e-Protection Review

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

Ageing workforce poses industry challenges and opportunities

Between 2004 and 2010, the average age at which people leave the labour market—a proxy for the average age of retirement—rose from 63.8 to 64.6 years for men and from 61.2 to 62.3 years for women, the **Office for National Statistics** (**ONS**) revealed on 16 February. For men the peak ages for leaving the labour market were 64-66 years and for women the peak ages were 59-62 years.

The news comes on top of last year's abolition of the Default Retirement Age (DRA) which is certain to increase the average age of retirement still further. It poses a particular challenge for health and protection insurers, as morbidity tends to increase with age and therefore average claims per group risk are likely to rise and there is likely to be a demand for longer term policies to meet the needs of industry and older employees.

A poll for **GRiD** (**Group Risk Development**, the industry trade body) last October found that 23% of employers believed that removing the DRA would enable them to retain the best talent within the business, with 12% saying it would increase diversity in the workplace. A further 19% said they had already encouraged staff to work beyond retirement age before the DRA was removed.

However, 17% of employers were worried about their older workers being fit and able to do the job, while 11% believed abolishing the DRA would drive up sickness absence costs with knock-on impact on their whole team. A further 8% were worried about managing the capability process (performance management/appraisals) fairly.

GRiD spokesperson Katharine Moxham said: "Put simply, businesses fear that older workers are more likely to be sick than their younger colleagues and will have less incentive to return to work. It's for this reason that the group risk industry worked with Government to ensure that businesses can take the same practical approach as the State does with working age benefits (which cease at State Pension Age). Employers are therefore not obliged to extend the provision of insured protection products (such as group life, income protection and critical illness) beyond age 65 or State Pension Age, as this increases."

GRiD's research also found that 57% of the 500 UK business respondents polled by **Lightspeed Research** were unaware of the exemption. (*Continued on Page 2*)

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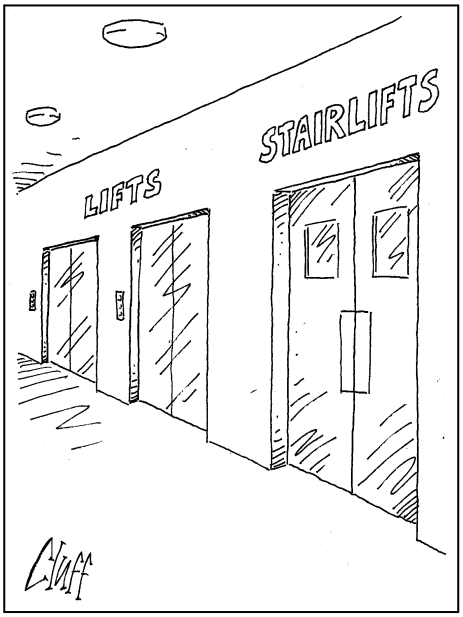
Inside this issue:

Quotes of the month:

"Older employees can bring so much in the way of experience, confidence and mentoring skills to a business so it's great to see employees recognise the benefits of an 'ageless' workforce." Katharine Moxham, GRiD, 8 February 2012.

'As a result [of more occupations being accepted on an own occ basis] the definition of incapacity will be less severe, and the benefits fairer and much clearer for customers.' Aviva income protection press release, 13 March 2012.

"The legislation is flawed; at its core, even with amendments, it places too much emphasis on using market forces and risks greater fragmentation of our health service." Dr Hamish Meldrum, BMA, 21 March.



Key statistics:

- NHS RTT median wait England January 2012: 8.7 weeks (See Page 11)
- e-Protection Review Long Term Protection Sales Index: 116.24 (Quarter 4, 2011, compared to base 100 in Quarter 1, 2000).
- e-Protection Review Employment Index: 107.09 (To end January 2012, compared to January 2000, see Page 11).

(*Continued from Page 1*) The ONS's report noted that in 2010 there were 3.2 people of working age supporting each person of SPA and over in the UK. That is expected to fall to 2.9 by 2051. SPA will have risen to 68 by 2046; without that rise the 'old age support ratio' would have dropped to 2.0.

The report also notes that in 2008, UK men at age 65 had 9.9 years of healthy life expectancy, compared with 17.6 years of life expectancy, whereas UK women at age 65 had 11.5 years of healthy life expectancy and 20.2 years of life expectancy.

Despite fears over rising claims costs for older workers, an argument can be made that working longer is beneficial for most people's health, with knock-on benefits to their life expectancy and overall health. Moreover, more flexible working practices mean that for a growing number of workers the plan will be to slide into retirement rather than have the sudden stop typified by the old rigid retirement age rules. That could mean working fewer hours or days each week, taking more holidays or focusing on where the older worker can add value (e.g. around their experience and mentoring skills) rather than in areas where they may be weaker (e.g. their physical strength and ability to think as quickly as they once could). Care needs to be taken when looking at the pathology, as the slowdown in people's mental acuity as they grow older is actually offset by their greater experience.

For insurers, the challenge will be to extend their coverage for older workers (fundamentally, why would any industry want to restrict its potential market?) while still making insured solutions affordable and good value for money.

That may mean developing more solutions to meet the needs of older employees and their bosses. For example, income protection policies with shorter benefit terms, changing definitions and conditions covered for group critical illness plans and health insurance benefits linked to those medical conditions that will stop an older person working (or wanting to work) rather than necessarily trying to cover all acute medical conditions as they arise. That said, care also need to be taken that such moves cannot be construed as unacceptable age or sex discrimination. Insurers will therefore need to tread a careful path in developing new solutions.

There should be knock-on effects in the individual or personal markets too. It is a generalisation, but nevertheless true, that most life and health insurance is sold to people of working age to protect them, their families and their businesses against their income earning years being cut short for any reason. We can therefore expect to see a growth of age-segmented products and benefits. To some extent we have already seen this in the growth of over 50s guaranteed acceptance whole of life policies.

As our analysis on Page 3 shows, this product has been one of the success stories in recent years, illustrating that the underlying demand for protection actually increases in tough economic times, even if the ability to pay is decreasing. However, that fact seems to have been lost on many in the industry who, far from planning an expansion of their protection marketing spend have actually cut budgets, put back new product developments and trimmed their workforces. That is a generalisation, of course, and there is some evidence now that insurers are gearing up for a 'bonanza' 2012, not least because 2013 and beyond will bring expected price rises and should result in greater profitability too.

More employers looking towards protection

Further analysis of GRiD's research illustrates that employers too are now looking more at what protection insurance can do for them.

GRiD asked 'With pensions auto-enrolment going ahead from 2012, if you do not currently provide any group risk protection benefits, would you consider implementing any for your employees alongside your pension arrangements. Over half (52.6%, up from 49% when the same question was asked in 2010) said they would consider adding group life, while 67.8% said they would look at adding group income protection and 78.2% group critical illness insurance.

Perhaps surprisingly too more employers (16.3%) spent more on their employee benefits package in 2011 than decreased their spend (13.1%). This contrasts with 2010 when only 3.8% spent more (and 12.0% less) and with 2009 when 3.6% spent more and 20.9% spent less. Most however spent the same (70.6% in 2011).

There were mixed messages however about the way forward. While more than one in four (27.2%) employers said 'I think it's up to my staff to look after themselves, and this won't change' (down from 30.3% in 2010), 11.7% (up from 10.4%) said 'I'm more likely to up my benefit spend due to the actions of the Coalition Government' and 19.3% (down from 21%) said 'As public services are being cut, employers/employees need to work together to ensure we're covered' and 29% (up from 26.7%) said 'Life's still tough for us, but I might re-look at our benefits provision in the near future'. One issue for insurers is that while acute medical conditions was the main cause of long term disability for 12.9% of respondents, for 15.1% it was stress-related mental health and for 19.7% it was home and family issues—an area many insurers still offer little help.

Would fiscal benefits help?

What could the State do to help encourage a greater take-up of group risk benefits? If the Government incentivised employers to provide protection for their workforce—e.g. by reduced NI contributions—would this encourage you to offer these benefits? That was one of the questions GRiD asked its 500 business respondents last October.

There was overwhelming support for such a move:

- 67.8% said they would look at offering group life cover.
- 59% said they would look at offering group income protection.
- 61.2% said they would look at group critical illness insurance.

The findings show the value of lobbying for greater support from the Government for group risks—after all, a greater take-up would potentially mean less strain on already tight NHS and welfare budgets.

However, for a significant minority, a NIC incentive would not encourage them to offer group risk cover, so care needs to be taken not to place too much emphasis on the importance of fiscal incentives.

Another finding, that while 37% of employers thought their sickness absence was about average for their industry, 49.9% thought it was lower and only 5% that it was higher illustrates that many employers still do not understand fully their sickness absence data (only 80% actually monitor it) highlighting another area protection insurance can help in.

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ABI new business stats 2011

Sales of long term protection insurance policies increased by 6.3% last year, our analysis of the **ABI's** (**Association of British Insurers'**) latest market statistics shows. But total new annualised premiums fell by 2.6% to £750m, reflecting a weak underlying economy and continued price competition as Tables 1 and 2 show.

In the past, our figures included totals for each product plus that for CI rider plans, so there has always been an element of double counting. This year, additional ABI data enables us to go further.

