# Private medical insurance

## Andy Couchman

Harold Wilson once said a week is a long time in politics. He might have added that politics is a long time in business.

I was reminded of the late Prime Minister's words when reviewing my notes on putting this chapter together. In particular, a few weeks before the election on 7 May I had spoken to WPA's CEO Julian Stainton about how he saw the market post-election. Back then, you may recall, a Tory majority was just about the last thing most people expected. The pundits were certain that we were in for another coalition government and the only questions appeared to be who would it comprise and would it be formal or informal. Would it be another Tory/Lib Dem formal coalition? Or would Labour and the SMP come to some form of arrangement? What part would UKIP play? Or would PM David Cameron simply try to carry on and manage as best he could on a day to day basis.

In the event, the silent majority (OK, they were neither silent nor a majority) voted for the devil they knew and didn't buy in to the apparent shift to the left, with all the implications that had for 'aspirations'.

The political shift that the polls appeared to be recording - ignoring the fact that admitting you voted Tory was not the sort of thing every voter would admit to (I was reminded of the cake scene in jail in Mel Brookes' excellent satire Blazing Saddles) – certainly appeared to have implications for private medical insurance. Mr Stainton – one of the more strategic and politically astute thinkers in the sector – was worried.

One of his concerns was indeed the future political landscape and the 'law of unintended consequences'. The NHS has always been a political issue and Julian reminded me that back in 1952 when the NHS introduced charging for things like prescriptions, eyetests and dentistry that it was hugely controversial. Indeed, both NHS architect Aneurin (Nye) Bevan and future PMI Harold Wilson resigned from the Government then on this point of principle.

Back in April we were hearing much from the left that was of an anti-privatisation rhetoric (not that anyone was actually advocating privatisation but hey, this is politics!) and it seemed to Julian that the rhetoric had sharpened. If we ended up with a Labour Government supported by the SNP, how long would it be before the 'private' sector was kicked out of the NHS and denounced as witchcraft? We were at, he feared, an ideological turning point. Your voting public will hold you to account he thought, so this could be one election promise that might actually have to be kept.

But the polarisation of private and NHS need not entirely be a bad thing. Certainly, if it happened, existing independent hospitals' business models (many, especially outside London, have come to rely on NHS bread and butter business) would suffer and the direct consequence would be higher hospital bills, which would be very bad news for PMIs.

But he was already seeing evidence – certainly in London – of many larger employers now using private GP services. That meant no waiting (in many GP practices, trying to get an appointment to see a GP quickly is nigh on impossible). But it also meant it was harder to get back into the NHS. So, a

private GP would increasingly lead to private prescriptions and in turn to private hospital treatment.

Strategically, will independent hospital groups look to set up their own private GP links, knowing that there's a good chance that would lead to more business for them – and at their new, higher, post-NHS rates too?

In other words, any move towards private/NHS health polarisation could be driven not just politically, but also from the providers themselves too.

This law of unintended consequences would lead to longer waiting lists, capacity issues and yet another (will this be the 23rd in 25 years?) NHS reorganisation. The outlook for patients, almost regardless of how much extra funding goes into the NHS, certainly doesn't look great in this scenario. Ordinarily, that can lead (rather ironically, given its political origins) to greater demand for private healthcare. But the self-same political sea change could yet further polarise healthcare, because the private providers would have to respond to maintain as much of their income as they could. It could all get rather dirty, especially as the private sector would have to work harder (and dirtier?) to try to tempt business away from its biggest and slower competitor, the NHS. We ended the conversation with Julian suggesting that a Labour/SNP alliance (we couldn't use the word coalition…) could: "See a complete separation of the two within five years." All because of a small change in the tectonic plates.

It's an interesting thesis and I promised to revisit the issue again with Julian after the election. Certainly, the post-election political landscape is looking very different to how the pundits had forecast it but in fact, many of the underlying policy issues were little changed. Mr Stainton's concerns were little changed too, even if the colour of the Government had gone from striped to a solid colour blue.

