the report was debated, launched the **Institute for Health and Wellbeing** in early November to look at six health-related topics. The full report can be found at: http://ec.europa.eu/health/population_groups/docs/men_health_extended_en.pdf.

ISTC care as good as NHS

Care in England's 30 Independent sector Treatment Centres (ISTCs) is marginally better than in NHS facilities, even allowing for healthy status and other factors on admission the *BMJ* has reported (*BMJ*2011;343:bmj.d6936).

At present ISTCs only account for 2% of NHS elective activity and tend to treat less complicated cases. Researchers Chard et al compared 72 NHS facilities and 25 ISTCs in 2008 and 2009 for the survey.

What is The Insurance Charities?

If you are a member of the **CII (Chartered Insurance Institute)** you will invariably have come across **The Insurance Charities (TIC)**, not least for its annual charities day and its support from many local institutes as well as the CII nationally and through various other fund raising events. But do you know what it does?

The Insurance Charities was established in 1902 and has a board of trustees drawn from across the insurance industry. Its aim is to 'give vital financial and practical support to past and present employees of the insurance industry (essentially if they have worked in any role for at least five years) and their dependent relatives'. Last year (to end March 2011), TIC spent £824,000 on helping 605 people. Subscribers can join TIC from just £15 a year.

TIC is based in the CII building in Aldermanbury, London, and its CEO is Annali-Joy Thornicroft and current president is Graham Cave. TIC's website is at www.insurancecharities.org.uk, from which further details and its regular newsletter can be downloaded. The protection insurance industry helps many people each year in a range of ways, but it's good to know that TIC is there to help those who work in the industry too and continues to play such an invaluable role.

Circle takes over Hinchinbrooke

Circle Healthcare is taking over the running of **Hinchinbrooke Hospital** in Cambridgeshire after the hospital amassed debts of £40m on an annual turnover of £90m.

The long-delayed plan is expected to be the first of many as, arguably, the NHS moves to focus on its core activity of treating patients, leaving management of its resources more to the private sector.

The ten year deal will see Circle look to repay all Hinchinbrooke's debts with no subsidy from the Government. Circle is a partnership and run along 'John Lewis' lines, giving its employees—including 2,500 clinicians—a stake in the business.

Comment: *The medical profession (led by the BMA) is concerned at the growing role of the private sector in the NHS. That is ironic, given that most GPs are self-employed business people and most hospital consultants also do paid work outside the NHS. However, the real fear is that 'big business' will replace the 'corner shop' mentality of the NHS.*

The public's view is less clear. It has already accepted the effective privatisation of dentistry and accepts that pharmacy and alternative therapies are largely privately run and owned. Is running a hospital a step too far? Probably not—as long as it still says NHS over the door.

Breast cancer screening review

The **Department of Health** has announced that the effectiveness of breast cancer screening will be reviewed by an independent panel and also, following studies from the **Nordic Cochrane Centre**, breast cancer screening leaflets are to be rewritten for the second time following concerns that they exaggerate the benefits and fail to give due weight to the harms, *BMJ* 2011; 343: d6905 reported on 26 October. The latest leaflet suggests that one death is prevented for every 400 women screened whereas the Nordic team says the number needed to screen is 2,000. The leaflet at present refers to the risk of needless treatment but does not attempt to qualify it.

New guide to heart rehabilitation

The good practice guide on how to design rehabilitation programmes for heart patients from the **National Institute for Health and Clinical Excellence** has been published, the **British Heart Foundation (BHF)** announced in a press release dated 1 November. The guide complements the Cardiac Rehabilitation Commissioning Pack. However figures from the 2011 National Audit of Cardiac Rehabilitation show only 43% of people in England who had had a heart attack, bypass surgery or angioplasty took part in 2009/10, just one per cent higher than the previous year. The rehabilitation is cost effective (about £477 per patient) and proven to reduce hospital readmissions.

Health spending—up or down?