We continue to count CI rider policies separately in terms of numbers of policies sold, but are now showing three figures for new annualised premiums. The first is the true total, then we account for CI rider policies then for menu or multiplan policies. In this way we give a fair count of the numbers of policies sold (in effect still counting a term policy with CI attached as two policies) but the APE figure is both more accurate overall and takes account of how much of that is CI rider policies and how much is a multiplan (which could also include CI rider cover):

Table 1. New business sales, 2007-2011. 000s of contracts

Product	2007	2008	2009	2010	2011
Whole of life	203	255	359	473	564
Term non-mortgage	806	838	915	986	997
Term mortgage	771	692	643	662	571
Income protection	118	135	111	113	159
Standalone crit illness	85	27	20	***18***	15
Critical illness rider	417	392	417	510	629
TOTAL	2,400	2,339	2,465	***2,762***	2,935

All figures on this page in ***bold italics*** are changed from last year's analysis

Table 2. New business premiums, 2007-2011. £m APE

Product	2007	2008	2009	2010	2011
Whole of life	82	101	101	113	122
Term non-mortgage	306	354	383	368	361
Term mortgage	323	262	240	228	210
Income protection	51	56	51	49	49
Standalone crit illness	42	16	13	***12***	8
TOTAL	804	789	788	770	750
Of the total:					
Critical illness rider	228	219	222	257	269
Menu/multiplans (803,000 plans sold in 2010)	-				280
For comparison with previous years the 'artificial' APE figures (which adds CI rider APE to total APE) were:					
TOTAL	1,032	1,008	1,010	***1,027***	1,019

In terms of individual products, whole of life saw a 19% increase in sales (following a 32% increase in 2010), although new premiums only rose by 8%. Most (474,000, up from 432,000 in 2010) of the 564,000 sales were low premium guaranteed acceptance (over 50s or funeral) plans. That reflects continued high media spending, with such ads having now become a mainstay of daytime TV advertising. As we said last year, this again supports the premise that in times of economic difficulty, many people's natural inclination is towards thinking more about protection.

Mortgage related term plans were down 14% (up 3% in 2010), reflecting a flat mortgage sector, with new premiums down 8%. Non-mortgage term sales were up 1%, with new premiums down by 2%.

Critical illness (CI) rider plan sales rose by 23%, with new premiums up 5%. CI had a good year in 2010 (ignore the continuing fall of standalone CI as that is because CI cover is now invariably bought as part of a wider cover package). Income protection (IP) saw sales up 28% on 2010 but new premiums were static at £49m APE. IP appears to have had a very strong fourth quarter in terms of new policies but as that was not reflected in higher premiums, this looks to be questionable. Overall, the IP market looks to be making progress, but based around a move to more budget type cover.

Table 3 shows new group sales. These show regular premium new business down in all areas except group income protection. Table 4 shows single premium business and, as in 2010 single premium long term care business (new regular premium long term care insurance has now all but disappeared) was up by 2.4% compared to 22% in 2010. Even so, LTCI remains a poor seller—just 1,224 point of need plans were sold in 2011.

Table 3. Group new business sales, 2007-2011. £m prem

Product	2007	2008	2009	2010	2011
Collective life	63	70	95	35	11
Group life	174	160	187	157	150
Group CI	6	9	12	16	9
Group income prot'n	138	120	114	83	96
TOTAL	381	359	408	291	266

Table 4. Single premium product sales 2007-2011

Product	2007	2008	2009	2010	2011
Collective life	1,083	904	120	81	59
Other	82	8	16	22	31
Long term care	102	107	101	123	126
TOTAL	1,266	1,019	237	226	216

The ABI reports that across all long term product areas (e.g. including savings, investment and pension plans) monetary sales were down 2.6%, which means individual protection's APE was in line with the rest of the market.

CML (**Council of Mortgage Lenders**) data shows that gross mortgage lending in the UK in 2011 was £140.719bn. Gross mortgage lending was £135.342bn in 2010, £143.276bn in 2009, £254.022bn in 2008 and £362.758bn in 2007. In 2011 there were 509,500 new mortgages for house purchase and 378,600 remortgages (total 888,100). Tables 5 and 6 show sales for the fourth quarter of 2011 compared to Q4 of 2010 (Table 5) and compared to Q3 of 2011 (Table 6).

Table 5. New business premiums, Q4 2010 vs. Q4 2011.

Product	Sales 000s		APE £m	
	2010	2011	2010	2011
Whole of life	121	139	28	28
Term non-mortgage	241	238	89	85
Term mortgage	148	136	53	50
Income protection	30	51	12	12
Standalone crit illness	4	4	3	2
TOTAL*	684	723	185	177
Of which: CI rider	140	155	67	63
and menu plans	-	206	-	69

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Table 6. New business premiums, Q3 2011 vs. Q4 2011.

Product	Sales 000s		APE £m	
	Q3	Q4	Q3	Q4
Whole of life	142	139	31	28
Term non-mortgage	261	238	93	85
Term mortgage	151	136	54	50
Income protection	40	51	12	12
Standalone crit illness	4	4	2	2
Critical illness rider	169	155	68	63
Menu plans	-	206	-	69
TOTAL*	767	723	192	177

* Now counts CI rider sales as a separate policy, but APE total excludes CI rider APE and menu plan APE as this is accounted for in individual product totals.

The figures show a 6% rise in sales compared to the same quarter of 2010, but new premiums down 4%. Compared to the third quarter of 2011, sales were down 6% and new premiums by 8%. Lat year we thought the snow that affected the UK very badly in December 2010 could well have affected both sales to customers and processing. This year there was no similar excuse—the final quarter of 2011 was simply a disappointing end to what had looked like a more promising year than many expected.

The e-Protection Review Protection Sales Index now stands at 116.24. This compares the latest quarter's 723,000 sales with the 622,000 in quarter one of 2000. In terms of premiums though the figure would be lower.

Overall, the long term protection sector looks to have painted itself into a corner.

Sales are reasonably buoyant when we count the number of policies sold, but very competitive pricing (on the back of too much selling on price rather than quality or suitability of cover), and moves towards cheaper types of cover or lower sums insured has led to negative growth so far as new premiums are concerned.

We expect 2012 to be a much stronger year as advisers and providers gear up to potentially much higher premiums rate overall in 2013. We will also see more start-ups focusing on protection as, from 2013, advisers will no longer be able to take commission on pension and investment sales.

The key will be providers looking to grow the market in 2012 by building underlying demand and managing distribution better. It will not be good enough to focus simply on market share or even of achieving last year's targets plus 5-10%. This will be a pivotal year, when everyone from product marketers and up to CEOs' careers could be made or broken. The potential is there for 2012 to prove to be a more exciting year than the sector has seen for a great many years.

Group risk claims data revealed

GRiD (**Group Risk Development**), the group risk trade body, has released the findings from its *2011 Claims Survey*.

The research shows that in 2010, some 8,212 group life, 3,909 new income protection and 598 group critical illness insurance claims were paid by GRiD members, which represent all significant players in the sector.

Group life. There were 7,764 lump sum claims for a total of £610.885m (average £78,677) in 2010 plus 448 death in service pension (WDISP) claims for £133,765 (average £298,839). Total 8,212 claims for £744,650 and an average claim amount of £90,678.

Largest claims heads were cancer, 44%; heart 19%; respiratory 7%; vascular 5%; accidents 4%, suicide 2% and other 19%.

Group income protection. There were 3,909 new claims in 2010 for a total annual benefit claimed of £82,350,072, giving an average annual income benefit claim of £21,067. The total number of claims in payment was 13,571 (giving an average claim of just under four years). Total annualised claims in payment were £292,345,151 and average annual claim was £21,543.

The main claims causes were mental health 25%; musculoskeletal 20%; circulatory 9%; cancer 14%; respiratory 2% and other 30%.

Group critical illness insurance. There were 598 claims in 2010, for total sums insured of £28,414,803, giving an average claim of £47,493.

Main claims causes were cancer 69%; heart attack 10%; stroke 4%; ; CABG (coronary artery bypass graft) 4%; multiple sclerosis 3%, and permanent total disability 1% (three claims) plus others 9%.

For more see www.grouprisk.org.uk.

Comment: *These data are useful as a benchmark for levels of cover in the individual market. They also help illustrate that more workers need group risk cover and that the main claims heads for income protection are not covered by most critical illness plans.*

Protection is least understood: ABI

Life and health insurances are among those products least understood by the public, according to the **ABI's** latest *Quarterly Consumer Survey*, for the fourth quarter of 2011.

The best understood products were savings/current accounts, loans, mortgages and car/van insurance, in that order. However the most poorly understood were payment protection insurances, critical illness cover and pensions. Private medical insurance was better understood than investment products and life insurance.

When it came to difficulty of comparing product features, the best products were car/van insurance, savings/current accounts and loans and mortgages. The hardest to compare were PPI style plans, critical illness insurance and pensions. PMI plans were felt to be easier to compare than life insurance plans.

The survey of 2,500 adults in December by **YouGov** also revealed that 42% of people knew someone that had a long term care need.

Just a third (34%) of people believed that 'Care is free like the NHS', while a third (35%) agreed that 'There is no point planning for future long term care costs'.

When it came to what help was available with care costs, only 17% claimed to know what help they would be entitled to, with 48% not knowing and 36% not sure.

First stop for information about care would be a GP (34% of respondents), followed by **Citizen's Advice** (**CAB**) or a charity (24%). For advice about how to pay for care, 52% would go to a CAB, 27% the internet, 21% their council, 11% a GP and just 8% a financial adviser. But, if they knew they would need care in future, 23% would consider insurance, 23% ignore it and 17% put savings aside.

