

e-Protection Review

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

Awareness is key to desire for protection: The Syndicate

The best way to get people to appreciate the value of protection (life and health) insurance is to increase awareness of the limited support provided by the State. That was one of the key findings from the first wave of consumer research commissioned by **The Syndicate**, which launched its findings on 18 January.

The poll of over 1,000 UK adults undertaken by **ICM** in September 2011 found that 41% of people supported that, followed by 32% who suggested that people wanted the reassurance that protection insurance can provide financial security in the event of illness or death. Almost a third (29%) supported greater media coverage of the benefits of protection and 28% felt that people should be informed face to face or over the telephone.

The Syndicate is a new and innovative research partnership between **Protection Review** and **Hannover Life Re (UK)**. It offers members, who pay a single low annual fee, input both into the research undertaken and its findings. An annual conference for members is used to further discuss the findings, but only after more analysis on key areas has been undertaken by industry experts. Whilst it is not intended to replace research organisations carry out themselves, it gives them access to additional very high quality research that takes place on a regular basis, so that trends over time can also be monitored.

The first waves of the research focused on gender and lifestyle issues. On gender it found very little difference between the sexes as to who was the main decision maker, with just under half of men and women saying they were the main decision maker, and 41% of both saying they were an active contributor. However, there were key variations both regionally and by age. In the North East, 52% of women said they were the main decision maker, compared to just 37% of men, but in the North West the positions were reversed, with 66% of men claiming to be the main decision maker, compared to 50% of women.

Only around one in ten people were uninvolved and uninterested in financial matters, but for 18-24 year olds that rose to 42% of men and 50% of women. That group is still very influenced by its parents on financial matters, suggesting that finance for them goes beyond just 'the bank of mum and dad'. More encouraging was the finding that two thirds of people in all age groups say they like to keep up to date with (Continued on Page 2).

Quotes of the month:

'Why should someone who is prepared to put time and effort into getting their affairs in order before they die be thwarted by the law of the land from doing so?' Paul Grimwood, head of civil litigation, Hart Brown, 26 January 2012.

'The whole approach to caring in this country needs to be reset. And it needs to start with this simple fact. Caring is what nurses do. Everything else comes second.' PM David Cameron, 6 January 2012.

'For too long the lack of competition amongst private hospitals and consultants in private practice has pushed the price of health insurance up to unsustainable levels.' Dr Natalie-Jane Macdonald, MD of Bupa Health and Wellbeing, 8 December 2011.



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Inside this issue:

News

OFT's private healthcare referral; NHFA £10.5m fine; Simplyhealth acquires Denplan; WPA's moratorium variant; Employee absence up.

2-6

Reviews

New products from Ageas Protect; Benenden; Bupa; Medicare International; PruProtect and Universal Provident.

7-9

Medical and political

Private hospital sector static; Demand for care beds up; Unemployment still rising; Breast cancer screening may do harm.

10-12

Features

Blogs; People news; Sales and marketing ideas; Protection Review.

13-15

Statistics

UK households 2010; UK family expenditure 2010; Health at a glance 2011: OECD indicators (selected).

16

Key statistics:

- NHS RTT median wait England November 2011: 8.1 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: 107.090 (To end November 2011, compared to January 2000, see Page 11).

(Continued from Page 1) financial matters. However, while over 40% of women aged 18-24 and a third of men in that age group said they had sound knowledge of products such as income protection (IP) and critical illness (CI) cover, that figure fell to less than 20% of over 55s.

Life insurance was the product that people felt most met their insurance needs (more than 50% of respondents), but over 40% had never looked into buying CI, IP or private medical insurance (PMI) at all.

Interestingly, the figure varied little between the three product types and the results of this and other questions suggest that in consumers' minds they look not at different product types at all, but only at their needs. Whilst that is entirely logical from a consumer's point of view, it perhaps also highlights that within the industry, we still tend to see these areas as very different, partly because in technical terms, they are.

Awareness of need continues to rise

Compared to a year ago, more than half of respondents said they were more aware of personal protection products—a finding even higher than the 49% recorded earlier in 2011 in the Protection Review 2011 report. But, when asked whether they were now more likely to look into taking out or increasing their family's life and health cover than they were 12 months ago, only around a third of respondents agreed, with highest agreement being 18-24 year old women and 25-34 year old men.

Confusion over what protection insurance does and how it can benefit people is highlighted in the report's findings, with a worryingly high proportion of people not understanding what cover they actually have.

The report terms this phenomenon 'imaginary cover'. It says: 'we think the public are dangerously vulnerable to imagining levels of cover and even types of cover that they in fact do not possess'.

That is not a criticism of people (it would be foolish for any industry to try to blame its customers for not buying their products and services), but it does highlight an important and dangerous knowledge gap.

Ignorance of State help

Linked to that is ignorance of what the State does actually provide. Many people over-estimate State benefits (both availability and quantum) and also tend to over-estimate the help their employer would offer if say a health problem hit them.

It is sobering to note that in the same week The

Syndicate published its report, **CPAG (Child Poverty Action Group)** pre-announced publication of its excellent annual guide to welfare benefits and tax credits in April, which this year will run to an eye watering 1,696 pages. One conclusion is that State benefits are now so complex that no consumer can be expected to understand them all. Instead, the protection insurance industry surely has a duty both to advise people of the main provisions and also why it is important to top-up those benefits for the vast majority of people and families.

Enlightenment not information needed

Recognising that consumers today—thanks in part to greater compliance and stronger industry regulation in recent years—have much more information than before, the report points out that 'information alone does not convey enlightenment'.

The report also opines on the issue of simplicity and the growth of online buying, information and drivers. 'To expand the market and to engage younger consumers it is almost certain that protection will have to be sold in much greater volumes online' it says.

The report concludes that '[the industry] needs to be much closer to its potential clients, it needs to embrace simplicity as a very key component of its proposition and it must perhaps be a little more trusting in developing propositions that the public intuitively might buy'.

Founding members of The Syndicate include **Exeter Family Friendly**, the **Finance IT Net-Work**, **Friends Life** and **Zurich**. More members have already committed to join following publication of the first report, and the next waves of research will be commissioned later this year.

Conference calls for more passion

The conference in London that was held to launch the report was chaired by Hannover Life Re general manager, business development, Stuart Paton Evans and Protection Review co-chairman Peter Le Beau.

Stuart Paton Evans said: "At the heart of everything we do is the consumer, so we have here a research programme which will continually monitor both consumer behaviours and attitudes to our industry and its products." He added that: "The idea is to gain greater insight so that we can, if necessary, change the way that we approach the market." Peter Le Beau added that the industry now needs a 'spark of passion' injected into it if it is to fully address the needs of modern consumers.

To find out more about becoming a member of The Syndicate, please contact Peter Le Beau (see contact details on Page 15) or any of the Protection Review team or see the website at www.protectionreview.co.uk.

Changes to your e-Protection Review this month

Since *e-Protection Review* started life (as *HealthCare Insurance Report*) in 1998, we have constantly sought to make it as relevant as possible to those in all areas of the UK's life and health insurance sector and, periodically, that means making changes to the format.

Now, with this our first e-only (PDF) issue, we are introducing further positive changes. Here are the main ones:

- Developments at Protection Review have grown to the extent that they now command their own page. This month we start with explaining what we do and also tell you how you can be actively involved.

- We are featuring in each issue some of the blogs that we have featured on the website. This month we have two—from Zurich's Phil Brown and from our own Kevin Carr.

- We have dropped the T&C (Training and Competence) and 'What is?' sections, which were not as widely used as we had hoped.

- If you're new to e-PR, two conventions that otherwise might be puzzling: the first mention of any organisation in an article features its name in bold (makes it easier to find things). Italics signify websites and titles of papers/books etc. All designed to help you and save you time!

But do tell us how we can make e-PR even better and more useful to you. It really is *your* publication. E-mail andy@andycouchman.com.

OFT to refer private healthcare

The **OFT (Office of Fair Trading)** announced on 8 December 2011 that it had provisionally decided to refer the private healthcare market in the UK to the **Competition Commission** for further investigation.

Amongst the features identified were:

- Choice has a key role in driving competition. The OFT referred to a recent **King's Fund** report that found that 75% of patients thought choice was either 'very important' or 'important', and a *British Social Attitudes Survey*, which found 95% of people think there should be at least some choice over which hospital a patient attends.

- 'A lack of easily comparable information available to patients, GPs or health insurance providers on quality and costs of private healthcare services.'

- The cost of treatment may not always be transparent to private patients.

- There is a high concentration of providers in some parts of the country that may give a degree of market power to them.

- There are significant barriers to new competitors entering the market.

- Some providers were giving 'certain incentives' to consultants, including loyalty payments, for treating patients at a particular facility.

The OFT also announced that it will work with the **FSA (Financial Services Authority)**, **ABI (Association of British Insurers)** and health insurance providers to make the possibility of shortfall payments clearer to customers.

Consultation on the referral is open until the end of January and the OFT expects to reach a final decision by the end of March. See www.oft.gov.uk for more.

Consumers will pay £38.90 an hour

Consumers would accept paying £155 in fees for a full financial review after advisers move to an adviser charging model in 2013, research by **CoreData** claims.

