

HEALTH INSURANCE

CONTENTS

<i>Part</i>		<i>Page</i>
-	FOREWORD by the Director General of Fair Trading	3
A	BACKGROUND	
	A1 General introduction	5
B	PRIVATE MEDICAL INSURANCE	
	B1 Introduction	11
	B2 PMI and its suppliers	12
	B3 The PMI market	19
	B4 Presentation and comparison of PMI plans	27
	B5 Underwriting	32
	B6 Increases in premiums	35
	B7 Managed care	42
	B8 Conclusions and recommendations	47
C	PERMANENT HEALTH INSURANCE	
	C1 Introduction	51
	C2 The PHI market	53
	C3 The complexity of the product	57
	C4 Promotion methods	63
	C5 The moratoria approach to underwriting	65
	C6 Over-insuring	66
	C7 Conclusions and recommendations	68
D	CRITICAL ILLNESS INSURANCE	
	D1 Introduction	71
	D2 The CII market	73
	D3 Comparisons between CII products	77
	D4 Sales on an acceleration basis	79
	D5 Conclusions and recommendations	82

<i>Part</i>		<i>Page</i>
E	LONG-TERM CARE INSURANCE	
	E1 Introduction	83
	E2 Care needs and providers	84
	E3 LTCI products	88
	E4 Buying and selling LTCI	92
	E5 Should LTCI products be regulated?	95
	E6 Conclusions and recommendations	97
F	SUMMARY OF RECOMMENDATIONS	
	F1 Part B: Private medical insurance	99
	F2 Part C: Permanent health insurance	100
	F3 Part D: Critical illness insurance	101
	F4 Part E: Long-term care insurance	102
 <i>Annex</i>		
1	ASSOCIATION OF BRITISH INSURERS: SELLING OF PRIVATE MEDICAL INSURANCE TO INDIVIDUAL PURCHASERS	103
2	ABI STATEMENT OF BEST PRACTICE: LONG-TERM CARE INSURANCE	107
3	NUMERICAL LIST OF REFERENCES	110

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FOREWORD

by the Director General of Fair Trading

On 19 May 1995 my predecessor, Sir Bryan Carsberg, announced an investigation into health insurance. His concerns at the time were that the various health insurance products appeared to be complex, with sales often made to vulnerable consumers, and there appeared to be substantial scope for misunderstanding and mis-selling.

My Office's enquiry team has looked into all four of the sectors into which health insurance is conventionally divided: Private Medical Insurance (PMI), Permanent Health Insurance (PHI), Critical Illness Insurance (CII), and Long-Term Care Insurance (LTCI). A separate section of the report is devoted to each. Much health insurance is bought in the form of group policies, for example by companies to cover their employees, but this report concentrates on sales to individuals. There are nevertheless some lessons which are relevant to group policies, particularly about the information that members should be given.

The sections on CII and LTCI are rather shorter than the others. These sectors of the market are much smaller than the PMI and PHI sectors. The products are newer, so that there is less experience on which to draw. In the case of LTCI, recent Government policy proposals are likely to have a material effect on the market.

Although the four sectors are different in the cover they provide, and in market structure, a number of main themes run through this report.

- Products are complex. They also differ from each other in ways that make it difficult for consumers to compare the products on offer, even where these are aimed at similar needs. We have recommended that the industry should develop 'benchmark' products, which would allow comparisons to be made more easily. We have also recommended that the industry should develop common definitions of some frequently used terms.
- Perhaps because of the difficulty of comparing products, consumers typically do not shop around very much. Most individual purchasers buy direct from the company, though in some sectors there are significant sales through financial advisers. This also limits the scope for competition to work to the benefit of consumers. Once a purchase has been made, it can be difficult to switch. In the largest sectors of the market, PMI and PHI, a consumer who switches may well lose cover, permanently or temporarily, for existing conditions.
- Premium levels for any given consumer are likely to escalate faster than inflation. This is partly due to the way premiums rise with age, but in the case of PMI at least it also reflects underlying cost increases. The reasons for this are discussed in the report. We recommend that consumers should be made more aware than at present of the likelihood that premiums will increase substantially over time.