Health department spending as a whole rose to £105.6bn (a 0.28% rise) and NHS spending specifically rose to £87.61bn (a 1.29% rise) during the first year of the coalition government, according to an analysis of departmental

spending published in the *Guardian* on 26 October. However John Appleby, chief economist at the **King's Fund** says the figures include annually managed expenditure that the Treasury would normally strip out before assessing departmental spend and also spending on personal social services for which local authorities now have responsibility which should also be removed. His calculation for health department spending in 2010-11 is £101.9bn (£99.6bn in 2009-10), a 2.3% increase which becomes a health spending fall of 0.6% in real terms when inflation of 2.9% is taken into account. See: *BMJ* 2011; 343: d7025.

Unemployment slowing?

Unemployment rose from 2.57m in June-August to 2.62m in July-September, according to the latest *Labour market statistics* bulletin, released by the **ONS** on 16 November.

During the same period, employment fell from 29.1m to 29.07m. 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 107.017 to 106.906. 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 remained at 1.6m in October but was up by 5,300 and though still up, the rate appears to be slowing. The latest unemployment rate is now 8.3%, or 4.9% for JSA claimants. Earnings in the three month period to end September (including bonuses) fell from 2.8% to 2.3% higher than a year before.

Although the number of number of employees fell 305,000 in the three months to end September, the number of self-employed people actually rose—by 10,000 to reach 4.99m.

On 15 November the ONS announced that in October the Retail Prices Index (RPI) fell to 5.4% compared to a year before, while the Government's preferred Consumer Prices Index (CPI) was down from 5.2% to 5.0%. This compares to an annual inflation target of 2.0%.

Hospital RTT waiting times up

The median Referral to Treatment (RTT) wait for NHS hospital admission in England rose from 8.1 weeks in August to 8.8 weeks in September according to **Department of Health** Statistical Press Notices released on 17 November. For non-admitted patients the median wait rose from 4.1 weeks to 4.5 weeks. The 95th percentile time wait for patients entering an RTT pathway rose from 22.6 weeks to 22.8 weeks for admitted patients and from 15.7 weeks to 16.0 weeks for non-admitted patients.

The number of patients meeting the 18 week target rose from 90.4% to 90.7%.

Cancer cases to rise to 432,000

The number of cancer cases is expected to rise from 298,000 in 2007 to 432,000 in 2030, mainly due to the ageing population, **Cancer Research UK** reported on 1 November. Three out of five cancers are diagnosed in people aged 65 years and over.

Medical briefs:

- A trial involving 4,500 women has found that switching from initial drug treatment with tamoxifen to the aromatase inhibitor exemestane after two or three years reduces the risk of breast cancer tumours recurring. After seven years those that switched were 18% less likely to have a recurrence of breast cancer than those who did not switch. See: <http://tinyurl.com/3urm4gp>.

- Researchers at **Addenbrooke's Hospital** in Cambridge have warned that using new antibiotics to combat healthcare acquired infections (HAIs) can lead to a greater risk of other infections after surgery. See: *British Journal of Urology International* (2011) 108: 1597-1602.

- **Nuffield Health** is acquiring the **BMI Oxford Clinic**, which is to now relocate to The Manor Hospital. The Manor offers wider services and has six major theatres, an intensive care unit and MRI and CT scanning on site. All staff will transfer across.

- A survey in four countries of 1,004 nurses and doctors has found that although 89% of clinicians said it was important to ask patients about their care expectations only 16% reported doing so. Clinicians were most likely to ask in Denmark (31%), US (16%), UK (13%) and Israel (7%). Nurses were more likely to ask than doctors (20% v 12%). See: *BMJ Quality & Safety* (2011) 20: 959-965.

- Yoga and stretching exercises are effective treatments for chronic lower back pain with 12 weekly sessions of either for 228 participants making modest improvements that seemed to endure for 26 weeks when compared to a self-help booklet. See: *BMJ* 2011; 343: d6870.