A poll of 1,020 advisory customers found that clients would expect to pay an average of just £38.90 an hour for advice. The research claims that just 2.1m households in the UK rely on the services of a financial adviser. But, 37.8% believe they do not pay for advice.

The 77 page report *Consumer Fee Threshold and Appetite* is available from www.coredatasearch.co.uk.

Comment: *There is a big gap between what most people would expect and are happy to pay an IFA and what an IFA actually needs to make their business model viable.*

That gap has led to a focus on HNW (high net worth) and high income clients, effectively disenfranchising the vast majority of people who could benefit from better advice. Focusing on marketing life and health insurance—both traditionally remunerated by commission—is one way to change that trend.

Another would be to change the adviser model so that significantly more people are advised and significantly less time is spent in giving them that advice. Both are possible, but only with major changes to how the advice model works. That would require a more efficient way of getting to people, raising the take-up rate and much greater use of intelligent systems to automate advice. We can't see that happening soon, so creating a huge opportunity for the life and health sector.

FSA fines HSBC/NHFA £10.5m

The **FSA** announced on 5 December 2011 it was fining **HSBC** £10.5m—the largest ever retail fine the regulator has imposed—because of inappropriate investment advice provided to elderly customers by its subsidiary **NHFA Ltd**. In addition to the fine (reduced by 30% as HSBC had itself reported the failings to the FSA), HSBC expects to pay £29.3m in compensation to NHFA customers.

Between 2005 and 2010 NHFA advised 2,485 customers to invest in asset backed investment products—typically investment bonds to fund long term care fees. The individual needs of elderly customers were not met. In a number of cases the individual's life expectancy was below the recommended five year investment period the FSA said. The combination of withdrawals (to fund care costs) and product charges led to faster reduction of capital than should have been the case had they received the right advice. NHFA was acquired by HSBC for £9m in 2005 and the FSA reportedly carried out a supervision visit in 2004. HSBC said it identified problems in 2009, when NHFA (which closed to new business in 2010) was moved into the UK bank as part of a compliance review.

Comment: *NHFA founder Philip Spiers has questioned the FSA's past supervision 'failures' if the advice was wrong and also HSBC's due diligence. He also said NHFA used investment bonds with an underlying guarantee that, on death, the value of the investment could not go down. However, the other parties do not accept his claims. We have an additional question—if an investment should be held for a minimum of five years, is it also bad advice to take any withdrawals from it in those first five years. Or have we missed something?*

Simplyhealth acquires Denplan

Simplyhealth announced on 20 December that it had acquired dental plan provider **Denplan** from **AXA** for £115m in cash. Adding in a pre-disposal exceptional dividend of £30m and a capital release of £6m takes the total cash proceeds to AXA to £151m. Denplan is the market leader in its sector, with over 1.8m patients.

AXA is now focusing on four key areas—personal insurance, commercial insurance, wealth management and healthcare, having earlier disposed of its AXA life setup to what is now **Friends Life**. AXA PPP recently confirmed its acquisition of PMI provider **Health-on-Line**, which is expected to complete in the first quarter of 2012. Health-on-Line has been running high profile TV advertising in recent weeks and is expected, at least in the short run, to remain a separate brand within AXA.

Perfect storm ahead?

As we go into 2012 a question increasingly being asked is whether we are going into a 'perfect storm'.

That recognises that at the end of 2012 there must be gender equality in insurance, while changes to I-E taxation and Solvency II will all result in a probable big rise in life premium rates in 2013. Couple that with the view that the RDR is expected to see many more advisers increase their focus on health and protection and a view that we need to move away from selling largely on price, and 2012 looks to be a great opportunity to expand the sector.

Can insurance help avoid the effects of a disputed will?

At Protection Review we have recently seen an increased awareness of the provisions of the *Inheritance (Provision for Family & Dependents) Act 1975*.

In effect, the Act allows certain parties (e.g. children, spouses and even previous spouses who have not remarried) to apply, under section 2 of the Act, to the Court to make reasonable financial provision for them if the deceased's will or the laws of intestacy do not so provide. The Act applies in England and Wales.

Case law appears to take a hard line so that, even if there has been a complete breakdown of the relationship, a child may still apply for financial provision for example. Even a letter of explanation from the deceased, making clear their intention and even explaining why, does not appear to override the Act.

We wonder though whether this may lead to another use for life insurance. A life insurance policy written in trust does not form part of the deceased's estate and therefore is not affected by the 1975 Act.

Care will need to be taken to ensure that the effects of the Act are being complied with (so, someone could not give away their estate just before death to get round the Act's provisions, for example) and legal advice should always be sought, but life insurance could ensure that the 'right' beneficiaries receive what the deceased wants them to receive.

Does anybody else think that this Act can, in extremis, be unfair to deceaseds when there are good reasons a person has not been made financial provision for? We support the aims of the Act, but wonder whether it should be updated now. The full wording of the Act can be viewed at www.legislation.gov.uk/ukpga/1975/63.

Will life companies pay out on assisted suicide?

Money Marketing reported on 26 January that protection advisers have called on life companies to clarify whether they will pay out in cases of assisted suicide.

Aegon; Ageas Protect; Aviva; Bright Grey; Friends Life; LV=; PruProtect, and **Zurich** all confirmed that they did not have any exclusion for assisted suicide and said that each case would be treated on an individual basis.

Although assisted suicide is not lawful in the UK, it is in some other countries and the UK Government is under growing pressure to allow the practice here too, subject to suitable safeguards.

However, a general rule of law is that someone cannot benefit from a crime they have committed. The situation is complicated by case law (and the fact that all suicide was at one time illegal). On assigned policies (a mechanism rarely used these days but common in the past especially on mortgage protection business) it has been common practice for the assignee to ask the life office to waive any suicide clause. Insurers without a specific suicide clause may also be able to decline a claim on the basis that it is not permissible to deliberately 'destroy the insured goods' (their own life) for gain.

Many life policies today also pay out on diagnosis of a terminal illness as well as on death, so it is likely that that could trigger a life claim before a suicide is arranged. Such action however could put the insurer in a difficult position if it knows the proceeds will be used to fund an assisted suicide in another country.

What is needed now is clear guidance from the **ABI** as to what action its members should take. Invariably this will not be wholly binding in every situation, as an insurer may still need to investigate some claims, especially where it fears the motive is not just to ease the suffering of its deceased life insured.

Suicide is a tragic situation for all concerned yet, as people live longer and as medical science is better able to keep them alive, even where their quality of life is very poor, so assisted suicide by whatever means and whatever name will become more common. Life insurers need to ensure that the practices they adopt are robust and fair, yet also recognising that there are rarely winners when it comes to any suicide.

Bright Grey wants GPR solution

Bright Grey has called on the **ABI (Association of British Insurers)** to resurrect an agreement it had with doctors body the **BMA (British Medical Association)** to pay an agreed fee of £97 for a GP report (GPR) in return for a guaranteed maximum 21 day turnaround. The agreement (which had seen doctors agree a 5% annual fee increase when inflation was significantly lower than that) expired in March 2011 and has not been renewed.

Since then, some insurers (including **Legal & General** according to *Money Marketing* on 19 January) have used a subject access request, where customers can ask their GP for access to their full medical records for just £10. However, such SARs can take up to 40 days to receive and, while they may save insurers money in the short run, many doctors are unhappy to accept such a low fee. An ABI spokeswoman was quoted by *Money Marketing* as saying "The issue of accessing medical records is a matter for individual insurers and customers."

Comment: *There are now alternatives to GPRs (paramedicals and tele-underwriting for example) but the GPR still has its place and the present situation suits neither doctors nor insurers. The situation is likely to get worse before it gets better, with service standards bound to fall. How long before a patient's family sues a GP practice—for the full sum insured of a policy being set up—for not meeting service standards regarding a SAR?*

One option may be for the ABI to look beyond just the GPR situation. For example, help with technology could be linked to a new fee agreement, with the aim of minimising the time doctors (or their practice managers) spend on compiling reports. Discussions could also extend to critical illness cover.

Currently each individual critical illness has its own definition. This can run to many paragraphs, much of which is of a very technical nature and beyond the understanding or experience of most CI customers. In an ideal world, the insurance industry would negotiate from time to time with doctors (either the BMA or, more likely, the Royal Colleges) to have an agreed set of CI definitions. Then 'if your GP says you've had a critical illness, we pay out'. It would be a great message, but we see little appetite for such radical thinking just yet...

WPA develops new moratorium

Private medical insurer **WPA** has introduced a new moratorium underwriting option for its Flexible Health plan.

Traditionally, insurers look back five years and then exclude all pre-existing conditions for two years and until free of treatment (a very wide definition, that includes not just physical treatment but also medication, advice and check-ups) for a full two years.

That means, for example, that someone with a chronic condition would never finish a two year period and so any related conditions would not be covered (this is usually called a 5/2/2 rolling moratorium).

Some insurers offer a fixed two year period (or other timescale) rather than a rolling moratorium.

This means that all pre-existing conditions are covered after two years, regardless of whether treatment is ongoing. That is attractive to customers but is likely to result in higher claims costs and selection against the insurer by people who otherwise could not get serious health conditions covered.