- In some parts of the market, the 'moratoria' approach to underwriting is common. Customers' medical history is not checked, but instead they are told that existing conditions will not be covered for (typically) two years after the policy starts. This keeps down the costs of acquiring new business and allows insurers to offer 'instant' cover. But it also greatly increases the scope for dispute when claims are made, and for consumers to find that their cover is less effective than they had thought. We recommend that this approach should be dropped as a general practice.

Other recommendations are specific to particular sectors. A full list is at the end of the report.

Health insurance, in all its varieties, is mainly bought by financially secure consumers. In the present state of the market, however, even the well educated will find it difficult to make good judgments. Furthermore, the insurance is called upon at a time when people are very vulnerable indeed; this is not the time to discover that they have made a mistake. I hope the industry will take this report seriously, and will change its practices, particularly by providing consumers with clearer and simpler choices. I believe that it will be in its own long-term interest to do so.

John S Bridgeman
Director General of Fair Trading

PART A: BACKGROUND

A1 GENERAL INTRODUCTION

A1.1 The private health insurance industry has four main types of product which, at present, constitute distinct markets. Consumers do not see these products as substitutes for each other, and different companies compete within the different markets, which are here listed in descending order of size.

- **Private Medical Insurance (PMI)** - If you become ill, PMI pays for care in a private hospital or in a private NHS ward. It is designed mainly to pay for the cost of short-term acute conditions. It does not generally cover primary care and routine health, dental and eye checks. Many, but not all, policies will also pay for out-patient treatment, and some offer additional benefits such as payment for home nursing or alternative medicine. This market in the United Kingdom is worth around **£1,700 million** a year.
- **Permanent Health Insurance (PHI)** - PHI is designed to replace some, or all of the income you lose should you become sick or disabled and unable to work. This replacement income is normally paid up to retirement age. The market is worth around **£400 million** a year.
- **Critical Illness Insurance (CII)** - CII provides you with a lump sum when you have a serious illness - such as cancer, a heart attack or a stroke. It can be used, for example, to pay off a mortgage, to provide for replacement income or to pay for private medical care. Some policies are stand-alone. Others provide for some or all of the payment under a life policy to be advanced in the event of a critical illness. The market for stand-alone policies is worth around **£50 million** a year.
- **Long-Term Care Insurance (LTCI)** - LTCI pays for long-term care if you become unable to look after yourself. This is most likely to happen in old age. The professional care may be provided either at home or in residential homes. Policies normally provide care up to a fixed sum, or a fixed sum per year. The market is a very new one, for which no reliable figures are available. While it is generally thought to be currently worth **less than £50 million** a year, it may grow as a result of recent government policy proposals.

A1.2 As noted, these are separate markets with distinct products. It is difficult for companies active in one market to enter one of the others without devoting a significant amount of time and expenditure to the attempt to do so, although - as recent developments have shown - cross-entry is possible in the longer term. Some insurance companies specialise in only one of these markets. Others operate in several areas. For example, British United Provident Association (BUPA), known mainly for PMI now has PHI, CII and LTCI products. Products within each of the four markets are not standardised and, as

with most insurance contracts, prices vary according to the product on offer and the purchaser (generally reflecting age).

- A1.3 Customers also differ between the markets. For PMI and PHI, more than 50% of sales are to corporate customers, purchasing health insurance for their employees. In contrast, CII and LTCI are mainly sold to individuals. It might be expected that the existence of sophisticated buyers for PMI and PHI would spur more effective competition in these markets. Corporate buyers are more likely than individuals to use the services of intermediaries and to switch between suppliers in order to take advantage of keener rates.
- A1.4 This report concentrates on individual policies, that is those policies where consumers decide whether to subscribe. The word 'individual' is therefore used to include situations where an employer, a trade union or some other body negotiates special terms with the insurer, but it is the individual employee or member who pays the premiums and who chooses whether to do so.