Indeed, when I next picked up on WPA's views, at a lunch with its PR guru Charlie MacEwan, the election was old news and so too were both Simplyhealth's and Universal Provident's places as independent providers, both having been swallowed up by the giant AXA PPP healthcare. Of course one can only speculate why both had sought new ownership but the political landscape as well as internal analysis may well have been a factor for both. Certainly, UP was a small niche player and, while it was highly regarded, long-time CEO John Stafford was perhaps looking towards retirement and so selling the business to AXA looks to be a neat and logical solution.

Simplyhealth's exit was more of a surprise but perhaps it shouldn't have been. CEO Romana Abdin is a very smart lady who I have a lot of respect for and her 18 month strategic review will have revealed a slightly uncomfortable fit between the caring side as exemplified by traditional cash plans, and the more red bloodied approach of hard-nosed private medical insurers. That's not a wholly accurate comparison, but increasingly, Simplyhealth would find that if it focused more on everyday health matters it would, sooner or later, come up against people's prejudices about PMI and that could be an issue – especially if those people were part of the ruling class. When was the last time you heard any Government minister praise Bupa for its mutuality for example? Could you ever imagine messrs Miliband and Sturgeon unveiling a poster campaign that said 'Go private and help take the strain off the NHS'. Thought not…

The fact is, no modern politician can be seen to embrace PMI as a 'good thing' and we appeared to be going back to the days when PMI was seen as a threat to our dear old NHS, which certainly has its own problems to face and is keen to find any scapegoats it can. That type of thinking remains a threat to PMI although old stagers will say 'twas ever thus'. They're right. My first experience of PMI was back in the 80s and the ENT consultant my employer had sought the views of so we could build

up our understanding of the market we were about to enter put it succinctly: "If you ask me what my politics are, I'd say right of centre. But if you ask me what my health politics are, they're left of centre, and you'll find most doctors are the same." An over-simplification perhaps, but those at the sharp (scalpel?) end are more aware then most of the troubles of the health underclass and their compassion and humanity – along with knowing that they can actually make a difference – makes them want to avoid medicine being available only to those that can afford it. The NHS, for all its problems, is still a national institution and we love what it does on a good day. Indeed it is a matter of national pride. And we don't want to think too much of what the future might bring.

The bottom line is that AXA PPP had been able to not just consolidate its position as the nation's second favourite PMI insurer (now with an estimated 29% market share) still ten points or more below Bupa), but to expand through careful acquisition, as it has done very successfully in recent years. Indeed, ignore AXA PPP at your peril – it's a smart organisation even if its public profile is often lower than one might have expected.

Will those be the last mergers and acquisitions? I doubt it. One constantly hears rumours of this or that medical insurer being up for sale by its owners and, while I have learned to ignore most such speculation, it is certainly true that PMI is fast approaching something of a crossroads. One reason for that is simply cost. As a Venn diagram, the big circle is those who would like PMI. The (much) smaller circle is those that can afford it. The intersection is being squeezed and, with above inflation price rises the norm year after year (worsened by the fact that cost rises sharply with age too as more things about us wear out or go wrong), finds itself increasingly being squeezed.

From November, the industry will be hit by another cost rise: a more than 50% hike in Insurance Premium Tax (IPT). Having been at 6% since January 2011, the rate jumps to 9.5%, as announced in the Chancellor's 8 July post-election Budget Statement. Stuart Scullion, chairman of industry body AMII (the Association of Medical Insurers and Intermediaries) was not happy:

> *"Making private insurance less attractive only puts additional strain on the NHS and the public purse. This has been proven in other models around the world where insurance is subsidised through taxation relief, typically saving the public finances up to three times the amount of relief provided. As an example, some governments will implement policies aimed at stimulating demand for private health insurance, such as the direct subsidy of insurance premiums.*
>
> *Not only does this mean that private health insurance is more obtainable for the people in that country, but it encourages uptake which in turn reduces the burden on public care. This helps to keep the cost of the public hospital system within manageable limits.*
>
> *In contrast, by increasing IPT to 9.5%, the UK Government is essentially putting further strain on public health – despite pledging to prioritise the needs of NHS .It is creating a tax on tax, which also represents a double blow for employees of company paid schemes.*
>
> *AMII will be making representations to Government to express our views and the likely impact of this announcement."*

Stuart makes the valid point that PMI (and the same also applies to other general insurance products such as insured dental plans and health cash plans) is already paid for by individuals out of after tax and NICs income (or is a taxable P11D benefit if paid for by their employer).