WPA's solution also looks back five years and forward two, but scraps the third time element, instead requiring customers to be able to confirm two things:

- They 'have not been diagnosed with heart disease, stroke, diabetes, cancer or undergoing regular screening for cancer owing to your family history, nor had a surgical procedure for a joint or back condition'.

- For applicants over age 18, their body mass index (BMI) must be between 19 and 32.

Comment: *Moratorium underwriting is quick and easy but the risk is that the customer does not fully understand the implications. WPA's variant means that more people will be able to benefit from the moratorium, provided that they can meet the two question criteria. If not, traditional full medical underwriting (FMU) is probably still best.*

We would commend WPA for how it has explained the risks too. For example, it says on the moratorium underwriting form: 'Your policy will probably never cover pre-existing long-term medical conditions such as high blood pressure, which are likely to require regular or periodic treatment, medication or advice. This is because the moratorium period starts each time you receive such treatment, so it's unlikely you'll ever have two consecutive years free of treatment.' Simple, understandable and concise—exactly what is needed in our view.

We would commend all insurers to look again at how they explain their moratorium underwriting approach. If nothing else, greater transparency should reduce complaints when claims are made—complaints that damage not just individual insurers but the whole market too.

Bupa and BMI reach agreement

Bupa has reached a new three year agreement with hospital group **BMI Healthcare** that will see Bupa PMI customers able to be treated at all but three of the hospital network's facilities. The three are **BMI Gisburne Park Hospital**, **BMI The Lancaster Hospital** and **BMI Castle Consulting Suite**.

Previously Bupa effectively delisted 37 of BMI's 70 hospitals from New Year's day and communications between the two groups grew increasingly acrimonious. On

22 December Bupa claimed that BMI prices were 'over 20% more expensive than at least one other national hospital group. This is despite, in our view, offering no better quality or service.'

MD of Bupa Health and Wellbeing, Dr Natalie-Jane Macdonald, said on 18 January it had 'agreed a number of improvements in the way Bupa and BMI Healthcare will work together in the future'. More than 7,000 consultants practice at BMI hospitals—the largest hospital group in the UK, which is part of the **General Healthcare** group.

Aviva and AXA up cancer cover

Both **Aviva UK Health** and **AXA PPP healthcare** have announced improvements in the cancer coverage under their private medical insurance (PMI) policies.

Aviva announced in 2011 that it was removing all limits on cancer cover and would fund treatments recommended by medical specialists in full. That included targeted therapies such as Herceptin and Avastin and unlicensed drugs not generally available on the NHS.

AXA PPP healthcare has now removed the one and three year time limits (depending on product) on prolonged cancer drug treatment. It will also now cover chemotherapy or biological drugs given to prevent a recurrence of cancer or for maintenance of remission. Monetary limits on out-patient tests and consultations for cancer treatment have also been scrapped. A number of other improvements in what is covered for cancer have also been introduced, some of them policy specific.

Health Insurance magazine published online a useful comparison of each insurer's cancer cover on 11 January.

Employee absence up in 2011

Employee absence levels rose on average from a mean of 3.4% (7.7 days) in 2010 to 3.8% (8.7 days) in 2011 according to the **CIPD Absence Management annual survey report 2011**, in partnership with **Simplyhealth**.

A number of factors affected absence. For example the smallest (1-49 employees) firms showed least absence (2.5% or 5.6 days) compared to 4.2% (9.6% for firms with 5,000 plus employees).

Long term absence (for which products such as income protection are most valuable) made up 19% of all sickness absence but that varied from 22% for manual employees to 15% for non-manual. 64% of all absence was up to seven days, with 16% being for 8-28 days.

The survey also found that only 43% of organisations monitored the cost of employee absence.

The most common cause of long term (29 days plus) absence was stress (21% for manual jobs, 33% for non-manual), followed by acute medical conditions (e.g. stroke, heart attack and cancer) at 21% and 24% and musculoskeletal (17% and 7%). Next came mental ill health (11% and 18%), back pain (11% and 4%) and injuries/accidents not related to work (8% and 6%).

On stress, 39% of respondents reported that it made up a higher proportion of sickness absence in 2011, 34% that it had stayed the same and 12% that it had decreased (15% didn't know).

See www.cipd.co.uk for more.

Briefs:

- The number of directly authorised firms providing financial advice has fallen from a high of 5,584 in September 2008 to 5,482 at the end of 2011 the **FSA** has reported. The number of appointed representatives fell from 9,372 in September 2008 to 8,590 at the end of 2011. The number of sole traders has fallen from 875 in January 2006 to 779 at 31 December 2011.

- **CPAG (Child Poverty Action Group)** is publishing the 14th edition of its annual *Welfare Benefits and Tax Credits Handbook* in April. The book (expected to run to 1,696 pages—reflecting the complexity of benefit entitlements) cost £42 from www.cpag.org.uk/publications.

- The **CII** has reported exam sittings up from 36,000 in 2010 to 76,000 in 2011 (+111%) as advisers plan to meet **FSA** RDR requirements. This year the CII celebrates 100 years of its Royal Charter. The CII has 95,000 members, of which 19,800 (including **Protection Review's** co-chairmen Andy Couchman and Peter Le Beau are Chartered titleholders and FCII's).

- The Association of **Medical Insurance Intermediaries (AMII)** reported on 26 January that the number of candidates who have taken the CII/AMII IF7 PMI exam has now exceeded 500.

- Over 90% of IFAs have now gained the QCF level four qualification they will need to continue working after the **FSA's** RDR kicks in next year, according to *Financial Adviser* on 26 January. **Tenet** and **Openwork** have reported 94% and 90% of their advisers respectively have attained level four or are close to it. Other figures reported were **New Model Business Academy** (94%); **The Personal Finance Society (PFS)** (58%); **AWD Chase de Vere** (99%), and the **Institute of Financial Planning** ('the majority', with 50% at level 6). Tenet says 1 in 5 of those already at level 4 wants to go on to attain certified or chartered status, while PFS says 47% of its members plan to become chartered.

- Income protection (IP) specialist for self-employed professionals, **DG Mutual**, has reported 99% of its IP claims were paid out in 2011, for the fourth year running. On average each new claim in 2011 was for 14 days absence (it offers 'day one' plans), average age of claimant was 45 and 7% of its members made a claim in 2011 (a high figure, due to its day one plans).

- Economic risks, business interruption and destructive natural catastrophes are the biggest risks companies fear in 2012 according to research by **Allianz**. We can't do much for the first and last, but business interruption can be caused by human factors (illness or death) not just 'things', so life and health practitioners can use this finding from our general insurance colleagues to advance the case for business life and health cover too.

- **Citizens Advice Bureau (CAB)** claimed on 12 January that over two thirds of ESA (Employment and Support Allowance) medical reports were 'seriously inaccurate'. It says the inaccuracies were sufficient to have a detrimental effect on the awarding of welfare benefits.

- 22% of advisers (up from 20% last year) expect protection business to dominate their workload in 2012, **Avelo** claimed on 5 January. 39% (up from 34%) expected to major on pensions and retirement planning. 29% of ad-

visers expected higher revenues per head/adviser in 2012, while 24% expected a fall and 47% no change.

- Belgium is the top country for expatriate health-care, followed by Germany and France, according to the *HSBC 2011 Expat Explorer Survey* of 3,385 expats living in more than 100 countries. The rankings are based on affordability, access and quality of care.

- The UK's largest private medical insurance providers are increasing premiums in 2012 'by up to 20%' *The Sunday Times* reported on 8 January.

- 55% of decision makers with HR responsibilities agree with the Dame Carol Black/David Frost report view that all companies should be given tax breaks to provide all their staff with medical insurance, according to research from **Simplyhealth**, it said on 21 December. 52% of respondents who only offer PMI to some employees said they would be more likely to extend PMI cover to all employees if there was a new tax break for all those who are standard rate taxpayers. The research was carried out by **YouGov** among 1,020 HR professionals.

- Solvency II may cost UK insurers £2bn to implement according to a 110 page **Treasury** consultation document published in December.

- Protection business made up 12.74% of IFA new business in the third quarter of 2011, compared to 8.82% in Q2, according to research by **Workload**, an **Equifax** company, through its MyTouchstone database. The research is also unique in giving a regional breakdown. Data comes from 76 life and pension providers. The **CII** publication *The Journal* includes a useful article (Page 27) on the new research.

- The cost of diagnosing and treating cancer in the UK is likely to rise by almost two thirds (62%) over the next decade according to **Bupa's Cancer Diagnosis and Treatment: A 2021 Projection** report, released on 12 December. The cost is expected to rise from £9.4bn in 2010 to £15.3bn by 2021. The average cost of treating someone with cancer was around £30,000 in 2010; by 2021 this is expected to rise to almost £40,000. Part of the increase is due to the ageing population, which is expected to lead to a 20% rise in cancer cases by 2021. The NHS faces a £5.2bn cost increase, the private sector £531m and the voluntary sector £131m the research, conducted by **Laing & Buisson** claims.

- 61% of car insurance sales will be driven by aggregators by 2013 according to **Datamonitor**.

- **SelectX** and claims expert Karin Lloyd have jointly produced a new strategic report on claims processes. See www.selectx.co.uk for more.