Private Medical Insurance

- A1.6 With some 3.2 million registered subscribers, PMI nevertheless provides cover for around 6.5 million people in the UK - since policies usually cover both subscribers and their immediate family. In 1994, total spending was £1.7 billion, equivalent to an average monthly payment of £22 per person covered. Clearly premiums can vary considerably around this figure, depending on the level of benefits and the individuals concerned. Some 60% of those enrolled are members of corporate schemes, leaving 2.4 million covered by individual subscriptions. The average subscription per person covered is greater for private individuals than for those covered by corporate schemes.
- A1.7 The PMI market is dominated by BUPA (with a 45% share) and Private Patients' Plan (PPP) (27%), although BUPA's predominance has fallen over the last decade. Increasing competition has led to more expenditure on advertising and marketing. The market share taken by the so-called commercial insurers (such as Norwich Union Healthcare, Prime Health, and Sun Alliance) has doubled since 1989.
- A1.8 The cover provided by the range of PMI products available differs widely. Variables include the permissible age-range for policyholders, what types of operation are covered, which hospitals are acceptable, and the maximum costs allowed (either per operation or per annum). Plainly, the cheaper the policy, the less cover and fewer benefits it provides.
- A1.9 Reasonably full details of the products on offer can be found on computerised quotation systems used by independent financial advisers (IFAs). One such is Mediquote, which holds details of more than 120 plans. Updated monthly, this allows the benefits and costs of each plan to be directly compared.

Permanent Health Insurance

A1.10 PHI replaces income that is lost through accident or illness. It is a well-established insurance product first introduced more than 100 years ago. About 50 companies operate in this market.

A1.11 In 1994, the 1.3 million individual PHI policies in force produced an income from premiums of £205 million, and the 1.1 million group policies produced £195 million. Thus the overall size of the market over the year was around £400 million, with payments averaging £14 a month. The market has been static for the last three years.

A1.12 As with PMI, customers comprise both private individuals and companies organising PHI for their employees. The same considerations apply as for PMI.

A1.13 As explained in Part C of this report, the products on offer differ greatly in such areas as: the proportion of earnings insured (down to 50%); the waiting period before benefit kicks in; the way benefits take account of inflation; and the conditions covering claims. Companies also vary in the way premiums are reviewed. Even more than in the case of PMI, these variations make it very difficult for private consumers to compare different policies.

Critical Illness Insurance

A1.14 CII is a relatively new product which was introduced into the UK by Cannon Lincoln in 1986. More than 60 companies now operate in this market.

A1.15 In 1995, 302,000 policies were sold to individuals with an average value of £40,023. Statistics on premium payments are not easy to come by, but a reasonable estimate would be around £150 million a year.

A1.16 Products differ by the size of lump sum provided, the illnesses covered (and their definitions), survival periods, the definition of total and permanent disability, the option to increase cover, and the type of policy - stand alone, whole of life, and so on.

Long-Term Care Insurance

A1.17 LTCI is an even newer product, introduced into the UK as recently as 1991. It has, however, been established in the USA since 1974 and had sold 2 million policies there by the end of 1990. One recent estimate suggests that, at most, 20,000 policies have been sold in the UK, with sales reported to be running at 5,000 a year. This number may, however, increase sharply if proposals put forward in the recent government consultative paper *A New Partnership for Care in Old Age* come to fruition.

A1.18 A much smaller number of companies operate in this market, though as with the other health insurance products, LTCI products vary a good deal in such things as cover provided, the number of activities of daily living (ADLs) which trigger the benefit (or a similar system of points), the frequency of premium reviews (generally guaranteed for

the first five or ten years) - see Annex 2 for details. The range of products available will be influenced by the proposals in the consultation paper.

Overview

A1.19 It is worth drawing attention to important differences and similarities between these four insurance markets.

- **Differences**

The markets vary considerably in *size*, as the estimates given in the preceding summary clearly show.

They vary in *maturity*. PMI and PHI are well established, while CII and LTCI are new and have perhaps not yet settled down.

They vary in *structure*. PMI is a concentrated market, almost three-quarters of which is held by two companies. Both PMI and PHI, however, have large corporate customers whose buying power may influence the market in ways not open to individual consumers.

- **Similarities**

Each market involves *complex contracts*. Notwithstanding the impact of the Unfair Terms in Consumer Contracts Regulations, individual consumers are unlikely to find medical insurance contracts easy to understand. This is partly because both the medical and insurance aspects are specialist areas of inherent difficulty.

There are *no fixed-price contracts*. As risks vary so will the price but, more importantly, medical price inflation will affect contracts over time. In some cases, notably PMI, premiums have increased faster than NHS costs.