3 protection campaigns launched

Three new major protection insurance campaigns are now up and running as elements of the industry look to take action to improve how protection insurance works. The three main campaigns now underway are:

• **Cover magazine's campaign to reform income protection definitions**. Started by Cover editor Paul Robertson on 1 March and in conjunction with **Protection Review**, the issue here is list-based occupational definitions (activities of daily living and working—ADLs and ADWs). A poll on our website had asked 'Should the industry seek to address the perceived ongoing problems with ADL and ADW-based definitions for IP (income protection) policies?' 16% of respondents were happy with the current situation, but 42% wanted change but were mindful removal would make policies more expensive for those on tight budgets, and 42% supported an outright ban.

Some IP insurers (primarily friendly societies whose focus is blue collar workers) already have only a single own occupation based definition (the most generous for customers) or a 'suited' definition, where claimants are expected to return to work but not necessarily to their old job, just one to which they are suited by training and education. But others use ADL or ADW type definitions too.

The problem with those is that the claims bar is set very high, yet simply reading the activities list does not clearly indicate that. As a result, a customer may think they have wider cover than they actually have and remain ignorant of that until or unless a claim is made.

In response to the campaign, **Aviva** and **Bright Grey** have both reviewed their occupation listings. In Aviva's case it has announced that 95% of all occupations can now be offered an 'own occ' definition, with Bright Grey's review likely to yield similar results. We expect other insurers to follow (the process is not simple, as such a review is time consuming and likely to involve reinsurers and complex actuarial modelling). We also believe a partial solution could be for insurers to give examples of what types of claim would and would not be paid under each definition. This would be similar to the examples already given by private medical insurers regarding cancer claims.

Ideally, we would like to see ADL and ADW based definitions dropped completely. The resultant simplification would be good for consumers, help encourage more financial advisers to look at IP and result in more people benefiting from IP cover. Claims management may need to be improved to compensate and some premiums may have to rise, but the value of IP is not in terms of how cheap cover can be made, but in how it delivers value in practice to its millions of customers and how its appeal can be increased to attract millions more.

It is worth noting too that one reason why encouraging IP was not seen to be a great priority in the recent Black/Frost sickness absence report (see *e-PR 139*) is that it currently covers too few workers and is perceived to be too *upmarket* (our italics) to be seen to be a major part of any future solution.

A secondary benefit of improving claims management is that a superficial analysis of claims data suggests too many claimants are being paid benefit rather than helped back into the workplace. As, by definition, IP claimants must always be slightly worse off financially than those in work, the industry needs to fully commit to—as the Government now is—the concept of recognising that working is better than not working and adjusting both its practices and sales methods accordingly. Most insurers are already a long way down this path—but not every one is, and practice sometimes falls short of rhetoric.

• **A single protection day**. *Money Marketing* revealed on 1 March its support for ex-**Ageas Protect** CEO Martin Werth's idea that there should be a single annual protection day. The aim would be for all insurers to send an annual benefit statement to existing customers setting out what protection they have and directing them towards an IFA to discuss options and further needs. The industry could then mount a campaign behind the day to further boost awareness of protection (and so protection shortfalls) and to encourage greater take-up and planning.

The concept is not without its issues though. In practice, getting every insurer to agree a single day (and, which day that should be) would be nigh impossible, while the resulting peak in admin resourcing needed both in advance of the day and following up the inevitable queries raised by customers, could be a logistical nightmare.

Alternatives include having a number of such days (confusing and not at all customer-centric), doing that alphabetically (either by provider or customer—the former confusing to customers who have more than one provider and the latter being difficult where people's names change such as on marriage), linking instead to the customer's birthday and, one of *ePR* editor Andy Couchman's favourites, setting a day three months before the customer's birthday (so allowing time for advice to be given and any new cover set up before the birthday when, inevitably, the cost of any solution is likely to rise). Even that is not without issues—how would joint life cases be handled for example? Linking in with group risk cover and perhaps health insurances too could also be part of any ideal solution.

Martin Werth's comments are apposite though: "The protection industry is too used to just talking about the problem but we have got to rise to the challenge and make people question if they have enough cover," he told *Money Marketing*.

And we are delighted that the **ABI** (**Association of British Insurers**) Protection Strategy Committee is considering the idea, so adding some heavyweight industry gravitas. Its chairman, Aviva's Richard Verdin told *Money Marketing* on 15 March: "A protection awareness day is something we are considering as part of a package of measures to increase take-up."

• **LifeSearch code of conduct for protection sellers**. Revealed at its awards lunch on 7 March, the code requires advisers to explain critical illness cover limitations in line with **FSA** requirements; explain the limits of highlighted terminal illness cover and ensure it is not confused with CI; if highlighted, explain the definitions used on total and permanent disability and income protection covers; make exclusions clear on PPI style policies and explain that long term IP cover is also available; advisers must make clear whether they provide regulated advice; and all sellers must demonstrate that they have properly provided for the repayment of indemnity commissions on lapsing policies. In effect, the LifeSearch code is supplementary to those required by regulators and professional and trade bodies and specifically targeted to protection weak spots.

Briefs:

• **Unum** has announced that it is leaving the individual income protection market, to focus on the group market. It stopped marketing products from 2 March but will honour quotations until 30 March. It had already left the individual critical illness market in May last year.

• Income protection insurance is more important than life insurance, according to 74% of 168 employers polled by **Jelf Employee Benefits**. Yet, while the majority of employers offer life cover as standard, IP cover is a long way behind Jelf says.

• **Highclere Financial Services'** partner Alan Lakey has launched a critical illness cover comparison website that allows advisers to compare policies from every CI provider. The *www.ciexpert.co.uk* site costs £280 plus VAT for a 12 month subscription (or £90 for a quarter or £160 for a half year) with an introductory offer of 15 months' subscription for just £300 plus VAT. The site includes a 400 brochure history of old plans and a consumer section that details product differences, common misconceptions and which conditions are most likely to occur.

• A survey by **Sesame Bankhall** reveals protection to be a key growth area for 2012, with 31% of IFAs expecting to expand their business by 10% or more and another 30% expecting up to 10% growth this year. But, 19% believed last year's Test-Achats gender ruling could adversely affect the market.

• **Drewberry Insurance** has launched an income protection comparison tool to enable consumers to compare policies, including making side-by-side comparisons.

• The **Association of Medical Insurance Intermediaries** (**AMII**) has welcomed changes made to **Defaqto's** Star Ratings for private medical insurance, following criticisms AMII made when the system was launched on 1 February. AMII vice-chair Brian Walters said: "Defaqto's ratings reflect the comprehensiveness of products; they are not necessarily a mark of quality. Not everyone wants or can afford five star cover; in many cases lower-rated products will perfectly meet an individual's demands and needs. The ratings are not a substitute for independent advice."

• Richard Sear, previously CEO at **National Friendly**, has launched a new business consultancy. For more see *www.searconsultancy.co.uk*.

• Well over a quarter of a million people (265,530 as at May 2011) are claiming Employment and Support Allowance (ESA) because of mental and behavioural disorders, **Legal & General** analysis claims. And almost a quarter of those are aged 24-34 it says.

• Almost two thirds (63%) of **Bupa's** turnover is now generated outside the UK its 2011 annual results show. In the UK, health insurance customers declined 'marginally' to 2.87m, with overall customer numbers up 3% to 10.8m. Revenues rose 6% from £7.58bn to £8bn. Global underlying surplus was up 20% to £559m.

• **Scottish Provident** paid out 91% of its critical illness claims in 2011, with an average payout of £82,000 and over £1m paid out in children's CI cover. Cancer accounted for half of all CI claims. The insurer has also revealed that it paid out almost £42m in life claims last year, with the average age of claimant being 56 and half of all payouts being for customers aged below 55. The average life claim was £84,744 . SP research says that the average life sum insured for men between their 30s and 70s is £148,559, compared to £100,463 for women.

• **Aviva** paid out £320m on 10,495 life claims in 2011 plus £114m on 1,568 CI claims. 99.7% of life and 94.1% of CI claims were paid, with just 0.4% of all claims being declined due to non-disclosure. Average CI sum insured was £73,591 and average age of claimant was 44 for women and 46 for men. Cancer accounted for 67% of CI claims, followed by heart attack (10%), stroke (7%), multiple sclerosis (6%) and benign brain tumour (2%). Terminal illness claims paid were over £47m.

• The **Life and Longevity Markets Association** (**LLMA**) has launched four longevity indices. The indices will be used as a global reference for the transfer of longevity risk from hedgers to investors and other counterparties. See *www.llma.org* for more.

• **Now Health International** has extended its 5% premium reduction on all new business quotes to the end of June. It had been due to run for six months to the end of March.

• **Simplyhealth** is launching a new module to its existing corporate cash plan to cover private medical insurance excesses. Full review next month.

• **AXA UK** has formally completed its takeover of **Health-on-Line**. It intends to leverage Health-on-Line's IT capability to develop lower cost PMI cover by attracting new market entrants.

• The **CII's** new *Cert CII* (*Health and Protection*) qualification has now been officially launched. The qualification was outlined in *e-PR* 139 Page 2).

• **Enrich** has teamed with **Health Management** to help employers manage their staff's protection benefits. It will offer affordable occupational health services and enable better data transfer between providers.

• 28% of advisers are not aware they will be unable to sell payment protection type insurance at point of sale from April, a **LV=** survey has found.

• **i-Protect** says it is in discussions with a charity provider to enter the group protection market through an online portal.