- Reinsurer **Pacific Life Re** has suggested that the industry should be urging the Government to insist borrowers take out a minimum level of protection insurance when buying a home.

- 31% of its group income protection claims in 2011 were due to mental health issues and 20% to musculoskeletal conditions **Canada Life** has reported. Both are subjective conditions where definitive evidence is difficult or impossible to obtain.

- **Key Mortgage Associates** director John Folan has been banned and fined £195,117 by the **FSA** for submitting at least 54 protection applications in his own or family members' names, in order to obtain commission.

Pick of the month

We look at a range of new products and ideas this month.

Benenden Healthcare has launched a cash plan for the over 65s with Engage Mutual, Bupa has entered the individual dental insurance space, Medicare International updated its IPMI plans, PruProtect introduced the loyalty Premium Saver concept and Universal Provident launched an interesting health hybrid.

Our pick of the month is Ageas Protect for the updates to its CI plans and its nice Christmas gift to its existing customers.

Ageas Protect Your Life Plan Critical Illness with Term Assurance

Ageas Protect, formerly **Fortis Life** (it rebranded in January 2011), updated its critical illness plan in December:

- The number of illnesses with ABI+ definitions has been increased from 11 to 15 (highest in the market, Ageas says) including ABI+ definitions for cancer, stroke and multiple sclerosis.

- Two of the existing TPD (total and permanent disability) definitions are now also ABI+.

- Total disability is Ageas' new name for TPD with temporary disability. This puts into one option two previous benefits and pays a monthly income after 26 weeks off work if the condition is likely to be temporary. If it becomes permanent, the balance of the benefit is paid as a lump sum. The monthly benefit is around the lower of 1% of the sum insured or 50% of pre-incapacity income.

- Double child payment (DCP). This doubles the benefit if treatment is not available in the UK but is overseas and the benefit is supported by **Best Doctors**. The benefit pays 100% of the sum assured up to a maximum of £100,000. DCP applies to all covers, so if each parent has a single life plan two payouts could be possible.

Ageas has taken a bold line by applying the improvements retrospectively, and contacted its customers before the end of 2011 to inform them that their benefits have increased. It says it is the only insurer to retrospectively apply improvements in this way two years running.

It has now gone a stage further by increasing payments already made in some cases. So, for example, a benefit limited child's claim could result in a second payment now being made.

The plan itself now covers 39 conditions (one of which pays out a partial payment), includes the Best Doctors service and has no standard exclusions.

Comment: Ageas has not only improved a number of its CI definitions, it has also applied them retrospectively. We also like the total disability idea, which moves from paying an income to a lump sum if a disability moves from temporary to permanent. TPD remains a controversial and vulnerable area for CI insurers and Ageas' approach helps takes TPD forward.

Product design points: Applying new improved definitions is something that a relatively new insurer can do easily, because it affects relatively few people and is fairly straightforward to do. But to a CI insurer that has been selling the product since the 1980s, that would be virtually impossible and potentially too expensive even if it could be done. Ageas

can exploit that and, by doing that just before Christmas (as it has just done) it could gain significant good PR by presenting its customers with a nice Christmas present. Other insurers could also look to apply seasonal 'gifts' too.

Total disability is also worthy of note. Most people need an income benefit but lump sums annoyingly have more consumer appeal. This benefit combines both, paying an income initially then switching to a lump sum if the disability becomes permanent. That can make practical sense as by then, the customer may need a lump sum to pay for home alterations, buy other capital items or to set up their new changed lifestyle for the future. We think TPD is a really important catch-all for CI, but the industry continues to struggle with getting the benefit right. Total disability is an improvement, but we think TPD is still not quite 100% the benefit is could or should be.

Plus points: New and improved definitions that have been applied retrospectively, so actively rewarding existing customers' loyalty. We also think total disability takes forward the TPD argument.

Not so plus points: Will Ageas always be able to retrospectively improve definitions? Probably not, but while they can, that's a big marketing point. Total disability income payments made will reduce any eventual lump sum payable.

Website: www.ageasprotect.co.uk

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

Benenden Health Cash Plan 66+

Benenden Healthcare Society subsidiary Friendly Healthcare Organisation Ltd has joined with **Engage Mutual** to develop this health cash plan aimed at individuals aged 66 and over. There is no upper age limit at outset or later and premiums start at just £10 a month. There are three levels of benefit available providing:

Benefit	Level 1	2	3
Optical 100%	£40	£80	£110
Dental 100%	£45	£85	£135
Complementary therapies (chiropractic; acupuncture; osteopathy; homeopathy) 100%	£80	£160	£249
Hearing aid 100%	£75	£150	£225
Hospital in-patient max 10	-	£10	£20
Hospital day surgery max 10	-	£5	£10

Plans cost £10 a month at Level 1 (for singles; joint plans, which also cover a partner, cost £19.50 a month and offer the same benefits to each insured person), £20 (£39.50) at Level 2 and £30 (£59.50) at Level 3. All pre-existing conditions are excluded, and there is a three month initial waiting period (that also applies if a partner is added or benefits increased).

Comment: It is good to see older people being targeted (Benenden already offers an HCP for those 65 and under) and this plan includes a range of benefits designed to appeal to older people who value the budgetary help HCPs can offer. Benefits are relatively low but then so is cost.

Product design points: HCPs provide benefits to help towards or pay for everyday health costs and this plan targets those costs most likely to be incurred by older people. In absolute terms, benefits are relatively low, but the help they can give to people on already tight budgets should not be underestimated. And, a plan could always be funded by the customer's

children (or even grandchildren) if cost is an issue. One area where we would like to see insurers generally improve is communicating potentially complex features such as not covering pre-existing conditions. All that is needed is a full explanation and an example or two of what is meant by a term that many people outside the insurance world simply never use.

Plus points: Useful range of benefits to appeal to older customers. Simplicity, with three levels of cover available.

Not so plus points: Benefits are relatively low. More explanation of what constitutes a pre-existing condition is necessary—especially as the target market is what many would consider as being potentially vulnerable.

Website: www.benenden.org.uk.

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

Bupa Dental Cover 20

Dental Cover is Bupa's first consumer dental insurance product. Previously dental cover was available to individuals but only as an option on the group Bupa By You product. The new plan is available in two versions.

Dental Cover 10 is annually renewable dental insurance for people with an NHS dentist. It reimburses 100% of all NHS treatment charges (in NHS bands 1, 2 and 3) and pays up to £15,000 a year for oral cancer treatment (which includes up to £400 a year out-patient costs and £380 for each course of radiotherapy treatments). Non NHS dental costs that may be incurred are not covered.

Dental Cover 20 is a more expensive version for customers with a privately registered dentist. It pays:

- Up to £150 a year for routine dental treatments.
- 75% of the cost of more expensive treatments (e.g. fillings, extractions and crowns) up to £700 a year.
- Up to £600 a year for emergency dental treatment given in the UK.
- Up to £5,000 a year for dental injuries that are treated in the UK.
- Up to £15,000 a year for oral cancer treatment.

An initial six month waiting period is applied for oral cancer care and four months for dental treatment (although not for emergency or routine dental treatment).

Cosmetic treatment is not covered and all pre-existing conditions are excluded, as is treatment for physical contact sport injuries. Other exclusions are fairly standard for this type of cover and include hospital treatment such as removing wisdom teeth.

Customers get access to a dedicated member helpline and Bupa says all claims are settled quickly and efficiently. No examples of pricing were given in the launch material but customers can phone to get a quote.

Comment: *The dental insurance market has stalled in recent times but the fundamental need for such cover remains and indeed is likely to grow as dental hygiene commands ever greater attention. This plan has much to commend it but the detail in the literature is quite thin. In particular, PECs are not covered but no further information is given. As many dental treatments are on top of previous treatments (e.g. replacing a filling with a crown or extracting a diseased and previously treated tooth) it is important to set out, with examples, exactly what is and is not covered.*

The issue is not so much what Bupa will pay for, but

what its T&Cs say it will pay for. This criticism is not unique to Bupa, but it is an issue we would like all insurers to pay much greater attention to, to improve transparency.

Product design points: *Most dental insurance in the past has been in the group market, where anti-selection is less of an issue. Bupa's plan offers true insurance (rather than the more common capitation or dental fees management plans) with a PEC exclusion rather than any dental examination and/or history being necessary. That makes cover simple to buy. But, if you do that, it is incumbent on the provider to explain fully what is and is not covered, not least because if you don't, problems are bound to arise when claims are made.*

Plus points: *Dental insurance for individuals with no pre-enrolment checks and a low cost version for people with an NHS dentist (although it does not cover non-NHS treatments). Cancer cover is useful but is no substitute for having critical illness cover too.*

Not so plus points: *Poor explanation of PECs (just a single sentence with no further explanations or examples given). Likely to pay towards rather than for many dental costs. Initial waiting periods apply.*

Website: www.bupa.co.uk/dentalinsurance.

Rating (max 5): Innovation: 3.5. Overall: 3.