- Most Magnetic Resonance Imaging (MRI) scanners are noisy and claustrophobic but **Bupa Cromwell Hospital** is the first to install an MRI scanner where patients can choose the music, colours and images inside the scanner to create a soothing and relaxing atmosphere. The scanner has a larger than normal space and is therefore less claustrophobic and scanner time has been reduced by 30%, according to a press release dated 1 November.

- A research team analysing data from the **International Agency for Research on Cancer** and the *United Nations World Contraceptive Use* report has found that use of the contraceptive pill in the population as a whole was significantly associated with both the number of new cases of, and deaths from prostate cancer. Other intrauterine devices, condoms and other vaginal barriers were not associated with an increased risk of prostate cancer. See: <http://presssprings.co.uk/Open/november/bmjopen311.pdf>.

- A new study challenges the definition of emphysema as enlargement and destruction of the alveoli suggesting instead that alveolar walls only collapse due to the narrowing and destruction of the terminal bronchioles due to inflammation. See: *N Eng J Med* 2011; 365: 1567-75.

- *BMJ* 2011; 343: bmj.d7055 reported that death rates from lung cancer surgery have halved from 3.8% to 2.1% over the past decade despite the increasing number of frail patients being operated on. The number of patients undergoing surgery has risen from between 3,000 to 4,000 to reach 5,265 in 2010. A decision was taken in 2002 to start training dedicated thoracic (as opposed to cardiothoracic) surgeons because of a lack of suitable candidates for consultant thoracic surgery.

Political briefs:

- In the quarter ended 30 September 2011, 12,952 elective operations were cancelled at the last minute for non-clinical reasons, the Department of Health reported on 11 November. This compared to 12,991 in the same period of 2010. Of the cancellations, 415 (3.2%) of patients were not treated within 28 days of cancellation, up from 351 in the same period of 2010.

- In October 2011 there were 1,244 breaches of the MSA (mixed sex accommodation) guidance in English NHS hospitals, the **Department of Health** reported on 17 November. This was up from 1,079 in September. Of 167 acute trusts that reported data, 114 (68%) reported no breaches of the guidance.

- Average medical student debt on graduation has risen from £23,909 to £24,092, with those who study a first degree before studying medicine having a higher average debt of £30,748, the **BMA** reported on 1 November. Students from low income families in medical school have dropped from 14% to 11% in the past year and 44% of medical students have financial assistance from relatives, averaging £3,702 a year. Medical degrees take five to six years to complete and the academic year can be up to 45 weeks (most other degrees are 30 weeks).

- *IFA online* reported on 31 October that the new Chair of the NHS Commissioning Board, Professor Malcolm Grant, admitted, when asked about his passion for the NHS, that he found it difficult to demonstrate "because I am not a patient of the NHS". He also revealed he had not met any health ministers prior to his appointment and had met Health Secretary, Andrew Lansley three times.

- Complaints against doctors went up from 5,773 in 2009 to 7,153 in 2010 and the number of investigations launched rose by 18%. In 2010 the **General Medical Council** struck off a record 92 doctors from the medical register. Male doctors and GPs were over-represented in complaints and the older that doctors were the more likely on average they were to be struck off.

- In the quarter ended 30 September, 89.2m UDAs (units of dental activity) had been commissioned the **Department of Health** reported on 8 November. That was an increase of 0.24% on the previous quarter.

- According to a press release from Scotland's chief statistician dated 26 October, the total number of weeks provided for respite care in Scotland increased by 1,450 weeks between 2009/10 and 2010/11. 69% of all respite weeks were provided during the daytime rather than overnight. Daytime respite at home or another daycare settings in Scotland increased by 0.8% on the previous year to 146,600 weeks in 2010/11. Overnight respite in a care home or other overnight setting in Scotland increased by 0.6% on the previous year to 64,650 weeks in 2010/11.

- The UK population could hit 70m by 2027 according to the **ONS** on 26 October, up from 62.3m in 2010. Average (median) age is expected to rise from 39.7 in 2010 to 39.9 in 2020 and to 42.2 in 2035. In 2010 there were 1.4m people in the UK aged 85 and over. By 2020 this is projected to reach 1.9m and by 2035 to 3.5m. The number of people aged 90 and above is expected to more than triple by 2035 and the number of centenarians to rise from 13,000 in 2010 to 110,000 in 2035.