• The **ABI** has published a new 16 page guide for consumers thinking about buying private medical insurance.

• Expectant parents spend on average £1,370 preparing for the arrival of their first baby, and a quarter moved to a bigger house according to **Aviva**. However, while 40% start a savings account for a new arrival, only 18% take out any life insurance. That is less than the number (25%) who had already nominated a guardian for their child if they were to die. The research was carried out by **One Poll** in January.

• **Allianz Worldwide Care** has launched a 'dormancy' option to allow individual customers to freeze their cover if they become eligible for an employer-funded plan, with the ability to reactivate up to five years later.

• Not much of interest in this year's Budget on 21 March, although cigarettes have gone up by 37p a packet. Smokers could do well to use the money saved and the average £5,490 saving on combined life and critical illness cover enjoyed by non-smokers (according to research by **MoneySupermarket**) to invest in boosting their family's health and protection cover,

Pick of the month

This month we review two health cash plans, an income protection plan and a group critical illness plan.

L&G has introduced a number of positive changes to its group CI plan, while Aviva has taken a similar tack for its income protection plan.

Perhaps the HCPs are most interesting though. Paycare is opening up a market for parents to fund adult kids' everyday health costs. Chances are mum or dad would end up paying them anyway so this could really appeal. Our pick of the month though is Medicash, which has squeezed a heck of a lot of benefits into a simple low cost HCP.

Aviva Income Protection Solutions

Aviva has introduced a number of underwriting changes to its existing Income Protection Solutions product:

• Around 250 occupational classes have been updated, with 221 (including journalists, chartered surveyors, vets and scientific professionals) seeing a reduction in class, and therefore premium. A further 21 occupations that were automatically declined (including roofers, tilers and scaffolders) are now covered.

• Aviva estimates that 95% of occupations are now accepted on an own occupation basis rather than a 'suited' or activities of daily working (ADW) incapacity definition.

• The plan already includes a number of features not common to income protection, such as: free accident cover during underwriting; 5% premium discount each if a mental health or back/neck exclusion is applied; lump sum benefit on death during the first 12 months of a claim; dual deferred period option; 24/7 GP and stress helplines.

• The plan offers a choice of 4, 8, 13, 26, 52, 56, 104 and 112 week deferred periods; choice of selected retirement ages up to age 70; guaranteed or reviewable rates; guaranteed insurability option; level or indexed (RPI) benefits; limited benefit period up to five years.

• Maximum cover is 60% of first £25K of earnings plus 50% of the remainder up to £180K.

Comment: *Aviva is one of the first mainstream IP insurers to pick up on the* ***Cover/Protection Review*** *campaign for more own occupation disability definitions. That is a great response and its other underwriting changes build on an already strong product. There are still some non-own occ occupations however—and 5% is still a big number.*

Product design points: *All IP insurers are now having to address the issue of ADL and ADW underwriting definitions following Cover's campaign on this issue, which we support. Some IP insurers—typically the smaller friendly societies—already do that, arguably by charging higher rates. As well as giving a better deal and greater clarity to customers, the greater simplicity of having all own occ definitions will encourage more IP take-up. Yes, it may mean a few more claims, but better underwriting and, especially, claims management can mitigate much of that. IP needs greater simplicity to become more attractive to customers and (especially) distributors, so we expect other insurers to follow suit (****Bright Grey****/****Scottish Provident*** *has already done so).*

Plus points: *95% of occupations now own occ; rating improvements for many occupations; 5% premium discount for some ratings; strong basic product; nice case study video on the adviser website.*

Not so plus points: *5% of occupations still won't be offered an own occ disability definition; some providers may offer higher benefits.*

Website: *www.aviva.co.uk/healthcarezone*.

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

Legal & General Group Critical Illness Cover

L&G has introduced a number of changes to its existing group critical illness (CI) plan. These include:

• Five new conditions have been added. These are: aplastic anaemia; bacterial meningitis; cardiomyopathy; encephalitis, and liver failure. This takes the total to 38 conditions (when the Additional option is selected – otherwise, only 12 conditions are covered under the Core option).

• The maximum benefit has been increased to the lower of £500,000 and five times scheme earnings.

• A free cover (underwriting free) limit of £500,000 for high earners has been introduced.

• The minimum survival period has been cut from 30 days to 14 days.

• The maximum benefit for spouses and registered civil partners has been increased to £150,000.

• The maximum benefit level for employees joining a voluntary plan has been raised to the lower of £250,000 and five times their P60 earnings.

Pre-existing and related conditions are not covered. Existing plans can be upgraded at no extra cost.

The minimum scheme size is usually 50 employees and children's cover (the lower of £20,000 or 25% of the member's benefit) is automatically included, with no maximum number of children. Target claims turnaround time is five days from receipt of all documentation. There is also a 24/7 employee and managers assistance programme called Worklife Solutions.

Comment: *Useful and positive changes that benefit both customers and advisers, although we still have concerns about CI overall.*

Product design points: *L&G is one of many providers that has chosen to update an existing design rather than develop a completely new one. That can make sense, not least because many advisers are quite conservative and like what they know, just want it a bit better. That strategy also enables insurers to react to changing market demands, drive new innovation or even create artificial activity boosts and save costs. The key issues are when to drop an existing product and invest in a new one and when or if the market gets change fatigue.*

Plus points: *Leading group CI provider introduces raft of positive changes.*

Not so plus points: *CI generally needs a bit more than a makeover; some fear that advisers will focus on counting numbers of conditions; the product literature could usefully include examples of what is meant by terms such as pre-existing and related conditions.*

Website: *www.legalandgeneral.com*.

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

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Medicash Proactive

Medicash Proactive is a group health cash plan with four option levels and premiums ranging from £1 a week. The main benefits the plan offers are:

Benefit	Level 1	Level 4
PMI excess/specialist consultation	£200	£400
Complementary therapies (physiotherapy; sports massage; acupuncture; osteopathy; chiro)	£150	£400
Alternative therapies (reflexology; reiki; Indian head massage; Bowen and Alexander technique; homeopathy; allergy testing; hypnotherapy)	£75	£200
Chiropody	£20	£50
Health screening	£100	£200
Prescriptions; inoculations; flu jabs	£20	£50
Routine dental treatment	£55	£170
Dental accident and injury	£200	£500
Optical	£55	£200
Personal accident cover	£5,000	£24,000

Customers also get access to the **Best Doctors** Inter-Consultation service. Children's (up to four children) benefits are usually half those of adults. Plans can be single or joint, with joint plans costing double. The PA insurance cover is on a sliding scale, based on severity.

There is also Medicash Extra. This is the ability to buy reloadable gift cards that offer discounts, including 5% off at **Asda** and **Sainsbury's** amongst other deals.

As we closed for press, Medicash was in the final stages of confirming its new employee assistance programme (EAP) benefit. This includes Day 1 stress intervention and a manager support helpline and was expected to be in place by 1 April. For an additional 15p a week per employee, telephone advice and support plus access to six face-to-face counselling sessions can be added.

Comment: *Medicash has included a number of additional benefits not usually included on HCPs, especially at this starting price point. The new EAP benefits sound as they will be attractive too*

Product design points: *Medicash's new plan is a good example of how far some providers are now going to offer a proposition that is much more than just paying out cash to pay bills. Helplines have long been inexpensive to provide but potentially of huge benefit to some customers, while such as Best Doctors offers a very focused service that could again be invaluable to some people.*

Splitting alternative and complementary therapies (with two separate caps) is an interesting solution. As is having 'PMI excess' as a main benefit. This is a potentially large market for HCPs, as they can enable customers to choose a lower cost PMI package and use the HCP to cover some of the PMI shortfalls.

Personal accident insurance (why do you need a benefit that only pays out if you have an accident rather than if you are ill?) and retail discounts may be seen as a gimmick but the acid test is whether they work and whether customers like and use them.

Plus points: *Low cost but high benefits including some not normally seen on similar HCPs.*

Not so plus points: *Details of the EAP to be confirmed. Retail discounts may be a bit gimmicky, but the savings look real. How do they make money on £1 a week plans?!*

Website: *www.medicash.org*.

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

Paycare Go

Paycare's new Go is a health cash plan aimed exclusively at young adults aged 18-24 (24 years three months at outset). The thinking behind the plan is that age 18 is when many previously 'free' NHS benefits stop. For example, young people (unless in full-time education or otherwise exempt or sometimes depending on which UK country they live in) are no longer entitled to free prescriptions, eyecare or dentistry after age 18 (or in some cases later). Despite the potential effect on their budgeting, most young adults are likely to have little or low income and so any unexpected bill such as even an NHS dental charge (so much for free NHS care—the top treatment cost in England is now going up to £209 per treatment).

Paycare Go offers a choice of two cover levels and pays the following maximum annual benefits:

	Level 1	Level 2
Optical charges. 100% of cost up to	£40	£80
Dental charges. 100% of cost up to	£40	£80
Specialist consultations and tests. 100% up to	£75	£150
Professional therapy (physiotherapy; osteopathy; chiropractic; acupuncture; homeopathy; hypnotherapy, and reflexology. 100% of cost up to	£50	£100
Inoculation/vaccination. 100% up to	£30	£60

In addition, there is a 24/7 Paycare counselling and help line. Level 1 plans cost £5 a month and Level 2 plans £10 a month.