Medicare International

MediCare International has brought in two changes to its International range of IPMI (international private medical insurance) plans. Now, customers can choose one of four voluntary excesses:

- A £500 (or the equivalent in US \$ or €) per claim excess gives a premium reduction of 10%.
 - A £1,000 excess gives a 20% premium discount.
 - A £5,000 excess gives a 35% premium discount.
 - A £10,000 excess gives a 50% premium discount.
- MCI has also added a multi-currency feature to its online quote and buy package.

The plan is available to both individuals and groups, with discounts starting from just three lives. The plan is available in four versions - International, International Plus, Executive and the top of the range Executive Plus. There are two geographic pricing areas (worldwide, with or without USA, Canada and Caribbean) and the maximum annual benefit is £1m per insured person per year.

All versions of the plan cover chronic conditions and cover is even available in more difficult geographies such as warzones and post conflict reconstruction areas.

The International plan pays for hospital treatment, medical evacuation, home nursing, cancer treatment, chronic conditions and newborn care. The top level Executive Plus adds HIV/AIDS benefit; out-patient services; complimentary therapies; dental cover; maternity care; wellness benefit, and psychiatric cover. The two other plans' benefits lie between these two.

Cover and exclusions are fairly standard, with all larger claims (that is, all in-patient care and all claims likely to exceed £2,500) having to be pre-authorized. There is a 5/2/2 year rolling moratorium on individual plans.

Comment: *MCI has taken its existing product range and added a useful excess option.*

Product design points: *At one extreme, customers*

can obtain a huge 50% discount, but only by selecting an equally huge £10K a year excess. That simply means this will appeal more to companies than to individuals (although wealthy individuals may also think it worthwhile). Should an excess be per claim or per policy year? For this plan, it's per claim but you can really make a case for either, and both have their potential disadvantages too. In an ideal world, it would probably be per year but with claims running over the policy anniversary date just being counted in the earlier year—but that would add complexity and cost to what should be a simple cost saver.

Plus points: Attractive premium savings by choosing an excess, with up to a 50% saving.

Not so plus points: Frequent claimers are always disadvantaged by excesses; the top level of excess is very high (but worth it to some); only two geographic pricing areas.

Website: www.medicare.co.uk

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

PruProtect Premium Saver

PruProtect's Premium Saver is an add-on benefit to its existing protection solutions. For a small extra premium (or built on new plans taken out), customers build up accrued premium discounts over a five year period.

After five years, those savings are then applied towards premiums over the next two years. A customer who fully engages with the Vitality programme could get up to two free years of premiums every five years. In year six, as well as benefiting from any premium benefits, the five year clock starts again and benefits start accruing for the next five year period.

How much benefit accrues depends on a range of factors including whether the plan is indexed, level or decreasing and what the customer's Vitality status is at each plan anniversary. The greatest benefits go to platinum members with index linked plans. Customers benefit from other premium discounts too, so the healthier they get, the bigger the premium discounts.

The insurer has also updated its quote tool and Vitality programme. New Vitality partners have been added (but some removed) and partners fall into two broad categories – health partners and reward partners. A customer could, for example, get 50% discount on various health screens and gym memberships, discounted **National Trust** membership and 50% off two year monthly subscriptions from **Vodafone** among other external benefits. Some of these benefits are available to all, some only to those with Vitality Plus, and in some cases the benefit or discount is dependent on Vitality status too. The changes take place between January and April 2012.

Comment: *PruProtect is one of the more exciting life offices, and has a strong tradition for innovation and we applaud that. Its latest changes will appeal to those who are most likely to benefit from them, although a smaller number may be disappointed at some of the changes. Overall, the Vitality concept adds complexity and rewards engagement (of both intermediary and customer) but the benefits can significantly outweigh any disadvantages.*

Product design points: *PruProtect's latest changes are not really a new product, but they are still noteworthy. They also raise new and different issues for insurers, not least is managing people's expectations, how to manage benefits that may*

have to be removed or cut later and whether the frequent changes that are almost inevitable create communications opportunities or risk change overload. None of those is insurmountable, but the strategy has to be developed carefully to ensure maximum benefit is achieved. Do benefits such as Vitality help create loyalty and avoid protection becoming commoditised? Potentially, yes and yes, but good communication is key.

Plus points: *Significant savings to those who fully engage, and a level of innovation and involvement that is hard for competitors to copy.*

Not so plus points: *Careful management of changes is necessary and PruProtect's proposition does require the adviser to engage, not just the customer. Having to wait five years to benefit then getting discounts over the next two rather than five years may be seen as odd by some, but there are benefits to going this way instead of having a 5/5 year model.*

Website: www.pruprotect.co.uk/adviser

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

Universal Provident Oasis

Universal Provident's Oasis is a new hybrid health/protection insurance product that pays cash lump sums for serious illness and major medical expenses and also has a hospital cash benefit. There are three main elements:

- **Serious illness.** This benefit pays a £15,000 cash lump sum on being diagnosed with bacterial meningitis, cancer, heart attack, or stroke. The policy then continues after a claim is made, albeit with some restrictions. For example, if the customer suffers a heart attack following a stroke (or vice versa), the plan's benefit would be halved for the second condition (or there would be no second payment if within 45 days of the first claim). Congenital, hereditary, pre-existing and related conditions are all excluded.

- **Major medical expenses.** The plan has three benefit bands, with the policy paying out £1,500 for surgical procedures in UP's band 1, £3,000 for band 2 and £5,000 for band 3 procedures. This should cover the cost of many but not all procedures and does not cover other hospital costs such as out-patient treatment costs or other benefits usually included in PMI policies.

- **Hospital cash.** This benefit pays £25 a night for each night hospitalised, up to 20 nights a year.

The plan is available to UK citizens aged 18 to 74 and dependent children (under 21 or 25 if in full-time education) may be included free of charge.

Exclusions are fairly standard and there is a 5/2/2 year rolling moratorium applied to the major medex and hospital cash benefits.

Comment: *This is a really innovative solution but falls down on the detail. For example, the critical/serious illness benefit is quite low and only pays out on diagnosis of four conditions. Major medex could be useful, but coverage is much less than on full PMI. And, the HCP benefit is just for each night in hospital, when the most popular HCP benefits generally are to cover dental and optical costs. It adds up to a product that does not (yet) fulfil its potential, although there is scope to extend benefits to change that in future*

Product design points: *Hybrid products have a mixed history—for the very good reason that it is hard to include all the good points without the end result becoming horribly*

complex and expensive. This product is a good attempt, but we are not convinced that the balance of benefits chosen is right. That said, the framework is commendable and, with some tweaking, a considerably better product could be developed. It won't be that easy though...

Plus points: A very innovative hybrid with the potential to meet a range of needs at an affordable price.

Not so plus points: Less breadth and depth of cover than its constituent products would normally provide.

Website: www.universalprovident.co.uk.

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

Medical...

Private hospital sector static

Revenues generated by independent hospitals providing medical treatments in the UK remained unchanged in real terms at £3.84bn in 2011, according to the latest *Laing's Healthcare Market Review*, published on 27 January.

Among the key findings were:

- PMI funded care has fallen to just 59% (£2.3bn) of revenues, compared to 65% in 2005.
- NHS patients using private facilities grew over the same period from 14% to 25% (£957m) but this may be reaching a cyclical high. Of the figure, 58% (£559m) is estimated to be local spending by hospital trusts, including £356 through the Extended and Free Patient Choice Networks, £357m is national contract spending through the ISTC programme and the remaining 4% (£41m) was generated from central procurement of diagnostics. Of this £357m (up from £365m in 2009) Care UK had 35%, Circle 18% and UK Specialist Hospitals 16%.
 - Patient choice (through Choose and Book) is expected to see revenues rise to at least £500m in 2011.
 - Pay as you go patients provided 14% of revenues (£534m) up by 0.5% post-recession.
 - Other sources made up the remaining 2.5% of revenues (£104m).
 - NHS income from treating private patients in NHS hospitals was flat at £445m in 2010/11, down 1.6% in real terms from the year before. Now that the Government is raising the private patient income cap to 49% in the NHS, independent hospitals look to face competing interest from this area.

- At mid 2011 there were 515 independent hospitals, compared to 454 in mid 2010. Of these, 211 offered 9,545 in-patient beds and 304 day surgery only. A further 73 were private patient units (PPUs) within NHS hospitals.

- The independent sector is estimated to have treated around 425,000 (overnight and day patient) NHS patients in 2020

The top five independent hospital groups in 2011 were (revenues plus market share):

Group	Turnover	Mkt share
1. General Healthcare Group*	£836.2m	21.5%
Netcare Healthcare UK	£19.0m	0.5%
2. Spire Healthcare	£643.0m	16.6%
3. HCA	£490.3m	12.6%
4. Nuffield Health	£391.6m	10.1%
5. Ramsay Health Care UK	£350.0m	9.0%

Top 5 providers £2,730.1m 70.3m
 All independent acute providers £3,883.0m 100%
 *General Healthcare was acquired by Network Healthcare Holdings in April 2006 and trades as BMI Healthcare. *Laing's Healthcare Market Review 2011/12* costs £430 (or £790 for PDF/Excel) from www.laingbuisson.co.uk.

Comment: Private hospitals are seeing PMI income become a smaller part of overall income but it still makes up the majority and, at least in the past, price has been less of a factor than might have been expected. As Bupa's recent spat with BMI suggests, this is now changing. One surprising finding is that self-pay has held up well post 2007—suggesting that there is still scope for PMI to expand to offer an alternative.