The Syndicate considers the effect of lifestyle on consumers' finances

Austrian psychologist Alfred Alder first coined the term 'lifestyle' in 1929 to provide a description of how people live their lives, handle problems and interpersonal relations. He stated: "The style of life of a tree is the individuality of a tree expressing itself and moulding itself in an environment. Every tree has a life pattern and is not merely a mechanical reaction to the environment". Lifestyles are made up of individual attitudes and values all of which affect the way consumers behave (including habits) and take action. Consumers' lifestyle is reflected in the things they say and do, this includes their purchasing preferences and behaviour.

At **Hannover Life Re (UK)** we have combined forces (*marketing manager Kirsteen Grant writes*) with **Protection Review** to build a research community with the creation of **The Syndicate** that will help to inform and educate the industry about how consumers think. The Syndicate conducts research to understand how lifestyle affects consumer's attitudes to their finances. This includes what they view as financial priorities, their spending habits, needs and expectations along with assessing how these are aligned against today's protection products.

One of the major challenges for the industry has been the speed with which technology has evolved and how this has impacted on today's lifestyles. This makes it very difficult to envisage what will happen next. In an industry that it not known to react quickly to change, this is going to be a challenge for the future. Keeping up with the next predicted lifestyle patterns is not for the fainthearted.

A good example of evolving technological change is the mobile phone. When first launched, mobiles were designed as a portable means of communication from one party to another. Today they are used not only to communicate everywhere with people vocally but also through SMS, provide access to information, allow transactions to be conducted as well as being a sophisticated entertainment tool. Most Britons admit they could not live without their mobile. This multi-faceted technology and the internet have dramatically changed the way people live their lives and conduct their daily activities, in particular their finances. They now have the freedom to action transactions and manage their finances from the comfort of their home, all day, everyday.

Technology has brought about many significant advances to consumers lifestyles but finances and in particular, protection has suffered. Protection is not a product that is high on a consumer's priority list. Most need to be prompted to purchase. Consumers don't wake up in the morning thinking 'I must remember to buy some life insurance today'. The other major hurdle for the industry is that the product is linked to a negative outcome, so consumers don't want to think about the 'what ifs' in life.

As much as lifestyle options have increased through technology, living standards have not. Research by the **Joseph Rowntree Foundation** (*A minimum income standard for the UK in 2011*) found that 'rising prices combined with stagnant wages means that a wide range of the population

has become worse off in real terms'.

Technology has also affected lifestyle in the creation of a more impersonal society. Remote access creates distant relationships; we need to reconnect with consumers to increase understanding of the products we offer and the benefits they bring. Unfortunately, the true benefit of life and health products is at the point of claim. This is the time when the real value comes into play and valuable relationships are created with the product providers.

Chief financial concerns

We asked consumers as part of our research to consider what their chief financial concerns were in the current economic climate from a range of monthly household expenses (see table 1). Interestingly, across all age groups, mortgage/rent was not the top main worry. This may be due to the low interest rate environment whereby they feel they can manage this monthly outlay. If interest rates do rise and the limited availability of mortgages continues to push rental prices up this may over time move up their list of concerns.

Table 1 - chief financial concerns by age-group

Age Group	Top Concern
18-24	Cost of Clothes for you and your family
25-34	Cost of petrol/Cost of running a car
35-44	Cost of petrol/Cost of running a car
45-54	Utility bills: Gas/Electricity
55-64	Utility bills: Gas/Electricity
65+	Utility bills: Gas/Electricity

The results do follow the life stages with the younger generation, who are less aware of the cost of household bills, being more focused on the acquisition of material goods. In years to come will this generation be able to claim that their top life goal is health and wellbeing rather than obtaining the latest iPad or gadget? Will life stage transformations follow the traditional pattern or will the explosion of promotion and access to luxuries at a younger age lead to a more material society? This is already being evidenced by a recent study by **The Children's Society** who found that 'materially deprived children are unhappier than their peers'.