At age 25, the customer is transferred onto Paycare's Direct Plan. At outset there is an initial 13 week waiting period, some restrictions on changing benefit levels and specialist and professional benefits cannot be claimed for pre-existing conditions. Premiums can be paid by parents or by the young person themselves.

Comment: *We see too little age segmentation in life and health insurance but this plan targets a hitherto untapped market. Many young people suddenly find themselves with funding responsibilities for their healthcare but no budget to pay for what can be quite significant one-off sums. This plan allows them effectively to spread many everyday health costs. Even better, they may be able to get a parent or other relative to pay premiums for them. A simple but effective solution.*

Product design points: *The industry has not been as effective as it might in attracting more young people—whether that is to buy long term protection or short term health cover. Quite simply, it has been hard to get young people to engage with what many see as 'boring stuff' or not really relevant to them.*

Paycare illustrates that there is a need for a young person's health cash plan and also recognises that 'the bank of mum and dad' may well end up paying for it. Other product marketers will watch with interest whether this is a real market—if it is, Paycare is well-positioned to be able to cross-sell and upsell to its new customers in future.

Plus points: *Targets a specific age group with specific issues; low cost and simple cover; can be funded by parents.*

Not so plus points: *Three month initial waiting period; some pre-existing conditions not covered; stops or rather converts to other cover at age 25, when parental funding responsibility will often go on longer than that.*

Website: *www.paycare.org*.

Rating (max 5): Innovation: 4.5 Overall: 3.75.

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Serious risks from metal-on-metal hip implants

'A story of the collective and systematic failure of the regulatory-industrial complex'. That was how the *BMJ* described the results on 29 February of a joint **BMJ/BBC Newsnight** enquiry into problems with metal-on-metal hip implants.

Unlike recent problems with the **PIP** silicon breast implant, this latest concern over prosthetics is not the result of one rogue company's actions, nor is it something that does not affect health insurers.

What it is about is around 49,000 UK patients with metal-on-metal hip implants with a femoral diameter of 36mm or more. They will need annual follow-up tests for the rest of their lives to check metal ion concentrations in their blood, the **Medicines and Healthcare Products Regulatory Agency** has announced.

Patients with hip symptoms indicative of problems with the joint, such as swelling, pain, or limping should undergo annual magnetic resonance imaging (MRI).

However, the agency has said that what constitutes a worrying rise in metal ion concentrations and whether a revision is necessary, are both clinical judgements. The expectation is that younger patients are more likely to be revised than older patients. Previous guidelines were that annual tests were only necessary for five years and even then only for certain patient groups.

Metal ions can destroy muscle and bone and leach into the bloodstream, spreading to the lymph nodes, spleen, liver and kidneys before leaving the body in the urine. The ions have also been linked to chromosomal damage and cancer.

Private medical insurers may come under pressure to pay for both testing and revisions but are likely to have subrogation rights to enable them to claim back any spend.

The articles in the *BMJ* do make worrying reading—cobalt poisoning was reported as long ago as 1967 and local tissue reactions associated with ions from metal hip replacements were first described in 1975. In 2000, NICE recommended that patients are warned of the uncertainty about long term effects. Deborah Cohen's report claims that over the past decade, manufacturers and regulators played down evidence that potentially carcinogenic and neurotoxic metal ions from implants were leaking into patients' tissue and blood.

See *BMJ 2012: 344:e1539*.

Regular smear tests up survival

Regular smear tests boost the chances of surviving cervical cancer from 66% to 92% according to a Swedish study. Some 1,230 women diagnosed with cervical cancer between 1999 and 2001 were studied by researchers at the **Centre for Research and Development** in Gävle and the **Karolinska Institutet** in Stockholm.

The research also found that three quarters of the 373 women who died from cervical cancer had not had a cervical smear in the recommended timeframe.

The authors conclude that screening reduces the risk of cancer and is associated with improved cure.

See *www.bmj.com.cgi/doi/10.1136/bmj.e900*.

Low mobile phone glioma risk

If mobile phone use is linked to increased risk of a glioma (a form of brain tumour), the incidence of glioma should have risen much more than it has, a US study claims.

Researchers studied data for 24,813 non-Hispanic white people diagnosed in the USA with a glioma between 1992 and 2008. This was a period of considerable mobile phone use (from virtually 0-100% use), yet age specific incidence rates of glioma generally remained constant. The study is important as a Swedish and a few other studies had suggested a link and the **International Agency for Research on Cancer** (**IARC**) has classified mobile phone use as a possible human carcinogen due to microwave radiation exposure.

See *BMJ2012;344:e1147*.

Alcohol related deaths have fallen since 2006

Despite significant increases in alcohol-related death rates up to 2006, more recent experience has shown the trend flattening out for most age groups an **ONS** report published on 26 January shows.

Excessive consumption of alcohol accounted for almost 1.5% of all deaths in England and Wales in 2010, with most deaths being for males in the 55-74 age group.

UK death rates per 100,000 population were:

Rate	**2006**	**2007**	**2008**	**2009**	**2010**
Males	18.4	18.1	18.7	17.4	17.8
Females	8.8	8.7	8.7	8.4	8.3

For males in England, alcohol-related death rates per 100,000 population in 2010 varied from 11.7 in the East of England to 22.6 in the North East.

For women death rates per 100,000 varied from 5.5 in the East of England to 10.2 in the North East.

See *Alcohol-related deaths in the United Kingdom, 2010* from www.ons.gov.uk.

Comment: *The data is interesting against the background of a minimum alcohol price now being introduced in England. However they only show deaths and not morbidity.*

Japanese managers' mortality increased following economic collapse in the 1990s

A study of Japanese workers' mortality between 1980 and 2005 has found that while managers generally enjoyed the lowest mortality up until 1995, that largely increased from then, whereas other non-professional workers' mortality steadily decreased. The period coincided with economic growth until the mid 1990s, followed by economic collapse then years of stagnation.

However, suicide rates increased in all occupations, but more so for management and professional workers.

The study suggests that economic crises should see an increase in suicide prevention in working age men and a greater awareness of the economic effects on health.

See *BMJ 2012; 344: e1191*.

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Medical briefs:

• 42% of women suffering a myocardial infarction (MI) present at hospital without any chest pain or discomfort, compared with 30% of men, US researchers have found. It helps explain why signs of MI in young women are often missed and why 14.6% of women, compared with 10.3% of men, die in hospital. The study was published in the *Journal of the American Medical Association* in February.

• The risk of type 2 diabetes is significantly increased if white rice is eaten regularly, a study from the **Harvard School of Public Health** claims. The authors estimate that the risk of type 2 diabetes is increased by 10% with each increased daily serving of white rice. Consumption varies between four portions a day in China, compared to less than five portions a week in the Western world. See *www.bmj.com/cgi/doi/10.1136/bmj.e2021*.

• One in three adults over age 50 is unable to completely understand their medicine label instructions a team of researchers at **University College, London** has found. It also found that adults with the lowest literacy scores were more than twice as likely to die within five years as those with the highest scores. They conclude that low health literacy is a significant predictor of mortality. The study was published in the *BMJ* on 15 March.

• Happiness is highest in people's teens and their 70s according to an **ONS** poll of 80,000 adults between April and September last year. The poll also found people were happiest in Northern Ireland, scoring 7.5 out of 10, compared to 7.3 in the other UK countries. People in London and the West Midlands scored lowest (7.2) for life satisfaction, while those in London were the most anxious too (3.5, compared to a UK average of 3.2) See *www.ons.gov.uk/ons/index.html?cardisp=2#id2*.

• Women who have endometriosis are substantially more likely to develop three distinct histological subtypes of ovarian cancer (clear cell, endometrioid and low grade serious) research in *Lancet Oncology* shows. Researchers at the **University of Southern California** undertook a pooled analysis of 13 case-controlled studies using data from more than 23,000 women. See *doi.10.1016/S1470-2045(11)70404-1*.

• Patients with rheumatoid arthritis have a 40% greater risk of atrial fibrillation than the general population, an article in the *BMJ* in March claims.

• Clinicians believe they provide more healthy living advice to diabetes patients than patients think they are given a study by **Newcastle University** researchers claims. 99.6% of clinicians said they routinely discussed physical activity and 88% diet with their patients, yet only 45% of patients said activity had been mentioned in the past year and only 57% that dietary advice was given. See *Diabetes Medicine* 29 (Supp 1): 450. The findings illustrate the importance not of what is actually said but what is received and understood.

• Nearly a third of nursing homes do not have a 'do not attempt resuscitation' (DNAR) policy, according to the **Care Quality Commission**.

• A **Royal College of Nursing** survey of 600 nurses found that 26% believed care homes did not have adequate equipment, while 38% said care homes were understaffed. See *tinyurl.RCNsurvey*.

Political briefs:

• General and acute hospital beds in England fell by a quarter from just under 136,000 in 2000/01 to 105,000 in 2011/12 (source: Professor John Appleby, **King's Fund**, in a *BMJ Data Briefing* on 14 March).

• **Reform** has published a report featuring ten case studies of successful health reform in various countries. The report challenges the view that competition will fragment NHS services and shows that instead it can bring in new providers able to integrate services that were previously uncoordinated. *Healthy competition* can be downloaded from *www.reform.co.uk*.

• There were 583 breaches of the MSA (mixed sex accommodation) guidance relating to English NHS patients in February, the **DH** announced on 15 March. The figure was down from 625 in January.

• The latest quarterly data (for October to December 2011) showed that 96.2% of people saw a specialist within two weeks of an urgent GP referral for suspected cancer (up from 95.7% in the previous quarter). For breast cancer symptoms the figure was 96.3% (up from 96.0%). Figures from **DH** press release, 24 February 2012.