BIBA CEO Steve White was a bit miffed too:

*"We are extremely disappointed in this rise in Insurance Premium Tax and it will mean insurance will become more expensive for the public as a result.*

*The Government has been working with the industry to reduce the cost of insurance for consumers - including a summit chaired by the Prime Minister. It therefore seems counterintuitive to be taking measures which will add to the cost - effectively taxing protection. We hope the Government will review this rise and correct it in further budgets."*

Will that happen – will the Government cut IPT in future? Looking at IPT equivalent rates around the world, that does not look likely, but it is fair to say that the industry was taken by surprise both by the increase happening and by the size of the increase. That said, IPT was always a soft underbelly and Governments don't like admitting they're wrong so (as at 9 July) it was not looking likely that the situation would be reversed any time soon. In fact, the tax started at just 2.5% in October 1994, before rising to 4% from April 1997, then to 5% from July 1999 and finally to 6% from January 2011. Spot a pattern there?

AXA PPP Healthcare's distribution direction Chris Horlick wasn't happy with the increase either:

*"While we fully appreciate the need to balance the country's books, imposing a higher cost is a retrograde measure that will do nothing to encourage individuals and employers to protect their health and wellbeing.*

*SMEs are the backbone to Britain's economic recovery and increased prosperity in the years ahead. Medical insurance is a valuable tool to many SMEs seeking to recruit and retain the very best talent in their sector and then keep them fit, healthy, engaged and in the workplace. Increasing the rate of IPT potentially makes this business critical health tool less affordable to many SME employers with a consequent impact on productivity, profitability and, ultimately, an increased burden for care that the NHS may be asked to pick up."*

What to do? Immediate thoughts include (and rather than repeat ourselves in the dental and HCP chapters, much of this section of this chapter applies to those spaces too):

1. Health and medical trusts and self-funding generally can be expected to increase. These schemes largely avoid IPT (except on any stop loss insurance). Such schemes tend to work best on larger schemes but we may see the minimum practical scheme size fall further, although issues around pool size and risk spread become a factor.
2. Similarly, firms and individuals would be well advised to revisit their policy excesses. WPA started the trend towards encouraging very high excesses, but taking over the management of all claims, insured or not. If, for example, your PMI scheme costs you say £100K a year, you might decide to have an £80K scheme excess and just insure the rest – the remaining £20K. So, IPT is then charged on £20K (the insurance premium) rather than the 'old' premium of £100K. The insurer's admin fee has to be added on and that's subject to VAT, but VAT is reclaimable and so preferable to IPT in many cases. The net effect is having a truly bespoke employee health scheme (for goodness sake don't do any of these things if your primary aim is avoiding tax…) with a net cost lower than a fully insured scheme.
3. Insurers will look at what they can take out of their insurance contracts and perhaps put into another contract that sits alongside the insurance policy. Again, this looks most feasible for larger rather than smaller schemes, and the systems issues could be tough if you're struggling anyway with inflexible legacy systems, but insurers' will be looking at what can legitimately sit outside their insured products. Will that amount to much at all? At this stage

it's hard to predict, but one knock-on effect might be for insurers to look at offering more not less soft, third party or non-financial insurance services and so, strategically, taking them in a different direction quicker than they otherwise might have travelled.

4. Insurers may look again at things like ISAs to see if they may play a role in future solutions for individuals and families.
5. Even long term insurers would be well advised to look at issues such as what they would do if long term protection only policies also attracted IPT. Impossible? The technical differences between life and general insurance are relevant to us maybe, but much less so to our customers. I'd put money on a lot of ordinary people fully expecting to pay IPT on their term plan if they also have to pay it on their PMI. Time to lobby to avoid this getting on any policy agendas methinks.
6. Grumble and moan and demand the Chancellor changes back to 6% (or even 5%) IPT. Yes, I can see that working…

But, ignoring the IPT issue for the time being, what are insurers doing to try to hold back the tide of rising prices more generally? AXA PPP healthcare's UK PMI intermediary director Paul Moulton sees improving customers' health as an important ingredient of tomorrow's solutions:

> "*For our part, at AXA PPP healthcare we work hard to ensure that healthcare providers' services represent good value.*
>
> *Treatment 'pathways' for the most prevalent medical conditions such as musculoskeletal and mental health problems continue to provide members with clinical, expert managed evidence-based treatment plans for a better member experience with better cost management, helping employers to get more from their healthcare investment.*
>
> *At the same time, knowing that (an unhealthy) lifestyle can be a significant factor in the cause and/or exacerbation of conditions such as diabetes and heart disease, for which medical intervention may be necessary, it makes sense to help members lead healthy active lives to enable them to be fitter and healthier. Towards this end, for our part, we offer members a wealth of online health and wellbeing information and support to help them make lasting positive changes in their lives and, by doing so, reduce risks to their health and wellbeing.*
>
> *In a similar vein, with a focus on risks such as poor diet, stress and physical inactivity and health issues such as diabetes, high blood pressure and obesity we can help businesses adopt a proactive workplace health strategy to promote employee wellbeing."*

One cost cutting route is open referrals. The term was controversial when first introduced but now seems to be accepted as just a route to try to keep premiums in check. Was that how intermediary Brian Walters of Regency Health saw it?

> *"Open referral has been successful as a cost-control mechanism and such schemes are delivering more modest annual increases than traditional PMI schemes. Those who vehemently oppose open referral, such as the Private Patients' Forum, fail to appreciate that the rate of annual increase on private medical insurance is the bigger issue for consumers. Open referral is not suitable for everyone, but where it's presented as a choice and the customer is happy to accept the compromise in exchange for a lower premium, it's no more contentious than any other cost-containment option in the PMI market."*

Was that how market leader Bupa sees it? I asked its corporate director Patrick Watt:

*"Open referral has been very successful and proved incredibly popular with our corporate clients – currently over eight out of ten of our corporate customers have taken up the option of open referral, representing the employees of over 1,000 of our corporate clients and over 650,000 lives.*

*Many of our clients who have taken up open referral have made significant savings or seen a dramatic change in their rates of claims inflation. In 2014, Bupa's corporate customers experienced some of the lowest premium increases on record. Because of our success in healthcare cost containment, we were able to reduce or hold premiums level for over half our renewing corporate customers.*

*Since introducing open referral we have also seen real improvement in the care patients receive – the right treatment, from the right consultant at the right time – leading to a faster recovery and better outcomes."*

That's a powerful case in favour. Of course, opponents still argue against open referral and most insurers still offer it as an option rather than make it mandatory, but the tide seems to be swimming towards open referral as a mechanism that can reduce costs – even if it also means some loss of choice. Factor in the view that patients might actually enjoy better results (overall) and it looks clear that some form of open referral is here to stay.

Another route to lower costs is hospital treatment insurance (HTI). These products essentially list what they will cover rather than covering everything. Think of it a bit like the different approaches taken by critical illness insurers compared to income protection insurers. Westfield Health has such a product so its Paul Shires is a fan:

*"PMI remains an excellent product which supports many people. However, it has become a VIP product often only affordable to key employees or wealthy individuals. Our HTI opens up the market to a much wider population given its affordability. It meets the needs of individuals and companies who worry about long waits for elective non urgent procedures on the NHS such as hips, knees, hernias etc. A market still exists for PMI but HTI has broader potential."*

Brian Walters saw it differently when I asked him if he thought they were the way forward:

*"Not at the moment. Cancer cover is a key driver for consumers taking out PMI and cancer is usually a standard exclusion on such plans. These types of plans may become more popular as traditional PMI increases in cost, though."*

So if HTI is not the way forward, what is? What's missing or wrong with today's plans? Brian Walters again:

*"Product design has evolved and the products available today are, in the main, the most generous and most flexible they've ever been. They are also the most complex, however, and new clients who have tried to source cover themselves often remark on what a minefield the PMI market is. Very high introductory no-claims discounts are undoubtedly the drawback of most PMI plans in the current market. The reward for not claiming is typically very modest while the penalty for claiming is often severe. Insurers have done some good work to address this problem, such as linking the loss of discount to value of claims, but this aspect of PMI still leaves much to be desired."*

How do we make PMI more affordable? I asked Exeter Friendly CEO Andy Chapman for his views:

> *"Making PMI more affordable is a challenge, but if anything the key challenge that faces us is not one of lowering prices, but educating advisers and consumers about the value of cover. Consumers don't have a full appreciation of the costs of medical treatment, so they can't appreciate just how much cover is likely to cost.*
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> *This process of education won't be easy, but there are some simple steps we could make that will help. Firstly, at the moment we don't always tell customers how much the treatment they have received would have cost if they were to pay for it themselves – a simple win, but one that reinforces value and why cover was bought in the beginning. Second, we don't always do a great job at explaining the vast range of conditions and illnesses that are treated privately - from the life threatening to the lifestyle threatening."*

AX PPP healthcare's Paul Moulton sees modularity as key:

> *"Choice remains key for individuals looking to secure medical insurance cover at a price that meets their healthcare needs and budget. Individuals can reduce premiums in several ways. Through modular cover, for example, they can prioritise benefits that are important to them. They can also opt for cost cutting measures (alone or in combination) such as an excess, a no claims discount or a six week plan (whereby members are treated privately if the NHS cannot treat them within six weeks of when treatment should take place).*
>
> *Small to medium sized businesses can also benefit from the savings to be made by choosing from plans with modular cover, excesses and six week options akin to those offered on our personal plans.*
>
> *Larger organisations seek value in the cover they provide to their employees. Open referral continues to offer a more cost effective, sustainable approach to securing employees' fast and convenient access to treatment to get them back to health, and back to work. Insurers also offer larger-sized groups considerable flexibility in benefit make-up, with opportunities to make savings by forgoing cover for treatment of certain conditions, such as psychiatric illness. Excesses can be used to help manage claims costs. And organisations can, if they wish, opt for the greater tax efficiency of using a self-insured 'healthcare trust' to pay for employee health benefits, these can be quite complex (legally) to set up and should only be entered into with appropriate expert support."*

Paul Shires brings us back to HTI as part of the solution:

> *"In many countries around the world, private insurance is incentivised through taxation incentives. It is proven that a reduced reliance on state provision allows for improved public services in both health and other public spending. However, it is unlikely that any major political party would put its name to, what the opposition would declare, is a two tier system. Is it a two tier system if an increasing volume of NHS work is delivered through private providers? I would argue not. It is more a case of where the funding comes from than how you are treated.*
>
> *Budget PMI products can become complicated. Customers may worry about exclusions, restrictions. Therefore a big decision for insurers is what isn't covered and is it still compelling for the customer.*

*Westfield is confident that its award winning Hospital Treatment Insurance provides this compelling value in the eyes of a customer. Diagnostics and outpatient elements are picked up in the cash plan. The Hospital Treatment Insurance can cover all surgical procedures which require a local or general anaesthetic and an incision, plus a list of invasive non-surgical procedures. Importantly cancer, heart and psychiatric are not covered. There is no excess to pay and no restriction on consultant or hospital (appropriate bandings are applied to procedures)."*

But is the answer PMI at all? Certainly, Cigna's head of insight and product, Kirsty Jagielko, sees employers looking wider than just insurance when I asked her if they were:

*"Yes, we've seen a notable shift in employers looking to provide more of a total healthcare package.*

*Almost half of patients in England are now waiting three days or more for an appointment with their GP[1], 31 million working days were lost in 2013 due to back and neck pain[2]. And in the past six years, there has been a 24% increase in absence due to stress, depression and anxiety[3]. As the working population continues to age, these figures are guaranteed to rise. That's why it's more important than ever for businesses to invest in a long-term healthcare strategy that meets their needs.*

*In 2007, approximately 16% of organisations surveyed[4] indicated that they had a fully implemented well-being strategy. And the majority of remaining organisations reported having numerous well-being initiatives distributed throughout their organisation, but no comprehensive strategy.*

*Recent research findings show employers are now starting to respond. In 2014, 20% of UK respondents said that they had a fully implemented well-being strategy. And interestingly, employers are thinking beyond simply physical wellness. 57% of respondents said they believed well-being to include overall well-being such as physical wellness and financial wellness[5].*

*We know that our clients are starting to think more about a health and well-being strategy as a cohesive offering. The focus has started to shift and employers want to know how they can offer benefits as a complete package, which will help them to deliver their overall well-being strategy to employees."*

*[1]NHS England's GP Patient Survey (2015)*
*[2] Sickness Absence in the Labour Market, The Office for National Statistics*
*[3] Chief medical officer annual report.2013)*
*[4] WORKING WELL: A Global Survey of Health Promotion and Workplace Wellness Strategies (2007)*
*[5] A global survey of Health Promotion, Workplace and Wellness and Productivity Strategies (2014)*

One hope that seems to have been dashed is that the Competition and Markets Authority's work would at least slow down rising hospital costs. What did Andy Chapman think about its findings?