As people progress through life the results shift; for 25-44 year olds the biggest concern was the cost of petrol/running a car, this is now redefined as an essential for this generation. This reflects a significant change in people's perceptions of what they now find necessary and what they can't live without. This is the age group most likely to have significant life stages such as purchasing their first home, marriage, children and career development. The focus is not on daily practicalities but maintaining an established lifestyle.

Overall the results showed a low concern for debt such as credit cards and loans, coming on average 7th in their priority list of financial concerns. Technology is making people more emotionally disconnected from their fi-

-nances; the invisible money can encourage consumers to spend more, even if they don't have the funds available. We are now in a society of accepting debt as part of daily living, which puts a long term strain on families and their finances. The simple fact remains that the more debt you have the less chance you have of prospering and protecting your family.

How can we get noticed?

Most industries have embraced technology to broadcast their messages from the rooftops, provide propositions that are easy to buy (engaging with the ipod generation) and easy to understand. **Amazon** is a good example of the successful monitoring of customers' purchasing habits. Taking this to another level by providing products that would suit individuals' needs as well as letting them know what other customers are looking at and have purchased: aligning lifestyle values and preferences.

We asked consumers what they thought would be the best way to get people to appreciate the value of protection insurance. 41% believed we should increase awareness of the limited support provided by the State to help people understand what cover they need to protect themselves. This was followed by reassuring them that protection insurance can provide financial security in times of illness or death and increased media coverage of the benefits it can bring.

We need to find ways of communicating with consumers in this fast paced technological world. Looking at ways to make them understand that to achieve their lifestyle aspirations will be dependent on the choices they make along the way.

If you wish to find out more about The Syndicate please contact jo@lebeauvisage.co.uk.

Marketing to needs and wants

AXA PPP Healthcare's Simon Miller asks whether we are doing enough to promote the quality experience of PMI.

Other than mortgage payments, school fees and perhaps car loan payments, there can't be too many direct debits on a family's monthly bank statement that exceed a (not unusual) £200 plus monthly premium for family PMI cover. And, like a bigger house, a more expensive car and private schooling, private healthcare is a discretionary purchase that appeals to one's aspirational instinct to afford their family the very best. A want and a desire to have the very best treatment, in the very best facilities from some of the very best people.

Research on reasons for buying PMI is often topped with the rational triggers of waiting times and choice and, as an industry, we do our best to highlight these messages. But do our sales and marketing activities go far enough to connect with the aspirational qualities of private healthcare that perhaps drive consumer emotional triggers to consider? Are we doing enough to ignite those triggers within new to market prospects or do we too often make an incorrect assumption that people understand what private healthcare is all about – assuming that non-purchasers are either opposed to it or can't afford it?

There is a considerable amount of opportunity to educate about the true benefits of private healthcare. Not about cover limits, chronic vs. acute or underwriting terms (we do more than enough of that in our extensive compliance literature), but about the true benefits of peace of mind, comfort, dignity and perhaps some of the little luxuries that go with the private hospital experience. In other words, the things we aspire to.

This is not to overlook that getting better quickly is what it is all about, but even when it comes to understanding the private healthcare system and treatment pathways, much confusion remains around the private healthcare experience.

Not so long ago a colleague shared with me a wonderful debate about the virtues of PMI that had come to light from our online buzz monitoring. In an online forum, a question posed of 'Should I go private?' led to pages of intelligent discussion clearly demonstrating many different viewpoints on the matter including much ideological debate. However, what struck me most was just how quite misinformed the debate appeared to be, with many skewed views on the differences between NHS and private care. The role of the health insurer was clearly tainted with the emotion attached to one's own general insurance experiences (usually unfavourable) and there was clearly little recognition of the health insurer adding any value to the healthcare journey or, in fact, doing anything other than paying the bills. And yet, despite very strongly held views about what the private experience did and didn't offer, many of the forum posters later confessed they had never had PMI or ever been treated in a private hospital but imagined this was what it would be like.