• In January 2012, 323 urgent operations were cancelled, compared to 489 in December 2011, the **DH** announced on 24 February.

• In the October to December quarter of 2011, the average number of NHS hospital beds available overnight was 138,074, down from 138,714 the previous quarter, the **DH** announced on 24 February. Average occupancy rate was 85.3% (up from 83.9%). There were 105,280 general and acute beds open (down from 105,673), with an average occupancy rate of 86.8% (up from 85.1%). The average number of day only beds was 11,324, down from 11,468 the previous quarter.

• The **2011 NHS Staff Survey** found that 87% of staff said they feel satisfied with the quality of care they provide to patients the **DH** reported on 20 March. But only 61% indicated being able to do their job to a standard they are personally pleased with and only 30% (down from 32% in 2010) said there were enough staff in their organisation to allow them to do their job properly. 15% of staff reported experiencing bullying, harassment and abuse from patients. Only 51% would recommend their trust as a place to work (down from 53% in 2010 and 55% in 2009).

• In April 2011 median gross weekly earnings for all employees were £498 **ONS** revealed on 21 March.

• One of our favourite comments on the *Health and Social Care Bill* came from a letter to the *BMJ* published on 6 March from Dr Rajan Madhok. He wrote: 'I am all for dropping the Bill, but I think we need a broader debate and to be clear about what happens next. Do we have a vision for what the 21st century NHS should look like? Defining ourselves by what we do not want is not the same as knowing what is needed.'

• Schoolboy humour department. *The Times* reported on 18 March a previous news item about a Dutch senator called Tiny Kox. Reader Richard Coombes then followed up, demanding that *The Times* recognise British achievement in this field saying: "There is also nothing remotely amusing about the Labour MP for Broxtowe from 1929 to 1953—Seymour Cocks." Quite.

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Two important Bills passed

Two important Bills passed through Parliament in March. The controversial *Health and Social Care Bill* passed its final stage in Parliament on 20 March and was awaiting Royal Assent (on 24 March). The less controversial *Consumer Insurance (Disclosure and Representations) Act 2012* received Royal Assent on 8 March.

The former Bill met increasing opposition during a stormy Parliamentary ride, yet elements of the Bill were already coming into effect and its ultimate passing (with amendments) was always pretty much a foregone conclusion. The latter Act in effect modifies the old utmost good faith (uberrima fides) maxim and brings consumer insurance contract law into the 21st century.

The Act provides that if an intermediary is an appointed representative of the insurer, or is acting as the insurer's agent, they will be considered as acting for the insurer. In all other cases, they are acting for the consumer. The consumer's duty to volunteer facts has been abolished and instead consumers must take reasonable care to answer insurers' questions fully and accurately.

Unemployment up marginally

Unemployment stayed at 2.67m in November 2011 to January 2012, according to the latest *Labour market statistics* bulletin, released by the **ONS** on 14 March 2012.

During the same period, employment fell from 29.13m in October-December to 29.12m in November-January. This means that the *e-Protection Review Employment Index*, which is a proxy for the growth in size of the main health and protection insurance markets since 2000, fell from 107.13 to 107.09. This index compares the latest employment figure with the 27.192m figure recorded for the first quarter of 2000.

The number of Jobseeker's Allowance (JSA) claimants rose from 1.60m in January 2012 to 1.61m in February. The latest unemployment rate is now 8.4%, or 5.0% for JSA claimants. Earnings in the three month period to end January 2012 (including bonuses) fell from 2.0% to 1.4% higher than a year before.

On 20 March the ONS announced that in February the Retail Prices Index (RPI) fell to 3.7% compared to a year before (down from 3.9% the month before), while the Government's preferred Consumer Prices Index (CPI) fell from 3.6% to 3.4% in January. This compares to an annual inflation target of 2.0%.

Hospital RTT waiting times up

The median Referral to Treatment (RTT) wait for NHS hospital admission in England rose from 7.7 weeks in December 2011 to 8.7 weeks in January 2012 according to a **Department of Health** Statistical Press Notice released on 15 March. For non-admitted patients the median wait rose from 3.8 weeks to 4.4 weeks. The 95th percentile time wait for patients entering an RTT pathway rose from 21.8 weeks to 22.0 weeks for admitted patients and from 15.7 weeks to 16.1 weeks for non-admitted patients.

The number of admitted patients meeting the 18 week target fell from 91.6% to 91.4%.

NHS hospitals—where does the money go?

An interesting analysis of NHS England hospital spending in 2009/10 (based on the National Reference Costs database) is given by **King's Fund** chief economist Professor John Appleby in a *BMJ Data Briefing* published on 14 March.

Of total spending of £44.3bn (just over 40% of the total NHS Budget), in-patients made up £17.3bn (£5.1bn for elective and £12.2bn for non-elective). Out-patients made up £7.5bn (£2.8bn for first attendances, £0.7bn for procedures and £4.0bn for follow-up attendances).

Mental health made up £5.5bn (£2.0bn in-patients; £1.4bn for community services; £0.9bn for specialist services; £0.8bn for secure units, and £0.4bn for out-patients).

The balance was made up of: £3.2bn for day cases; £2.4bn for critical care; £1.6bn for emergency care; £1.6bn for paramedic; £1.6bn for diagnostics/pathology; £0.9bn for high cost drugs; £0.8bn for chemotherapy; £0.5bn for renal dialysis; £0.4bn for rehabilitation; £0.3bn for radiotherapy; £0.2bn for coronary care; £0.2bn for audiology, and £0.3bn for other.

Bupa warns of care home squeeze

Outgoing **Bupa** CEO Ray King (who has now handed over the reins to Stuart Fletcher) has warned that a 'massive squeeze' in public funding will bring about a crisis in the care market, *The Times* reported on 14 March.

He said that 70% of people in care homes are dependent on Government money, yet there had been a 4% decline in the real level of public funding for care homes over the past two years. Public sector funding now needed to increase by 5-8% a year. He also warned that the private sector was likely to pull back on investment.

ESA: 1 in 3 found fit to work

Of the first 141,000 people going through Incapacity Benefit reassessment, over a third (37%) of those whose claims have been concluded have been found to be fit for work, the **Department for Work and Pensions** announced on 15 March.

Of the remaining 63%, 34% were placed in the Work Related Activity Group (and so will receive personalised help and support to prepare them for a move into suitable work in the future) and 29% were placed in the Support Group and will receive unconditional financial support and will not be expected to work.

NHS will soon have to specify what it will pay for: Nuffield

The NHS needs to establish a set of principles to help make decisions on resources and services a **Nuffield Trust** report concludes. And it found that 85% of English GPs polled agreed that the financial challenges will eventually force the NHS to set out more clearly what care is, or is not, freely available.

Rationing Health Care can be downloaded from www.nuffieldtrust.org.uk/publications/rationing-health-care.

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Blogs

In this section of e-Protection Review we feature some of the blogs that were first published on the *www.protectionreview.co.uk* website. You'll find blogs covering a very wide range of issues, products and markets. That's the aim. We want every blog to challenge and question, to inform and to stimulate. Our bloggers are a mixed bunch (we mean that nicely) but they are all people we like listening to and learning from. We hope you will to.

This month we feature three blogs. First, Marilyn Cole of Sapce01 challenges group risk insurers to use technology better—or at all… Then, Philip Cooke looks at barriers we put in front of customers and finally Phil Veale looks at simple products. Marilyn started us off on 28 February:

I would like to use this blog to ask a challenging question of the group protection industry.

Why does the group risk market still inhabit the technological dark ages when it comes to placing and renewing cover and obtaining quotes?

Space 01 has been researching the market with brokers. From what we have seen, generally brokers obtain the required information from the employer, clean it, and then usually email the information on an Excel spreadsheet to the relevant providers. They can then wait a very long time for a quote and longer still to put a scheme on risk.

In fact, there are still only a couple of providers who offer an electronic quote and even then not for all business and it is restrictive based on the size of the scheme.

We struggled to think of the term for what is needed, and realised that we are talking about straight through processing. The concept is actually so accepted in other financial services product areas, including individual protection, than no one even mentions it. It is almost invisible, but group risk is still crying out for it.

From a personal point of view, when I was working in a life office in the 1990s, this was the system in use then. It is little short of amazing, though not in a good way, that things have not moved on significantly.

There may be reasons why. First we suspect that the market has not been top priority. If it is always at the bottom of the 'to do' list then perhaps it is not so surprising if it doesn't get done.

Some aspects of the market, such as the need for large schemes to split their cover between insurers, may have lessened the competitive pressures. In addition, insurers turn down a lot of schemes. Perhaps the fact that the individual information required is so simple has also made automation less of a priority.

However, we don't see how anyone is benefiting – not employers, employees, brokers or insurers - from a system where an employer may receive a financial statement about cover as much as six months after a broker has got in contact.

There are of course other issues which may require some thought. How 'clean' does a case have to be before it is passed? Is there any way to increase the minimum cover levels before underwriting has to be done while remaining cost effective?

But even if a big percentage of schemes do require more detailed work, at least an automated system might identify them more readily.

There is one other reason why time may be of the essence. There is a huge opportunity to talk about group risk alongside auto-enrolled pensions. Some employers will simply want to comply with the legislation. However others may use the opportunity to examine their whole benefits strategy. It doesn't look like the State is going to offer a helping hand, as it does in Australia, where you can put a small part of your compulsory pension contributions towards protection.