Each market involves, potentially, a *lifetime commitment*. Consumers are likely to want medical insurance for a number of years, often decades. Switching to a new insurer can be difficult, for reasons that are discussed elsewhere in this report.

A1.20 Not all health insurance products fall clearly into one or other of the four categories that have been identified. Those that do not, however, are often constructed by bolting together existing products: for example by combining a permanent health insurance policy with a long-term care policy. In the future, this approach may change. We understand that some companies are considering being able to produce tailor-made policies, constructed from much smaller building blocks. But that day has not yet come. For the present it still makes sense to discuss the four sectors as distinct entities, as we

have done in the separate parts of our report. In doing so, we have naturally paid most attention to those sectors that are currently the most substantial.

PART B: PRIVATE MEDICAL INSURANCE

B1 INTRODUCTION

- B1.1 Private Medical Insurance (PMI) is the principal means of paying for private medical treatment for selected conditions. Only about 20% of private patients pay directly for their own treatment. Typical procedures covered by PMI are the removal of tonsils or wisdom teeth, hip replacements, the treatment of varicose veins, and coronary artery bypass operations. In general, accident and emergency services, and pre-existing conditions are not covered. Individual policies can provide cover both for subscribers and their dependants.
- B1.2 Most medical treatment in the UK is provided by the National Health Service (NHS). PMI has developed in a subordinate role, with policyholders being able to seek quicker treatment in more comfortable surroundings. The relationship between the NHS and PMI is, however, complex, with the NHS sending various positive signals to PMI companies.
- B1.3 PMI has grown into a substantial market worth some £1.7 billion a year. Senior company employees and professionals, particularly in London and the South East, appear to be the predominant users. The future growth of the market depends on several factors, in particular the state of the NHS, and the perceived value for money offered by PMI.
- B1.4 Our investigation of the PMI market and the practices followed within that market has focused on policies for individuals rather than those for company employees. To a large extent, the interests of the latter are looked after by the companies that employ them.
- B1.5 Our enquiries have drawn attention to some problem areas. These range from the way PMI is presented to how policies are underwritten. A particular concern is the seemingly inevitable real increases in PMI premiums, although these may in time be curbed by the further development of managed care techniques.

B2 PMI AND ITS SUPPLIERS

The central role of the NHS

B2.1 The NHS has provided the bulk of medical care in the UK for almost 50 years. It is largely financed through taxation and national insurance contributions. Although the total cost of the NHS has risen to about £40 billion a year, UK spending on health as a percentage of gross domestic product (GDP) is below that of many other member states of the OECD (Organisation for Economic Co-operation and Development) - see Table B1.

TABLE B1 - TOTAL HEALTH SPENDING AS A PERCENTAGE OF GDP

<i>Country</i>	<i>1975</i>	<i>1985</i>	<i>Latest available year</i> <i>* = 1993, † = 1994</i>
Belgium	5.8	7.2	8.2†
Denmark	6.5	6.2	6.6†
France	6.8	8.6	9.7†
(West) Germany	7.8	8.2	8.6*
Italy	5.8	6.7	8.6*
Netherlands	7.7	8.3	8.8†
Portugal	6.4	7.0	7.4*
Spain	5.1	6.0	7.3†
UK	5.5	6.0	6.9†
USA	8.4	10.8	14.2†

Source: *Managed Care in Europe*, a Financial Times Management Report by Donald Macarthur, 1996 (based on OECD figures). Latest figures taken from *OECD Health Data 96*, OECD, Paris, 1996.

B2.2 The figures reproduced in Table B2 suggest that the broad state of health of the population of the UK is much in line with that of other OECD countries. This includes the USA - despite much higher spending on health there.

B2.3 The rising cost of the NHS has, however, put increasing strain on government finances. Following a radical review in 1988/89, important structural changes were introduced in 1991. An 'internal market' was created within the NHS, with a split between 'purchasers' and 'providers'.