*"Managing costs within PMI will always be a challenge for insurers as the range and standard of medical treatment increases and people live longer, but with longer periods of*

*poor health. The pressure this trend has placed on medical inflation is a problem that affects all insurers, which has resulted in other areas of focus to control costs – such as the rates passed onto insurers by hospital groups.*

*If anything, the work undertaken by the Competition and Markets Authority didn't go far enough, with the focus being solely on promoting healthy competition between hospitals in the London area. Yes, this needed to be tackled, but what we need is greater competition between hospitals all over the country. As a result, the impact has been limited – we have seen little to no benefit in terms of lower rates from this area."*

Mr Chapman raises the thorny issue for the CMA that if there is only one independent hospital in a particular town, it is hard to ensure fair competition for the simple reason that there is no real local competition. I asked Kirsty Jagielko if she had seen any effect on PMI costs coming from the CMA's work:

*"No, we're not currently seeing any evidence that the CMA's investigation has impacted the cost of PMI. However, the implementation of the remedies will certainly improve the patient experience. With increased competition in the private market, patients will have greater choice. They'll also be able to access quality data and seek consultant costs up front."*

Another key factor in market growth is distribution. A couple of years ago at the annual Protection Review Conference we debated whether PMI was a product that should be embraced or avoided by IFAs. Andy Chapman's Exeter Family has feet in both the life and health camps so had he seen more IFAs and general brokers now looking more at PMI?

*"Yes, we have seen much more interest in PMI from what could be described as a more holistic type of adviser. However, this interest sometimes wanes when research uncovers the complex nature of many products in the market. As with protection, product simplification is vital to ensure long term and continued demand, from consumers as well as advisers. This simplification is a challenge given the pressure on claims and premiums, but it is possible. We have proven that with our approach."*

But (echoing the polarised views we heard at the conference) Patrick Watt had not seen much evidence of that:

*"Those who have always been involved in PMI continue to offer this service. We've not seen a change in new IFAs and brokers looking at this space."*

One factor that could change everything is people's perceptions of the NHS. The NHS has always been a confusing mix of being broke, over-stretched, having its morale constantly sapped, aching for no more change and yet… continuing to deliver quite brilliant healthcare to most of the people most of the time. But maybe, as it is now a couple of years into its retirement age (it's 67, having launched in July 1948) the gaps are just starting to be too wide to repair. Where did Andy Chapman see the NHS in another five years*?*

*"The reality is the NHS as we know it is a broken model, one which cannot be sustained at current levels of funding. But, admitting this to the public would be political suicide, so for the moment posturing and accusations from party to party will continue. In five years' time, unless as a society we have openly accepted tax increases or charges on certain treatment, services or admissions I expect the NHS to be a continual struggle and a service increasingly*

*focused solely on keeping people alive after acute conditions, rather than keeping people in good health."*

And where will PMI itself be in five years' time? Andy Chapman again:

*"Many of the same challenges will remain, but I hope we will see an industry that has simplified, communicates its benefits in a clearer and more accessible way and ultimately is beginning to attract the next generation of loyal PMI customer."*

Paul Shires was cautiously optimistic:

*"I believe as the economy improves, the market will grow slowly. I believe the individual market will fall as many decide to self-insure / self-pay and the corporate rise slowly alongside the organic growth of successful organisations."*

And Paul Moulton saw opportunities ahead:

*"In the corporate arena, there remain opportunities for PMI providers to further integrate their healthcare funding services with preventative measures and/or disease management (especially in light of an ageing workforce) to deliver more proactive and effective employee health and wellbeing strategies."*