But as the systems for pensions and payroll are automated to make auto-enrolment cost effective, surely group risk needs to get to a minimum technology standard as well. Otherwise sales could be lost because of the administration hassle and that's a shame for everyone; most importantly for employees.

I accept that there may be reasons why technology has not been widely adopted and I would love to hear from providers and technology firms what they are.

But surely it is about time providers automated their own processes, and somehow got together to provide a quote engine too? It is not as if the technology isn't tried and tested.

Marilyn Cole is managing partner at Space01.

Next, industry consultant Philip Cooke shares a recent 'customer service' experience. It was nothing to do with protection insurance, but it perfectly illustrates how barriers we spend great care constructing can end up stopping the very things we are trying to actually encourage...

When we put too many electronic barriers between the organisation and the customer—and the financial services sector is among the best at that—we need to be sure that those barriers are staffed by those who care, that they are empowered and are able to talk to people in the other barriers. Sorry, my language is wrong; I should have said 'points of contact' or 'stations of involvement', it's just that everyone I talk to feels that they are barriers.

I write about this now because it is fresh in my mind, after a startling encounter with such a barrier at the end of January. I was minding my own business when I received a telephone call; it was from India, where else? To be specific it was from the fraud/security department of my credit card company. "Mr Cooke, we have reason to believe that there may have been fraudulent activity on your card, so we need to check some transactions with you." So far so good; a chap is always impressed when the barriers are on the ball.

Having come successfully through the security questions—I was pleased to know that it was me they were calling—we moved onto the recent transactions check. They asked me about six transactions and they were all correct and bona fide. It was obvious that one of them was out of my normal pattern—an air ticket with **JAT Airlines** for a flight to Belgrade—and, on the face of it, ex-

to the east European mafia boys; that had been the trigger.

But all were mine and that seemed to be the end of it. Not so; I was then told that my card would be immediately blocked, "because there are indicators that the card has been compromised, and you are at serious risk" A new card would be issued "within 7-10 working days". You're right, it's not real is it – 7-10 days? So this customer digs in the heels' "not acceptable, old chap", I opine. "unless you can tell me how it has been compromised, you can accept this call as formal announcement of my termination as a card holder with your organisation. "Mr Cooke, I do understand how you feel", he read off the screen. He couldn't tell me how the card had been compromised; "I am not allowed to share that information with you?" I imagined the government's COBRA group listening, anxious, as this security issue developed. In response, I shared some information with him: stop this nonsense now, take a leaf out of **Amex's** book and get me a new card within 24 hours, by courier, or I'm off. "I'll put you on hold, Mr Cooke." Oh, good I mused, I haven't heard Vivaldi's *Four Season's* for a while. He's back: "Mr Cooke, we do not wish to lose your business, so we will lift the ban on your card, you can use it normally until the new one arrives. "So I will not be at risk then?" Silence. "How can I have been at severe risk five minutes ago, but not now." Much mumbling, no coherence, more on-screen script reading.

"I'm calling off now." " I do understand Mr Cooke, and thank you for your call." Next day I rang the UK Customer Services number and insisted on speaking to an advisor: she knew nothing about any of this and was appalled; perhaps she was upset that a one of her barriers was not talking to *her* barrier. The result – I'm no longer talking to any of them. Customer service? Hmm. Perhaps I am just a small pawn in the bigger game of market share and customer churn; but I'm not the only one who feels like this. Financial services is, of course a numbers game; but the banks, insurance companies and credit card companies had better wake up, because more and more customers are getting their number!

Philip Cooke is MD of D'Arcy Inspired Ltd.

Finally, Phil Veale of Chiltern Consulting wonders whether its better to focus on producing Ford Fiestas rather than Rolls Royces.

At a recent conference a guy from the **FSA** was advocating commitment to Simplified Products. Also recently, we've seen **Skandia** announce it is looking at alternative distribution options (having been an IFA-only distribution office). As a reminder,

"The Government believes that simple products should be developed so that they deliver against three clear objectives.

• To ensure that people understand the products they need;

• To help people make better choices; and

• To encourage competition in the market."

So, at least two things are going on:

1. The idea of Simplified Products is that consumers can make their own informed decisions more easily (where have we heard that before?), perhaps with less FSA 'policing', but I'm not sure about that. Certainly, they seem to want to vet the policy propositions

2. Then there is the interest from providers such as Skandia to re-grow market share, and that means mass market focus and to a degree that demonstrates the fact that current distribution channels do not fulfil current and probably future needs. Execution only should come into play a lot more, not popular with some but evidently will become an increasing means of distribution.

On the product front, providers need to get a grasp of reaching consumers' needs.

If we as an industry can produce products that are fit for purpose then that's great. They have been, but it's got more and more complex and I just wonder whether this has been a more competitive element for distribution rather than having the consumer at heart. After all how many Rolls Royces are there compared to Ford Fiestas on the road? Perhaps we should adopt a similar approach? IP doesn't have to be so complex and, as for CI, that seems to have gone mad with conditions and consequently definitions. Yes, we need to be fair and clear to consumers and one way, to coin an old statement, is to get back to basics. With IP this could be 'budget' plans and CI could see us return to core conditions only. Much easier to explain to consumers and for them to understand. I am convinced people give up on the complexities and end up doing nothing. Surely some cover is better than none?

There is a strong challenge for marketers. Protection products, particularly, have a record of needing to be sold, rather than being bought. So there is still a need to reach consumers. Opportunities are there!!

Protection Review news

What's happening at **Protection Review**? Here's our monthly round-up of news:

• Your chance to vote for the *Protection Review Awards* shortlist. What's the fairest system to determine who should win any award? There is no simple answer and every system has its drawbacks as well as merits, but the advantage of our system is that we spend most of our year analysing the industry and that and our probably unique industry experience at senior levels gives us a great insight into which organisations and people have stood out as being very special over the previous year. But we can't make those judgements without you, as your votes determine who will be on the shortlist. So do please see the website and vote for who you think should win now.

• On 4 April our generic industry training programme moves to the media (and is supported by the industry and **Headline Money**). This is on top of training for intermediaries. Again, the website gives more detail.

• Members of **The Syndicate** are joining up for this year's research. Membership offers not just remarkable value but is also building a research community that every member directly benefits from.

• We are researching and writing this year's Protection Review book. Launched on 11 July at The Landmark, Marylebone, London the book, all day conference and evening dinner are hugely popular. Places at the conference and dinner are going fast so for more on this and all things Protection Review please see www.protectionreview.co.uk.

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2012/13 NHS and LA changes

From April 2012 a number of NHS charges have increased, as have local authority capital limits and some NHS nursing contributions. The main changes are:

• The costs of an **NHS prescription** in England has risen from £7.40 to £7.65. However three and twelve month pre-paid certificates (PPCs) remain at £29.10 and £104.00 respectively.

• Other NHS charges up include a surgical brassiere (up 60p to £25.70), an abdominal or spinal support up 90p to £38.80 and a full bespoke human hair wig up £5.95 to £245.40 (no, we didn't know the NHS did them either).

• **NHS dental charges** have gone up to £17.50 for Band 1 treatment (up 50p), to £48.00 for Band 2 (up £1.00) and to £209.00 for Band 3 (up £5.00).

• In **England** and **Northern Ireland** the Local Authority capital limits have stayed the same, with a lower threshold of £14,250 and an upper of £23,250. However the weekly personal expense allowance (PEA) has increased from £22.60 to £23.50.

• In **Scotland** the lower limit has increased from £14,500 to £15,250 and the upper from £23,500 to £24,750. The PEA is up from £22.60 to £23.50.

• In **Wales** the single limit has increased from £22,500 to £23,250. The PEA is up from £23.00 to £24.00.

• In **England** the NHS Nursing Care Contribution remains at £108.70 a week (the justification for no change being that nursing salaries have been frozen too). Older rates remain unchanged too. In **Wales** it remains at around £120 a week (the rate being set individually by each Welsh local health board). In **Northern Ireland** it remains at £100.00 a week. In **Scotland** (which operates a different system) the Nursing Care figure is up from £72.00 to £74.00 a week, while the Personal Care contribution is up from £159.00 to £163.00 a week.

Sources: www.dh.gov.uk and www.firststop.org.uk.

People news

• **Ageas Protect**. Darren Spriggs has been promoted from operations director to managing director (replacing Martin Werth). Jane Dale, whose previous roles include at **Legal & General**, has now been appointed permanently to the position of finance director.

• **Aviva UK Health**. Andrew Watkinson has been appointed to the new role of customer relations director. He was previously head of contact centre planning at **HSBC-First Direct**.

• **Association of Medical Insurance Intermediaries** (**AMII**). **Jelf's** Wayne Pontin has taken over from Andrew Tripp as chairman.

• **Defaqto**. Asitha Rodrigo has been appointed its chief technology officer. He joins from **Standard & Poor's** and had previously been with **Money Marketing**.

• **Department for Business Innovation & Skills** (**BIS**). Graeme Nuttall has been appointed the Government's independent adviser on employee ownership. Mr Nuttall is a partner at European law firm **Field Fisher Waterhouse**.

• **Department of Health**. Dr Felicity Harvey CBE has been appointed Director General for Public Health. Charlie Massey has been appointed Director General for External Relations. Karen Wheeler CBE has been appointed Director General for Group Operations and Assurance. All will take up their posts shortly.