TABLE B2 - INTERNATIONAL HEALTH STATUS INDICATORS

<i>Country</i>	<i>Life expectancy at birth - years</i>		<i>Infant mortality - % rate per 100 live births</i>
	<i>Male</i>	<i>Female</i>	
Belgium	73.0*	79.8*	0.76
Denmark	72.3*	77.6*	0.54*
France	73.6	81.8	0.61
(West) Germany	73.1*	79.5*	0.58*
Italy	74.7	81.2	0.73*
Netherlands	74.0*	80.0*	0.56
Portugal	71.2	78.2	0.79
Spain	73.3	81.0	0.76*
Sweden	76.1	81.4	0.48*
Switzerland	75.1	81.6	0.56*
UK	74.2	79.5	0.62
USA	72.3†	79.1†	0.85†

Source: *OECD Health Data 96*, OECD, Paris, 1996

Note: Latest available figures - all for 1994, except * = 1993, † = 1992.

- As from 1 April 1996, the purchasers of healthcare are fundholding General Practitioners (GPs), and 100 unitary Health Authorities (HAs).
- The providers of healthcare include GPs themselves but also, importantly, hospital and community NHS Trusts.
- The volume of patients using a particular purchaser or provider determines the allocation of funds.
- Patients enter the NHS system through their GPs, who act as 'gatekeepers' for access to consultants, and therefore to hospitals.

A developing role for PMI

B2.4 The amount spent on PMI has grown steadily since the 1950s, with particularly rapid expansion between 1977 and 1990. Most of the increase stems from a rise in company-paid PMI rather than from payments by individuals or affinity groups.

B2.5 For managerial staff, a company health insurance scheme is probably the most valued perk after pensions and cars. For companies, a major benefit is that key personnel may receive medical treatment promptly and at convenient times.

B2.6 The present enquiry, however, is more concerned with the effects of PMI on individual buyers. Providers and others have told us that individuals purchase PMI:

to avoid the NHS waiting lists, typically for elective conditions (such as tonsils, hips, and varicose veins);

to be sure of being treated at convenient times;

to have more comfort and privacy; and

to be treated by a consultant and not, perhaps, by a junior doctor.

B2.7 In June 1994, an NOP Survey for Guardian Health Services asked people what they thought was the main reason for taking out PMI. Respondents answered as follows:

quicker service or treatment	44%
better service or treatment	17%
treatment when you choose	8%
peace of mind/security (against accident or illness)	7%

Other reasons given each accounted for 3% or less.

B2.8 Although comparison is very difficult, the cost of medical treatment provided under PMI policies seems broadly to equate to around 10% of the NHS hospitals budget.

B2.9 Even so, as Table B3 shows, in comparison with other OECD countries the UK occupies only a middling position in the percentage of total medical expenditure financed by private health insurance.

B2.10 The PMI market has now been static for some five years, and the 1995 Mintel survey¹ suggested that many would-be purchasers were deterred by such factors as presentation and cost.

**TABLE B3 - PRIVATE HEALTH INSURANCE:
PERCENTAGE SHARE OF TOTAL HEALTH EXPENDITURE**

Latest available years:

<i>Country</i>	<i>%</i>	<i>Country</i>	<i>%</i>
Belgium	1.7	Netherlands	13.3
Denmark	1.6	Spain	3.7
France	3.3	UK	3.5
Germany	5.3	USA	33.5
Italy	1.1		

Source: *Managed Care in Europe*, a Financial Times Management Report by Donald Macarthur, 1996 (based on OECD figures)

NHS signals to PMI subscribers

Waiting lists

B2.11 A key factor in the purchase of PMI is the existence of waiting lists in the NHS for the acute and elective conditions that such insurance typically covers. Indeed, a recent survey suggested that there was a positive relationship between the length of local waiting lists in different parts of the UK and the purchase of private health insurance. It is less clear how far reductions in waiting lists have affected the willingness of subscribers to continue existing policies or take out new ones.

B2.12 There are two stages in the waiting process:

the wait for a consultation with a specialist after a patient has been referred by a GP; and

the wait for surgery or other treatment after the consultation.

B2.13 The Department of Health's *Patient's Charter* of January 1995 promised that average waiting times would be cut further. This indicated that, from April 1995, in the NHS:

nine people out of ten could expect to see a consultant within 13 weeks after referral by a GP, and everyone could expect to be seen within 26 weeks;

all patients who needed hospital treatment would be guaranteed admission within 18 months of having seen a consultant; and

those who required coronary artery bypass grafts and some associated procedures could expect treatment within one year.