Demand for care beds rises

Other research from **Laing & Buisson** shows that despite public policy favouring non-residential solutions to support the care needs of the country's ageing population, demand for care home beds has risen.

The number of elderly or physically disabled people in care homes in the UK rose to 421,000 in the year ending April 2011 (up 6,500 on 2010). The number of care home hours provided in 2009/10 (the latest available figures), dropped by 8% from 200m a year to 183m.

Some 41% of residents (159,000) were fully responsible for their own fees in 2011. If those who pay 'top up' fees are added to self-payers, this group would make up 55% of care home residents. NHS funded residents have also increased their share to 8.5% of residents across all home types and to 20% of those more specialist homes.

Care home fees have risen at a compound annual growth rate of 3.5% for nursing homes and 4% for residential care over the last four years and the upward trend seems set to stay for 2011/12.

At April 2011 capacity stood at 481,100 places in residential settings for long stay care of elderly and physically disabled people (474,600 in 2010, 467,600 in 2006).

Average care home fees in 2011/12 were £722 a week for nursing care and £542 for residential care.

The annual value of the market is £14.5bn (for-profit sector- £10.5bn, voluntary sector-£2bn, public sector-£2bn). *Care of Elderly People UK Market Survey 2011/12*, is £795 for hard copy and £1,155 for hard copy and PDF.

Comment: More good reasons for insurers and advisers to look again at long term care solutions?

More medical stories:

- Faster walking speeds (more than 1.36 metres per second or 3mph) help protect against early death according to Australian research published in the *BMJ* on 15 December. But it found the average walking speed was just 0.88 metres per second in men aged 70 and over participating in the CHAMP survey.

- Cognitive decline can start as early as age 45 research into the Whitehall II cohort study of civil servants aged 45-70 has found. See www.bmj.com/cgi/doi/10.1136/bmj.d7622.

- A third of all cancers in the UK is caused by just four risk factors: smoking; poor diet; alcohol, and excess weight the *BMJ* reported on 6 December.

Unemployment still rising

Unemployment rose from 2.62m in July-September 2011 to 2.64m in August-October then to 2.68m from September-November, according to the latest *Labour market statistics* bulletins, released by the **ONS** on 14 December 2011 and 18 January 2012.

During the same periods, employment actually rose, from 29.07m to 29.11m then to 29.12m. This means that the *e-Protection Review Employment Index*, which is a proxy for the growth in size of the main health and protection insurance markets since 2000, rose from 106.906 to 107.054 then to 107.090. 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 1.60m, although up by 3,000 in November and by 1,200 in December. The latest unemployment rate is now 8.4%, or 4.9% for JSA claimants. Earnings in the three month period to end November (including bonuses) fell further, from 2.3% to 1.8% then rose again, to 1.9% higher than a year before.

On 13 December the ONS announced that in November the Retail Prices Index (RPI) was up 5.2% compared to a year before (down from 5.4% in October). Then, on 17 January it announced an RPI figure for December of 4.8%. The Government's preferred Consumer Prices Index (CPI) was down from 5.0% to 4.8% in November and fell further, to 4.2%, in December. This compares to an annual inflation target of 2.0%.

Comment: *The employment situation remains confusing, with the national media focusing on the fact that the number of unemployed people is higher than since 1994 and the unemployment rate (8.4%) is highest since 1995. However, JSA claimants have been rising much less and the number of employed people has actually risen. If nothing else, this supports the view that it is best to read the full bulletin rather than just read the (often misleading or at best incomplete) headlines.*

Hospital RTT waiting times down

The median Referral to Treatment (RTT) wait for NHS hospital admission in England fell from 8.8 weeks in September to 8.4 weeks in October and to 8.1 weeks in November according to **Department of Health** Statistical Press Notices released on 14 December and 19 January. For non-admitted patients the median wait fell from 4.5 weeks to 3.9 then 4.0 weeks in November. The 95th percentile time wait for patients entering an RTT pathway went from 22.8 weeks to 22.0 weeks then to 22.2 weeks for admitted patients and from 16.0 weeks to 16.1 weeks to 16.2 weeks for non-admitted patients.

The number of patients meeting the 18 week target rose then fell from 90.7% to 91.2% to 91.1%.

Heart deaths halve in a decade

The death rate from heart attacks in England has halved in the past decade research published in *BMJ.com* reported on 25 January. Based on national hospital and mortality data, of 840,175 men and women who had suffered 861,134 heart attacks between 2002 and 2010, the death rate fell by 50% in men and by 53% in women.

Half the reduction was due to fewer new heart attacks and half to fewer deaths after the attack. Better cardiovascular health and better NHS care were key factors.

The research also found:

- 61% of those who had a heart attack were men.
- 36% of heart attacks were fatal.
- 73% occurred in people aged 65 and over.
- Of 311,419 fatal heart attacks, 70% were sudden deaths that occurred without a hospital admission.
- The greatest declines in heart attack rates were among middle-aged individuals.

Breast cancer screening may cause more harm than good

Breast cancer survival rates established by the *Forrest report* in 1986, which led to the introduction of breast cancer screening, have been updated by researchers at the **University of Southampton**.

The original survival rates estimated the number of screened and unscreened women surviving over a 15 year period and costs and benefits were measured in quality adjusted life years (QALYs), but it omitted the harms, suggesting that screening would reduce the death rate from breast cancer by almost a third with few harms and at low cost. Harms include false positives (abnormal results that turn out to be normal) and overtreatment (treatment of harmless cancers that would never have caused symptoms or death during a patient's lifetime).

The new results are based on 100,000 women aged 50 and over surviving by year up to 20 years after entry to the screening programme. The inclusion of false positives and unnecessary surgery reduced the benefits of screening by about half. The best estimates generated negative net QALYs for up to eight years after screening, minimal gains after 10 years and after 20 years net QALYs accumulate, but by much less than predicted by the Forrest report.

The authors suggest more research is needed. A French study published in November put overdiagnosis of invasive breast cancer due to screening at around 1%. See: www.bmj.com/cgi/doi/10.1136/bmj.d7627.

UK healthcare spend exceeded OECD average in 2009

Health at a Glance, the sixth in a series of annual reports shows the UK had exceeded the average of the **Organisation of Economic Co-operation and Development (OECD)** for the first time in 2009 (see Page 16).

Health spending in the UK was 9.8% of GDP (gross domestic product) whereas the OECD average was 9.6%.

Across all 34 OECD countries the quality of medical care has risen too. Only 4% of people hospitalised after a heart attack now die in the 30 days after admission (8% in 2000) and 84% of women survive five years after diagnosis with breast cancer (79% in 1997). However the report warns that not enough is being done for people with chronic conditions such as asthma and diabetes with too many being admitted to hospital. Also 50% or more of the population is now overweight if not obese in more than half of OECD countries.

Medical briefs:

- The *Heart Protection Study* from the **University of Oxford** involving over 20,000 patients at high risk of vascular disease allocated either 40mg simvastatin or a placebo daily for five years with a follow up of six years, has concluded long term use of simvastatin is safe with no increase in cancer or deaths from non-vascular causes. See: <http://tinyurl.com/cqjnamx>.

- Asking the questions: 'During the past month, have you often been bothered by feeling down, depressed or hopeless?' and 'During the last month, have you often been bothered by little interest or pleasure in doing things?' are as accurate at identifying risk of depression as more complex surveys, according to researchers from the **University of York** who reviewed 113 studies. See: *British Journal of General Practice* (2011) 61: 733-734.

- A Swedish study of more than half a million patients with autoimmune diseases and 15,607 with pulmonary embolism has confirmed a powerful association between the two conditions. Adults with any one of 33 autoimmune diseases admitted to hospital between 1964 and 2008 had a significantly higher risk of pulmonary embolism. See: *Lancet* 2011; doi: 10.1016/S0140-6736(11)61306-8.

- Warfarin is responsible for a third of the 100,000 older adults admitted to US hospitals with adverse events each year. Other drugs causing hospitalisation include oral antiplatelet agents, insulins and oral hypoglycaemic agents most commonly through overdose resulting in haemorrhage or hypoglycaemia. See: *New England Journal of Medicine* 2011; 365: 2002-12.

- Newer alternatives for hip implants appear to have no advantage over traditional implants. US researchers analysed 18 studies involving 3,139 patients and over 830,000 operations in the annual reports of registries. The authors called for a large randomised trial of bearing surfaces before any claims of benefits are made. See: www.bmj.com/cgi/doi/10.1136/bmj.d7434.

- A team from the **University of Lyon** in France found that surgeons aged between 35 and 50 years provided the safest thyroid surgery care compared with their younger or older colleagues. This accords with the ages of peak performance (or after about ten years' experience in their speciality) found in other studies. See: www.bmj.com/cgi/doi/10.1136/bmj.d78041.

- The hypothesis is that famous musicians are at an increased risk of death at age 27 (the "27 club"). But a study has found that among the sample of 522 crooners, death metal stars, rock and rollers and even Muppets (the actors not the puppets), only three deaths occurred at age 27 and similar peaks were seen at age 25 and 32. See: *BMJ* 2011; 343: d7799.