The individual suggested he would be looking into it further but one thing I suspect he and many other new to market prospects will not initially be enquiring about is what excess levels, reduced cover options or coinsurances exist. Instead, they often set out wanting the best – comprehensive cover with no strings attached. And even if at point of sale they do end up choosing options to ensure they meet their budgets, I doubt many would still claim that the cheapest of PMI premiums is 'affordable'.

There is definitely a place for feature-led discussions that support this purchase decision making, but is it in our headline sales and marketing messages? Can we do more to first raise awareness and educate on the benefits of PMI and make the product more tangible? Can we do more to appeal to those aspirational and emotional triggers?

There are some good examples. Some brokers arrange private hospital tours for prospective clients, enabling people to touch the product they might be about to purchase. Free or discounted private health screen incentives enable new members to get a taste of the private health experience and reaffirm their purchase decision. Many of the private hospital websites do an excellent job of portraying the real benefits of private healthcare while subtly highlighting differences between that and the NHS.

At AXA PPP healthcare we have recently introduced a suite of online videos featuring private hospitals, specialists and hospital staff and our claiming members. We not only plan to promote the private healthcare experience to prospective customers but will communicate to new members to reassure them of their purchase and to the many members who, despite paying premiums year

after year, may have been fortunate enough to not yet have to walk into a private hospital. And this is perhaps where the PMI direct debit often does differ from the other very tangible aforementioned discretionary purchases. Our challenge then is to bring the private experience to life before, during and after purchase and ensure that the emotional triggers for buying in the first place are not overcome by the transactional relationship that can soon form thereafter.

Marketing guru Philip Kotler cites 'satisfying needs and wants' as the essence of good marketing. We are in a price sensitive industry in tough economic times, but that doesn't stop people wanting the best and we have the means to satisfy their wants. But first we must help them understand what the best looks like.

Simon Miller is Senior Marketing Manager at AXA PPP health-care. Their 'Seeing is believing' online video initiative can be viewed at www.axapphealthcare.co.uk/experience.

People news

- **Denplan.** Richard Ward has been appointed as head of marketing.
- **Financial Ombudsman Service (FOS).** Aviva's Sir Nicholas Montagu has been appointed chairman.
- **Financial Services Authority (FSA).** Zitah McMillan has been appointed communications director. She was previously acting director of communications at the **Department for Work and Pensions.**
- **Laing & Buisson.** Justin Merritt has been promoted to operations director.

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 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. The lifetime risk of prostate cancer is 1 in 8 but what is the risk below age 65? a) 1 in 8, b) 1 in 15, c) 1 in 33 or d) 1 in 43.
2. Lost economic output due to sickness absence is estimated at how much each year? a) £5bn, b) £10bn, c) £15bn or d) £20bn.
3. ABI has just published a new SoBP for which product? a) PMI, b) PPI, c) CI or d) IP.
4. Which private sector organisation is taking over running the NHS's Hinchinbrooke hospital? a) BMI, b) Circle, c) Spire or d) Bupa.
5. What is the top financial concern for people aged 18-24? a) The cost of clothes, b) the cost of a housing, c) the cost of utility bills or d) the cost of life insurance.

Protection Review news

- The Syndicate is holding its first conference for its consumer market research members on 18 January.
- Plans are well advanced for next year's generic protection training programmes. See website for updates.
- Don't forget to diarise the book launch, conference and dinner. All on 11 July at The Landmark, London. For more news see www.protectionreview.co.uk.

Private sector employers size

Firm size	Firms	% of employees
Micro (1-9 employees)	941,000	18.4
Small (10-49)	168,000	17.4
Medium (50-249)	30,000	14.9
Large (250+)	6,000	49.3
(of which 500+)	3,000	43.6
Total	1,145,000	100

Source: *Health at work—an independent review of sickness absence*, The Stationery Office, November 2011.