B2.14 Real reductions in NHS waiting lists have already been achieved. By the end of 1995, 97.3% of in-patients had been found a hospital bed inside a year, compared with 78.8% at the end of 1990. Nevertheless, it seems unlikely that - in the short term at least - waiting lists will be reduced to such low levels as to remove any strong incentive to purchase PMI.

General practitioners

B2.15 Both the NHS and PMI use GPs as gatekeepers for secondary health treatment. PMI policyholders, like other patients, need a GP's referral in order to see a consultant for an outpatient's appointment.

B2.16 GP practices with more than 5,000 patients can become fundholders. As such, they can use their funds to purchase hospital and other treatments for their patients. Clearly however, they have an incentive to limit their outgoings, and PMI providers often claim that GP fundholders encourage patients with PMI to make use of their policies rather than depend on the NHS. But we found no hard evidence to support the claim.

Consultants

B2.17 Representatives of PMI providers, hospitals and health analysts told us that the deployment of consultants is a key factor in the relative developments of NHS treatment and private treatment financed by PMI.

B2.18 Consultants can choose between three different types of contract with the NHS: whole-time, maximum part-time, and part-time. Each has rules about earnings from, and time devoted to, private work.

B2.19 Perhaps inevitably, concern has been expressed that some consultants have been spending too much time on private work, possibly at the expense of their NHS patients. This question was examined by two studies published in 1995, but no firm conclusions could be drawn from the evidence presented.^{2,3}

NHS private patient units

B2.20 The availability of NHS private patient units for PMI patients provides another interface between the two markets. Indeed, between 1979 and 1994, the annual revenue earned for the NHS by such units rose from £37 million to £215 million - the latter figure representing some 15% of the 'private' hospital market.

B2.21 Since the mid 1980s, NHS hospitals have once more been allowed to establish separate private wings, or 'dedicated pay-bed units' which, in most cases, are broadly comparable with private hospitals for facilities and general ambience. Naturally, the possible effects of these NHS private-patient units has caused some concern, particularly among private hospitals. It has, for example, specifically been questioned:

whether the NHS benefits financially;

whether there is unfair competition with private-sector hospitals; and

whether PMI providers using such NHS units are being subsidised.

B2.22 A recent study for Norwich Union Healthcare has suggested that such concerns are largely unfounded.⁴ This found that the average revenue of the NHS hospitals per private patient was £1,710 in 1994/95 while the best estimate of the average full treatment cost was £1,400, giving them a surplus of £310 per patient. A buoyant PMI market should lead to greater use of such units, with higher receipts to the NHS. In fact, it is a condition of some PMI policies that patients should use NHS units.

B2.23 There may be some advantage to consumers in receiving treatment in NHS pay-bed units rather than in independent private hospitals. Some policies which provide hospital care only in NHS units are around 10% cheaper than equivalents which include care in private hospitals - although these differentials have been narrowing.

B2.24 Most consultants who undertake private work hold maximum part-time NHS contracts, which means that they do 10 sessions a week for the NHS. Most, if not all, of these sessions will be undertaken at the local Trust hospital. Consequently there is a good chance that such a consultant who also has private patients in the pay-bed unit is physically present 'on site' during the bulk of the working week, or - if not - at least a member of his or her team will be, on a 24-hour basis.

B2.25 NHS pay-bed units are likely to have ready access to intensive therapy units (ITUs) within the Trust premises, if that should be necessary. While the chances that ITU care will be needed unexpectedly are very slim (and all hospitals carrying out cardiac and neuro-surgery are in any event required to have ITUs), if it *is* wanted and cannot be obtained there is a real emergency.

B2.26 The position is summarised in the following terms in Laing's Report for 1995.⁵

- 'The two major advantages of NHS pay-bed units over independent hospitals are convenience (the consultant does not have to travel from his or her NHS base) and safety, with the on-site facilities and staff of a major hospital to deal with any emergencies.'

PMI and the private healthcare industry

B2.27 In 1994, total spending on private acute healthcare (both in-patient and out-patient) was estimated at just over £2 billion. Of this total, treatment in private hospitals accounted for £1.2 billion, private treatment in NHS hospitals another £0.2 billion, and physicians' fees £0.6 billion. In 1992/93, about 12% of patient revenue came from people who were *not* insured. This proportion has, however, fallen substantially in recent years following

a drop in the numbers of patients from overseas and greater penetration of the UK market by insurance.