But as a broker, Brian Walters had concerns on a number of fronts:

*"In five years we're likely to have seen more provider and broker consolidation and premiums will, of course, be substantially higher than they are today, far outstripping inflation over that period. The market is likely to remain challenging but relatively resilient given the value that PMI policyholders place on their cover."*

Finally, I asked our correspondents for their comments on any other aspect of the market. I started with a broker viewpoints from Brian Walters:

*"Commission in the individual market is getting out of control. It's no coincidence that, as average commissions have risen, so has the starting level of no-claims discounts. Five years ago the average introductory no-claims discount was around 33%; now it's double that at 66%, which means there's far more for policyholders to lose over time. High commissions have to be paid for and insurers need to deliver attractive initial premiums so high claims loadings are necessary in order to square the circle."*

This is an oft-overlooked point. The 'best' NCD from a customer's viewpoint is NOT that which offers the highest discount at outset. Indeed, the best deal at any particular start premium is to have the lowest NCD when you start, for that NCD to increase as quickly as possible to the highest level and for any fallback when a claim is made to be as small as possible. Yet, unless you actually think about it offering the highest NCD rates to new customers 'sounds; like the best deal, doesn't it? It isn't (do the maths if you still don't believe me!).

What were Andy Chapman's views:

*"The PMI and protection markets have much in common, but there is one likeness that stands out most clearly to me – and that is a struggle to entice new customers to buy cover. Whilst sales of PMI remain higher than protection, a high proportion of those is simply*

*customers who move from one insurer to another – rather than a new customer buying cover for the first time.*

*So one of the key trends I think we need to address is a lack of growth – which will only happen when we successfully appeal to a different and probably younger audience than we do currently."*

As with so many life and health insurance solutions, our publics have to first know they have a problem, then understand how we can offer the best solution for them to that solution and then want to buy it from us through their chosen delivery mechanism. So they need education and trust. Are we yet really optimising what we do on both?

Patrick Watt's views were:

*"The UK health insurance sector remains challenging. However, we are starting to see growth in the corporate sector with an increasing number of businesses extending private healthcare to more, and in some instances, all employees.*

*In fact, employers are increasingly realising that their future success depends on having a healthy, happy and motivated workforce. As a result, a growing number of companies are revisiting the health and wellbeing initiatives they offer to attract, retain and engage employees.*

*We therefore predict that in 2015 we will see a growth in Bupa UK's corporate client base of approximately 10%."*

That's positive and indeed a significant target. Kirsty Jagielko added:

*"The most notable trend is health engagement. Employers want to drive health engagement amongst their employees, and it's not just about reducing sickness absence figures. It's about attracting and retaining a healthy and motivated workforce.*

*The only way for employers to manage long term medical benefit costs is to help staff become healthier. By helping employees to make the right lifestyle choices, they will ultimately improve their health risk profile and maintain a healthy workforce in a cost efficient way. Alongside the increasing popularity of health engagement, we're also witnessing the creation of more care pathway solutions, enabling employees with a private medical plan to reach the right treatment quickly and easily."*

And the final word went to Paul Moulton:

*"Mindful that people's health and wellbeing is as much about achieving and maintaining a healthy lifestyle as it is about receiving medical treatment and care should they suffer injury or illness, we foresee a continued drive in the development and introduction of innovative health technologies designed to inspire positive behavioural change and enable people to take greater control of their own and their families' health."*

So, there is certainly no shortage of challenges going forward. Perhaps the big test will be whether insurers can keep premium inflation within acceptable limits for both corporate and personal customers. Will the latter even be a priority for insurers going forward? And will providers see

themselves more as an adjunct to the NHS rather than an alternative to it? The questions are big, yet the market – certainly as measured by specialist broking firms and providers, is consolidating.

But health remains a key priority for almost everyone. Research by The Syndicate and others confirms that time and again. So the challenge is how best to meet the clear underlying demand and what shapes tomorrow's solutions will take. It seems doubtful that it will just be more of the same. But there also seems to be a dearth of really innovative propositions emerging. Are we not quite ready for such heady solutions yet? And if not, when will we be, and what, exactly, will those solutions be and what will make them successful?

And, ultimately, will the political landscape reward or thwart our efforts? Time will tell.