- The *BMJ* (BMJ2011;343:d7732) reports the first case of 'Manchester United induced Addisonian crisis'. A 58 year old woman reported a significant deterioration in her exercise tolerance in late 2010 plus anxiety, panic and a sense of impending doom. A diagnosis of autoimmune mediated Addison's disease was established, and it was found that this was brought on by the stress of watching high profile football matches at Old Trafford. Cortisol replacement therapy has helped her overcome the disease. Good job she doesn't support Arsenal this season...

Political briefs:

- In November 2011 there were 983 breaches of mixed-sex accommodation in NHS hospitals in England and in December, just 767, the Department of Health reported on 15 December and 19 January. This compares to 11,802 in December 2010. The often distressing position of a patient finding themselves in a mixed-sex ward has now all but been eliminated, with 73% of trusts now reporting zero cases.

- MRSA bloodstream infections across the NHS have been sustained at under 100 reported cases per month for the last six months, the DH reported on 13 January. There were just 86 reported cases in November. Government targets are to reduce MRSA infections to 880 and clostridium difficile infections to 16,100 a year.

- A new drive to free up nurses to provide more time on frontline care in wards was announced by the Prime Minister David Cameron and Health Secretary Andrew Lansley on 5 January. It follows revelations of poor care standards in some hospitals.

- In November, 419 urgent NHS operations were cancelled at the last minute for non-clinical reasons the DH announced on 23 December.

- The average daily number of NHS beds in England available overnight was 138,714 in the quarter ended 30 September, compared to 137,455 in the previous quarter, the DH announced on 24 November. Average occupancy rate was 83.9% (down from 84.8%). Of the available beds, 105,673 were general and acute beds (up from 104,620), with an average occupancy rate of 85.1%. The average daily number of day only beds was 11,468 (up from 10,705 the previous quarter).

- A *Nursing Times* survey on 22 November found just 8% of respondents would be happy to see the private sector take over the running of their trust; 92% would not.

- There were an estimated 25,700 excess winter deaths in England and Wales in 2010/11 a figure virtually unchanged from the previous winter, the **Office for National Statistics** revealed on 22 November. Excess winter mortality is associated with low temperatures but circulatory and respiratory diseases cause the majority of these deaths, not hypothermia.

- The Romanian health system could be radically changed from one based on a state health insurance scheme to one based on private insurance companies, *BMJ* 2011; 343: d7611 reported on 24 November. If passed by the Romanian parliament, the new two tier scheme will have a basic health services package covered by all private insurance companies and a supplementary charge for additional services.

- If trends continue, health insurance premiums in the US are set to reach £16,500 by 2020. State by state analysis showed premiums rose by 50% from 2003-2010. In 2010 an estimated 62% of the population lived in states where health insurance ate up 20% or more of a typical income. See: *BMJ* 2011; 343: d7503.

- The Government has announced that when Disability Living Allowance (DLA) is replaced with Personal Independence Payment (PIP) in 2013, disabled people in residential care will continue to receive any mobility component on PIP they are entitled to.

Blogs

We feature some of the blogs that first appeared on the www.protectionreview.co.uk website. We start with Phil Brown of Zurich UK Life who considers the issues of gender and protection. This blog was first published on the website on 3/1/2012.

One of the biggest issues to be addressed in 2012, in a year when many other changes are likely to be afoot, is how the EU Gender Directive will impact on protection. From 21 December 2012, the use of risk factors based on gender in connection with insurance premiums and benefits will officially become incompatible with the principle of equal treatment for men and women under European law. The rule of unisex premiums and benefits will apply.

So, what does all this mean for our industry and, specifically, for protection?

On 22 December the European Commission published its guidelines on the application of Directive 2004/113/EC to insurance in light of the Test Achats judgement earlier this year.

It is pleasing that the guidelines seem to reflect the industry's view on the main implications of the ECJ ruling. Contracts concluded before 21 December 2007 and/or expiring before 21 December 2012 should be unaffected. However, certainty is still needed on contracts concluded after 21 December 2007 that continue after 21 December 2012 and contain mechanisms for review, renewal, or other adjustment.

Whilst the EC guidelines are now final, HM Treasury is currently consulting on the national implementation of the judgement. The consultation closes on 1 March 2012 and seeks views on the Government's legal interpretation of the judgment and the accompanying draft regulations that amend the Equality Act. It also seeks comments on the Government's impact assessment and requests additional data that would contribute to a better understanding of the impact on consumers and insurers. Finally, it asks for views on some of the key issues arising from the judgment, such as the scope of indirect discrimination.

The area that is currently getting a good deal of attention, not surprisingly, is what the impact might be on premium rates. Whilst it is hard to look at gender impacts on premium rates in isolation, given the future removal of protection business from the income minus expenses life tax system, many industry commentators are already predicting that gender may cause some reasonable reductions in male rates, whilst female rates would need to increase.

With the tax regime changes (that will affect different companies to varying extents) overlaid on top of the gender impact, we may see male rates reduce or remain broadly neutral, although female rates could increase quite significantly.

Underwriting has also been a focus for protection providers and the EC guidelines provide some good news in this respect, confirming that the industry should be largely OK in maintaining existing underwriting practices. This is a very positive outcome and is a result of industry lobbying.

Whilst we can debate whether the gender directive changes help the existing protection gap or hinder it, advis-

ers may see this as a good time to reinforce the importance of protection cover to their potential clients.

Phil Brown is head of protection and underwriting at Zurich UK Life.

Next, Protection Review MD Kevin Carr asks 'PR vs. marketing—is it time to re-write the manual?' (First posted on the website on 13/1/2012).

Is PR a form of marketing, or is marketing a form of PR?

In the knowledge that we'll never get everyone to agree let's begin with the premise that PR is a form of marketing. After all, that's what all the books tell us.

But, the 'public' is everyone and 'relations' are everything. So shouldn't it be the other way around?

I've thought this for many years. I've also thought that not every marketing manager out there 'gets' PR while many PRs get marketing.

The issue becomes ever more valid with the development of social media. PR has always been about communicating positively with the public, which is everyone, and social media is fast becoming one of the quickest ways to communicate. Whether or not it sits within the press office, the marketing department or customer services depends largely on the individual organisation, its product and its audience. What is becoming clear, however, is that it must sit somewhere, because without 'listening' to what is out there most marketing efforts are unlikely to be as successful as they could be.

Some multinational companies have full-time social media employees, and one even has a CLO – Chief Listening Officer.

'Listening' is about knowing everything that is being said about your market, your company and its products – and who by. It's about being aware of everything being said on social networking sites and blogs – then understanding it and acting on it.

It's not all about what you/we want to say anymore, it's about what they want to hear, which arguably makes the role of PR within the marketing mix more important than ever, especially if good PR is more cost-effective than traditional marketing or advertising when budgets are tight. Because that's how PR has always worked: The answer is yes, what's the question?

Some companies are now prioritising complaints made via social media sites ahead of those made directly by phone or email. They do this for two very good reasons. Firstly, a traditional complaint is private in that unless you tell someone about it nobody else knows except you and them. This is changing. A complaint made via social media is instantly spread to 100s or even 1000s of people. Secondly, if that company can impress you and fix your problem quickly you might just say so.

Most people accept that things will occasionally go wrong but when a company cares enough to fix it quickly most people will think more of that company as a result. Thus overall this practice could turn complaints into new customers within hours, if not minutes.

Despite decades of claims to the contrary the financial services industry has lots of good news to put out there including paid claims, investment performance, new

products and deals etc—we just don't tend to tell people what we do well often enough or well enough.

And talking of positive endorsements, a modern company's greatest asset is its people. If they are happy and engaged about what the company does the chances are they will promote it. So think twice before banning all use of social media. It's not just about who had what for breakfast. In fact, it never has been. That's just a myth. Social media sites such as Twitter are not replacing face to face, phone or email communication, at least not yet. They are simply a new way of communicating in addition to what already exists.

Ah, but what about measurement? It's early days but the resources are out there. More importantly while we can ponder the potential return of investment all week long, the better question might just be who is thinking about the return of ignorance?

So for me, marketing is an excellent form of PR. But 'the times they are a changing' and it's not the only one.

Kevin Carr is Managing Director of Kevin Carr Consulting and Chief Executive of Protection Review.

People news

- **ABI (Association of British Insurers).** Stephen Gay is leaving his role as director general of the **Association of Independent Financial Advisers (AIFA)** to take up the new role of director of life, savings and protection. He joined AIFA in September 2010 from **Aviva**.

- **Bupa.** Stuart Fletcher, a former president of drinks giant **Diageo**, has been appointed chief executive, succeeding Ray King whose retirement was announced last year. Mr Fletcher joins on 1 March.

- **Cigna Global Health Options (CGHO).** Phil Austin has been appointed global head individual private medical insurance. He is tasked with creating a world class international individual business. He has rejoined Cigna from **Chartis**, where he was vice president of its European group accident and health business.

- **Defaqto.** David Cartwright has joined as head of insight. He was previously head of research and development at **AXA-Bluefin**.