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.

Lifetime cancer risk

Cancer	M<65 ML		F<65 FL	
	%	%	%	%
Bladder	0.36	2.51	0.12	0.93
Brain etc malignant	0.38	0.77	0.27	0.58
Brain etc malig + non-mal	0.66	1.31	0.64	1.32
Breast	0.03	0.1	6.13	12.51
Cervix	-	-	0.54	0.75
Colorectal	1.57	6.95	1.16	5.37
Kidney	0.52	1.66	0.3	1.0
Leukaemia	0.42	1.41	0.28	0.96
Liver	0.18	0.73	0.08	0.41
Lung	1.37	7.52	1.15	5.45
Malignant melanoma	0.67	1.64	0.89	1.67
Multiple myeloma	0.18	0.81	0.13	0.62
Non-Hodgkin lymphoma	0.65	1.93	0.49	1.62
Oesophagus	0.46	1.74	0.15	0.85
Oral	0.55	1.08	0.22	0.54
Ovary	-	-	0.73	1.87
Pancreas	0.29	1.31	0.21	1.28
Prostate	2.32	12.06	-	-
Stomach	0.29	1.65	0.12	0.84
Uterus	-	-	0.87	2.19
All cancers	25.7	40.3	24.4	38.8

Note: Most cancers occur at older ages. So, while 1 in 8 men will get prostate cancer, only 1 in 43 will be below age 65. The lifetime risk of being diagnosed with cancer grew from around 1 in 4 in 1975 to 2 in 5 in 2008. The table shows the percentage risk of being diagnosed with a cancer before age 65 and the lifetime risk for males and females.

Source: www.cancerresearch.org, based on 2008 data.

Networks October 2011

Network	Total ARs
Sesame	1,345
Personal Touch Financial Services	990
Openwork	939
Tenetline/Connect	646
Intrinsic	574
Financial Ltd	389
First Complete	377
Pink + BDS	302
Mortgage Next/Mortgage Intelligence	221
Legal & General	225

Source: *Mortgage Strategy*, 17 October 2011, based on FSA register data on 3 October 2011.

Cancer median survival in months UK, 1971/72, 2000/01 & 2007

Cancer	1971/72	2000/01	2007
Bladder	29	118	108
Brain	3	5	7
Colon	7	58	120
Kidney	9	48	64
Leukaemia	4	34	36
Lung	3	5	5
Myeloma	5	26	30
NHL	12	75	120
Oesophagus	2	7	8
Others	17	21	26
Ovary	8	29	37
Pancreas	2	3	3
Rectum	15	75	106
Stomach	2	6	8
All cancers	13	51	69

Notes: Life expectancy is now over ten years (120+ months) for breast cancer (female—66 months in 1971/2), Cervix (92), Hodgkin's (110), Larynx (males—120), melanoma (108), prostate (27), and continues to be for testes and uterus (which were 10 years+ in 1970/71).

Source: *Living after diagnosis: Median cancer survival times*, Macmillan Cancer Support, November 2011

Deaths by cause 2010 E&W

Underlying cause of death	Male	Female
Ischaemic heart diseases	40,721	29,475
Cerebrovascular diseases	16,909	26,454
MNs trachea, bronchus, lung	16,807	13,170
Chronic lower respiratory diseases	13,137	12,848
Influenza and pneumonia	10,620	14,903
MNs of prostate	9,638	-
MNs of female breast	-	10,290
MNs colon, sigmoid, rectum, anus	7,700	6,402
Dementia and Alzheimer's	7,347	17,759
MNs of lymphoid etc	5,826	Not in top 10
Diseases of the liver	4,724	Not in top 10
Diseases of urinary system	Not in top 10	7,365
Heart failure	Not in top 10	6,461
All deaths	237,916	255,326

Note: Figures for England and Wales only

Source: *Deaths registered in England and Wales in 2010, by cause*, ONS, 28 October 2011.

Protection Review: financial services consultancy and communications solutions

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

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