B2.28 As these figures show, the vast majority of private treatment is done not in NHS pay-bed units but in private hospitals, although - as previously noted - most of the doctors who carry out work in the private sector also work for the NHS.

B2.29 In its 1995 Survey of Acute Hospitals in the Independent Sector,⁶ the Independent Healthcare Association identified 227 hospitals providing a total of 11,681 beds. At that time the top three groups owned between them 91 hospitals with 5,000 beds. In 1993, the latest year for which full data exist, these groups earned nearly 53% of the sector's operating revenue of £990 million. BUPA's own hospitals alone accounted for 20% of revenues.⁵

B2.30 For comparison, at the beginning of 1995 there were 74 dedicated pay-bed units in NHS hospitals, providing 1,376 beds. Of these, 20 units, providing 586 beds, were in London.

B2.31 Capacity in private hospitals has increased substantially since the end of 1980, when 154 private hospitals between them provided 7,035 beds. The proportion of total private acute healthcare spending undertaken in independent hospitals increased from just over 40% in 1980 to nearly 60% in 1989, declining slightly thereafter as NHS capacity in dedicated pay-bed units increased.⁵

B3 THE PMI MARKET

B3.1 As Table B4 shows, the total amount spent on PMI subscriptions has more than trebled since 1985, although the number of subscribers has remained relatively static over the last five years.

TABLE B4 - PMI: RECENT GROWTH IN THE MARKET

<i>Year</i>	<i>Subscribers 000s</i>	<i>Persons covered 000s</i>	<i>Subscriptions £m</i>	<i>Claims £m</i>
1985	2,380	5,057	520	456
1990	3,251	6,625	1,100	975
1994 <i>estimated</i>	3,398	6,365	1,655	1,345

Source: *Laing's Review of Private Healthcare*, 1995

Procedures covered and typical costs

B3.2 Table B5 (on page 20) shows, by volume and by cost, the procedures that are most commonly covered by PMI.

B3.3 The costs of operations can vary substantially from hospital to hospital and from region to region. Table B6 (on page 21) shows typical costs quoted in a 1994 publication, with a broad indication of how those costs were made up.

Companies providing PMI

B3.4 In terms of size, the PMI market has long been dominated by two companies, BUPA and PPP. In 1984, they together took as much as 84% of the total subscription income raised in that year. Ten years later, in 1994, they still held 72% despite the entry of additional competitors to this market. The share of subscription income taken by the largest single company in this field, BUPA, fell from 59% to 45% over the period.

B3.5 The PMI market is now much influenced by the commercial insurers, who increased their collective market share from some 7% in 1985 to 20% in 1994 (see Table B7 on page 21). Most of the recent growth is thought to have been achieved by two companies, Norwich Union Healthcare and Prime Health. Indeed, Norwich Union Healthcare is now believed to be the third largest PMI provider with a market share of 9%. There are currently more than 20 insurance companies operating in this market.

TABLE B5 - TOP 10 IN-PATIENT AND DAY-CARE PROCEDURES

<i>By volume</i>	<i>By total annual cost</i>
Oesophago-gastro-duodenoscopy (windpipe, stomach, duodenum)	Coronary artery bypass graft
Colonoscopy (colon)	Hip replacement
Surgical removal of impacted, buried or unerupted teeth	Cataract removal with lens implant
Cystoscopy (bladder)	Trans urethral resection of prostate
Excision of lesion of skin or subcutaneous tissue (removal of growths, lumps on or near surface of the skin)	Colonoscopy
Magnetic resonance imaging	Arthroscopy of knee
Hysteroscopy (womb)	Surgical removal of buried or unerupted teeth
Arthroscopy of knee	Hysterectomy
Laparoscopy (abdominal cavity)	Oesophago-gastro-duodenoscopy
Myringotomy and grommet insertion (making a hole in the eardrum in order to release fluid from the middle ear)	Knee replacement

Source: A PMI provider

Note: The suffix 'oscopy' means 'looking at'. A miniature camera is inserted to view the required object. Such operations are primarily diagnostic.