- **MetLife.** Stephanie Baillie has been appointed employee benefits director to spearhead the expansion of its rapidly developing UK EB business. She was previously head of group protection at **Friends Life**.

- **PHP (Private Health Partnership).** Andrew Middleton has been promoted to head of sales.

- **Spire Healthcare.** Simon Gordon has joined Britain's second biggest hospital operator (from **Virgin Active Group** where he was group finance director). Also new to the executive management team are commercial director Peter Kahn and national operations director Andrew Gore. Other appointments include business development director Neil McCullough and head of sales and marketing Debbie Colebourn.

Please tell us about your organisation's people news—who's joining, who's leaving and even key industry positions that need filling.

Please e-mail info@andycouchman.com and let us know your news.

Sales and marketing ideas

This section includes sales and marketing ideas from across the life and health insurance sector. This month we look at the use of the analogy.

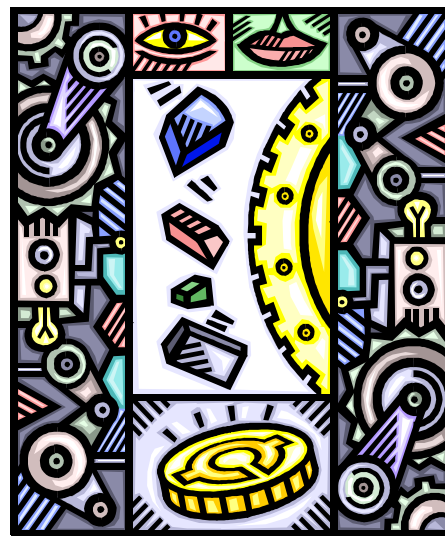
Life and health insurance can be—let's face it—a bit dull. At least, for many of our potential customers. Aside from the fact that we don't really want to think about 'what ifs' when they involve poor health, pain and even death, it is often hard to cut through the technical stuff and to realise what a particular product solution does.

One way to get across what a product can do is the use of the analogy. This can 'paint a picture' of what something does or how it works, by reference to another thing.

For example, one idea long used in income protection (and we were reminded of it at The Syndicate launch in January by **Exeter Family Friendly's** Mike O'Brien) is the machine insurance analogy. It goes like this...

'Imagine that you had a machine, in the corner of this room over there, that each month produced income. Every month you switched it on and it produced income for you and your family.

Would you insure it? Would you want insurance so that if the machine could no longer produce income, the insurance would take over until the machine could be repaired? Well, you have a machine like that—it's called YOU. Every month it produces income but if you couldn't work because of illness or disability, what would happen?



Income protection is how you can insure your income. If you are unable to do your normal occupation (assuming the client qualifies for that definition) income protection will pay £x per month after your first three months off work (or whatever the deferred period is).

The picture above is complex but a simple cartoon type drawing of a machine would suffice, or you could just rely on the client's own imagination.

Is the analogy dumbing down an important concept? No. Nor is it an alternative to all the compliance approved material clients need to be made aware of when it comes to buying protection insurance. But what it does is to contextualise the solution in an easy to understand, even humorous way. It supports other material, not replaces it.

Protection Review—helping you

Protection Review has grown since it began in 2003 to become one of the UK life and health insurance sector's most valued and used resources.

We started life publishing the first serious annual review of everything the industry was doing, and the trends and issues it faced, launched at a dinner in London. Since then, we have grown to meet the increasing demand from the industry (intermediaries and providers) for what it does and what it stands for.

Everything is based around one fundamental belief: we believe that people and businesses need protection and we want to see more people helped to achieve that and for people to be able to buy the best solutions, at the best value, to meet their needs. We work hard with the industry, but on behalf of the consumer, in a number of ways:

- The Syndicate, in association with **Hannover Life Re (UK)** is new and is how we find out what consumers think. It is unusual in that, over time, each wave of research builds not just our understanding of consumers, but also changes and trends in attitudes and actions taken. Getting real value from research is tough—The Syndicate is unique in that it pools the collective thinking of its members. Collectively we better understand trends that affect our markets, even though the action each member then takes is down to it alone. To ensure consumers' needs are met in the best way possible, we must better understand what those needs are and how they are evolving.

- The annual Protection Review book also includes much original research, including more quantitative consumer research. One important area is understanding what intermediaries are thinking. We achieve that in three ways. First, we undertake with the **PFS (Personal Finance Society)**, a poll of its members. The result is one of the largest research reports of its type, and we now have data to compare trends over time, not just look at intermediaries' views today. To that we add our annual intermediaries' forum, a Chatham House rules discussion of the issues of the day. All this is supplemented by questioning leading intermediaries on a range of topical questions (we also ask similar questions of leading insurers, reinsurers and others too). The book also includes analysis of each of the main

health and life insurance markets, international developments, new product trends and what the media and leading market people think plus views and comment.

- Since it started in 1998 as *HealthCare Insurance Report*, e-Protection Review brings you information and expert-led opinion succinctly. Now, thanks to our sponsors it is a free to download PDF.

- The annual conference brings together a range of top speakers on key topics that will mould what the industry does in future. It's much more interactive than many conferences and, being held on our annual dinner and book launch day, adds up to a great day that will pay for itself many times over.

- The annual Protection Review dinner is another must-attend event. Again, the focus is on business (no discos or the like for us!) but you'll enjoy a relaxed evening where you can discuss what's really happening in the industry. We always have a fantastic after dinner speaker to give us more valuable business insights and we say a little about the key findings in the new book too.

- Training. Last year we pioneered industry generic training for intermediaries. These half day sessions recorded attendee feedback of 4.7 marks out of five—an astonishing result, reflecting just how much attendees got from the day. Sponsorship from the industry means the events are free to attend to PFS members, and just £50 to non-members. Being independent, we can tell it like it is, aided by an experienced underwriter and a top IFA to ensure your practical questions are answered by those who really know, without the risk of bias that can arise in some company own training (good as they otherwise may be).

- We also undertake other commissioned work and consultancy for industry names and bodies, based on our experience, knowledge and contacts.

Protection Review is funded by a large number of partnership arrangements we have with insurers, reinsurers, providers to the industry and others. That means we can offer real value for money (and much of our output is now free to users) and independence too. You can find out latest news and how you can access our output and take part (e.g. in our regular industry polls) by regularly clicking onto www.protectionreview.co.uk. The website is a fount of information, opinion and interactivity. Do join us.

About e-Protection Review

e-Protection Review is a free to user PDF publication and is published ten times a year, usually 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 free to download from www.protectionreview.co.uk.

A range of partnership opportunities are available 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.

UK households 2010

Type	No of households	%
Where:		
Urban (2008-10 average)	19,600	78%
Rural (2008-10 average)	5,620	22%
Total all households 2010	26,320	100%

Tenure of home:

Owned outright	8,340	32%
Buying with a mortgage	9,100	35%
Social rented from council	2,590	10%
Rented from social landlord	2,150	8%
Private rented—rent free	370	1%
Rented unfurnished	2,890	11%
Rented furnished	880	3%

Number of persons in household:

One person households	7,800	30%
Two	9,210	35%
Three	4,330	16%
Four	3,420	13%
Five	1,110	4%
Six	300	1%
Seven	90	<1%
Eight	20	<1%
Nine or more	40	<1%

No of economically active persons in household:

None	8,430	32%
One	7,420	28%
Two	8,320	32%
Three plus	2,140	8%

Homes that have household goods:

Telephone	22,890	87%
Mobile phone	21,100	80%
Home computer	20,370	77%
Internet connection	19,330	73%
One car or van	11,780	45%
Two cars/vans	6,390	24%
Three or more cars/vans	1,560	6%

By country:

England	21,640	83%
Wales	1,280	5%
Scotland	2,380	9%
Northern Ireland	690	3%

UK family expenditure 2010

Item of weekly expenditure	2010 spend
Transport costs	£64.90
Housing, fuel and power	£60.40
Recreation and culture	£58.10
Food and non-alcoholic drinks	£53.20
Restaurants and hotels	£39.20
Miscellaneous goods/services	£35.90
Household good/services	£31.40
Clothing and footwear	£23.40
Communication	£13.00
Alcoholic drinks/tobacco/drugs	£11.80
Education	£10.00
Health	£5.00
Other expenditure	£67.30
Overall	£473.60

Source (all): Family Spending, ONS, 29 November 2011.

Health at a glance 2011: OECD indicators (selected)

Hospital beds per 1,000 population 2009

Highest (Japan)	13.7
Lowest (India)	0.5
OECD 27 average	4.9

UK	3.3
USA	3.1

Total health expenditure as % of GDP, 2009

Highest (USA)	17.4%
Lowest (Indonesia)	2.4%
OECD 27 average	9.6%
UK	9.8%
France	11.8%
Germany	11.6%

Total health exp, 2009, per capita, public and private

Highest (USA)	\$7,960
Lowest (Indonesia)	\$99
OECD 27 average	\$3,233
UK	\$3,487
France	\$3,978
Germany	\$4,218

Average annual growth 2000-2009

OECD27	4.0%
UK	4.8%

Source: *Health at a glance 2011*, OECD, 2011. www.oecd.org.

Protection Review: financial services consultancy and communications solutions

We're passionate about protection and 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 maximise their potential in a fast and cost-effective way.

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