• **Financial Services Authority** (**FSA**). CEO Hector Sants announced on 16 March that he would step down in June, having been CEO for five years.

• **Friends Life**. Rosie Harris joins in April as chief risk officer, from **Lloyds Banking Group**.

• **XL Re**. Ex-**Bupa** CEO Val Gooding CBE has joined the reinsurer as a non-executive director.

Sales and marketing ideas

ABI (**Association of British Insurers**) director general Otto Thoresen was reported in *Financial Adviser* on 15 March as saying that financial services providers must consider innovative ways, such as social media and new technology, to engage with young people. He was particularly talking about saving, but his comments could equally well apply to health and protection insurance too.

Which brings us to one of our favourite words—subrogation. Subrogation is defined (*Wikipedia*) as the legal technique under common law by which one party steps into a customer's shoes, so as to have the benefit of their rights and remedies against a third party.

You will see the term used in general insurance policies and it often features in medical insurance.

We like to look at it in a wider context too—simply putting yourself in your customer's shoes.

That is important for a whole bunch of reasons. For example, we know that most young people do not think a great deal about insurance—unless it is generally accepted as being a necessary, such as for a car or perhaps even for some, their mobile phone.

So, if we believe young people need a particular type of health or life cover, we have to put ourselves in their shoes and ask what would make us move that insurance from 'boring—not interested' to 'yeah, cool'.

Part of that will be down to the medium we use to get our messages across. So, a young person is likely to use a range of social media, and their choices may not be the same as those of us who are older. Similarly, the language used must be appropriate too and we have to avoid jargon, unless that is jargon our target group uses too.

Who communicates is also important and younger people may place greater emphasis on what their peers say than what an older generation may say. That fits with using customers themselves through social media—even though we have less (or no) control over the messages or even the language used.

It is increasingly important for both providers and intermediaries to have both a social media and a communications strategy. And to focus efforts in areas of most value to your customers because, ultimately, that will be of most value to you too.

As a simple test, look at something you have written recently and test it with a young person—perhaps a son or daughter, family or friends or even the youngest member of your staff. If you have children yourself, you will know how difficult communication can be between the generations. Why should financial services be any different?

2012/13 State benefit rates

New State benefit rates were announced by the **Department for Work and Pensions** in December 2011. They come into effect from the first benefit week after the beginning of the new fiscal year on 6 April. This year, that is week commencing 9 April. Key benefits for disabled people, carers and parents were raised by 5.2%, compared to a rise of 3.1% last year (when inflation was lower, as now).

Attendance Allowance (age 65+)

Higher rate	£77.45
Lower rate	£51.85

Carer's Allowance (was Invalid Care Allowance) £58.45
Only paid if carer earns no more than £100 a week.

Disability Living Allowance

Care component	
Highest rate	£77.45
Middle rate	£51.85
Lower rate	£20.55
Mobility component	
Higher rate	£54.05
Lower rate	£20.55

Employment and Support Allowance

During the first 13 weeks (assessment phase)	
Single person aged under 25 gets up to	£56.25
Single person aged 25 or over gets up to	£71.00

Then, during the main phase (14 weeks onward) claimants in the Work-related Activity group get:

Single person aged under 25 gets up to	£84.40
Single person aged 25 or over gets up to	£99.15

While those in the Support group get:

Single person aged under 25 gets up to	£90.30
Single person aged 25 or over gets up to	£105.05

Additional weekly premiums are paid to pensioners, some younger couples, those with an enhanced or severe disability and carers.

Incapacity Benefit (IB) Now replaced by ESA for all new claimants and for some existing claimants too.

Short term (under State pension age)	
Higher rate	£88.55
Lower rate	£74.80
Short term (over State pension age)	
Higher rate	£99.15
Lower rate	£95.15
Long term	£99.15
Increase in long term benefit if under 35	£11.70
Increase in long term benefit if aged 35-44	£5.90

Industrial Injuries Disablement Pension

100% assessment and age 18+	£158.10
20% assessment and age 18+	£31.62

Other rates (10% increments) are broadly pro-rata.

Maximum life gratuity (lump sum)	£10,500

Jobseeker's Allowance

Flat rate (min 2yrs NICs paid): age 25 or over	£71.00
Age 18-24	£56.25

Alternatively, income based JSA pays the same weekly sum (also for up to six months), but in addition pays weekly premiums based on situation and dependents.

Statutory Sick Pay

Earnings must be £107 a week or more.	£85.85

Bereavement Benefit

Bereavement Payment (lump sum)	£2,000
Widowed Parent's Allowance	£105.95
Bereavement Allowance standard rate from age 55, payable up to 12 months	£105.95

Lower rates of Bereavement Allowance are payable at younger ages but not below age 45.
The weekly benefit at age 45 is £31.79.

Pension credit (replaced minimum income guarantee)
This ensures that the poorest single pensioners get a minimum of £142.70 a week. Couples get £217.90 a week.
Source (all): *www.dwp.gov.uk/docs/benefitrates2012.pdf*, December 2011.

Comment: *Those who cannot work are protected by the State safety net, but the benefits are not generous, although higher inflation last year has seen benefits rise more than usual.*

About e-Protection Review

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Many of this month's *Top 10 in the press* articles show to some extent a renewed joie de vivre (or should that be joie de protection?) affecting the life and health insurance sector just now. This new feature of e-PR is our pick of the news stories over the previous month—not necessarily the biggest stories, but those that have most struck us.

1. *At last, insurers pay up on protection: Suffering a serious illness is bad enough, but at least the wriggling out of claims seems to have ended*. Your reaction to the headline on Jeff Prestridge's article for **This is Money** on 17 March will show if you're a glass half full or glass half empty type. The former will be delighted that one of journalism's big hitters has put his name behind the huge progress the industry has made on being seen to pay out claims. Pessimists will say that the headline still uses too many negative words. We're with the former—it's a well structured piece packed with facts and has a good case study too. *http://www.thisismoney.co.uk/money/news/article-2116348/At-insurers-pay-protection-Suffering-illness-bad-wriggling----claims-ended.html*.

2. *Lifestyle factors hitting productivity of UK workforce*. On 12 March **Health Insurance** picked up on **Canada Life** research about how people's personal lives can affect their productivity. It's a news story relevant not just to group risk but also to PMI and HCP insurance—our propositions now go much further than just paying cash when things have gone wrong. *http://www.hi-mag.com/health-insurance/product-area/group-risk/article393432.ece*.

3. *ABI considers annual protection awareness day*. Paul Thomas's piece for **Money Marketing** on 16 March featured the **ABI** protection strategy committee's idea for a national protection day. The piece is a good way to test reaction to an idea that already has some traction behind it, having been broken by ex **Ageas** CEO Martin Werth. http://www.moneymarketing.co.uk/protection/abi-considers-annual-protection-awareness-day/1048007.article

4. *Code aims to tackle sellers' failings*. **LifeSearch's** protection sellers' code of conduct is really an add-on code (and none the worse for that), launched at its annual awards ceremony. **Money Marketing's** Paul Thomas is again the scribe (15 March). He explains clearly the thinking behind this much overdue code which, unusually, is from an intermediary. http://www.moneymarketing.co.uk/protection/code-aims-to-tackle-sellers-failings/1048094.article.

5. *Over a third have Incapacity Benefit withdrawn on reassessment—DWP*. Paul Robertson of **Cover** reports on 15 March the controversial taking away of benefits when there is no medical case for their continuance. It's an incontrovertible fact that the Government now rejects many more claims than life and health insurers do. http://www.covermagazine.co.uk/cover/news/2159850/incapacity-benefit-withdrawn-reassessment-dwp.

6. *Quality care accommodation crisis looms for elderly*. Fiona Nicolson reports for **FT Adviser** on 15 March, **Keames Capital** and **Target Advisers'** prediction that longer life expectancy will lead to a chronic shortfall in the provision of quality care accommodation. It's a growing concern. http://www.ftadviser.com/2012/03/15/insurance/health-and-protection/quality-care-accommodation-crisis-looms-for-elderly-GhNLE91kGo3tQpSQY4lDEP/article.html.

7. *20 million Brits without financial safety net*. It's a theme that has been run many times before, but **Health Insurance's** 5 March piece on **Bright Grey's** *Financial Safety Net* report shows that there is still a case to remind readers that many people are woefully unprotected. http://www.hi-mag.com/health-insurance/product-area/income-protection/article392837.ece.

8. *Life insurance premiums to rise by 30%*. Emma Simon's piece for the **Daily Telegraph** on 15 March reports the 'perfect storm' that will see premiums rise from 2013. http://www.telegraph.co.uk/finance/personalfinance/insurance/lifeassurance/9146169/Life-insurance-premiums-to-rise-by-30pc.html.

9. *Claiming for cover*. Nicola Culley reported for **FT Adviser** on 15 March 'a protection topic so hot you could burn your hands on it'. Yes, it's the growing view that there are fundamental flaws with ADL and ADW based incapacity definitions. There's now quite a head of steam behind this view. http://www.ftadviser.com/2012/03/15/insurance/health-and-protection/claiming-for-cover-mFFCOGDvc9uitzlGykpu3K/article.html.

10. *IP Campaign: Aviva moving to own occupation*. Paul Robertson of **Cover** reported on 13 March how **Aviva** has already moved to offer own occ IP to 95% of its customers, following a campaign we started with them. http://www.covermagazine.co.uk/cover/news/2158940/ip-campaign-aviva-moving-occupation.

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