Plans and premiums

B3.6 A wide range of PMI plans is available and premiums vary markedly. Some plans provide an option of particular hospital bands, with the premiums charged apparently reflecting the different facilities offered. In other cases, companies may vary premiums by post codes, or between regions, to reflect differences in hospital costs.

B3.7 Policies generally fall into four groups.

- **Comprehensive** - All comprehensive plans fully refund the cost of hospital accommodation, surgeons' and anaesthetists' fees and in-patient drugs and dressings. Some plans also fully refund the cost of out-patient services, home nursing, private ambulance, and parental accommodation, while others place limits on these items. 'Out-of-band' hospital benefits vary: some plans

TABLE B6 - TYPICAL COSTS OF OPERATIONS

<i>Procedure</i>	<i>Hospital</i>	<i>Surgeon</i>	<i>Anaesthetist</i>	<i>Total</i>
Tonsillectomy - child	£814	£310	£135	£1,259
Hernia	£1,021	£320	£140	£1,481
Varicose veins - one leg	£946	£285	£140	£1,371
Dilatation and curettage (D&C)	£664	£155	£130	£949
Prostate gland	£1,883	£640	£210	£2,733
Wisdom tooth	£644	£310	£135	£1,089
Hip replacement (incl prosthesis)	£6,686	£755	£290	£7,751
Slipped disc (laminectomy)	£3,504	£700	£320	£4,524
Hysterectomy	£2,542	£615	£235	£3,392
Heart surgery	£8,673	£2,075	£850	£11,598

Source: Norwich Union Healthcare figures quoted in *A Guide to Private Medical Insurance*, by Wendy Elkington, 1994

Note: In 1996, actual costs may be expected to be around 10% higher.

TABLE B7 - PMI: MARKET SHARE BY SUBSCRIPTION INCOMES 1985-94

<i>Insurer</i>	<i>1985</i>		<i>1990</i>		<i>1994</i>	
	<i>£m</i>	<i>%</i>	<i>£m</i>	<i>%</i>	<i>£m</i>	<i>%</i>
British United Provident Assn (BUPA)	308	59	551	50	754	45
Private Patients Plan (PPP)	130	25	316	29	461	27
Western Provident Assn (WPA)	34	7	73	7	77	5
Bristol Contributory Welfare Assn (BCWA)	9	2	28	3	34	2
Other providents	5	1	13	1	18	1
Commercials	35	7	124	11	333	20
<i>Totals</i>	521	100	1,105	100	1,677	100

Source: *Laing's Review of Private Healthcare*, 1995

(prestige or top-of-the-range plans) also provide for all or some of such items as NHS cash benefits, alternative medicine, chiropractors, dental treatment, pregnancy and childbirth, private GP fees, ophthalmic charges, travel insurance, and psychiatric treatment.

- **Standard** - Most standard plans fully refund the cost of hospital accommodation, surgeons' and anaesthetists' fees, and in-patient drugs and dressings, but some have limits. For other items - such as out-patient services, home nursing, private ambulance, and parental accommodation - the plans vary considerably with some providing full refunds or setting limits for particular items. NHS cash benefits and coverage of items like alternative medicine would generally be more restricted.
- **Budget** - In budget plans full refunds would again generally be provided for hospital accommodation, surgeons' and anaesthetists' fees, and in-patient drugs and dressings, but all or many other items, such as out-patient treatments, could be subject to specific limits or excluded altogether. Budget plans may also be subject to other limitations: for example, treatment might be provided only if otherwise, under the NHS, there would be a wait of at least six weeks, or it might be limited to certain preferred hospitals or NHS pay-beds, or cover might be provided only for specific conditions.
- **Over-60 plans** - These are usually based on standard or budget policies, but with lower premiums since tax relief is provided at 25%.

B3.8 Most individual PMI plans will not cover treatment for pre-existing conditions, normal pregnancy and childbirth, infertility and sterilisation, dental and optical care, HIV and AIDS, or drug or alcohol abuse, nor the cost of cosmetic surgery, appliances, out-patient drugs and dressings, and most transplants.

B3.9 Many plans make provision for paying 'NHS cash benefits', when policyholders are treated under the NHS. Typically this occurs where patients have to undergo more complex operations and an NHS hospital is able to provide medical back-up facilities which the local private hospital cannot. One PMI provider estimated that some 4% of operations potentially covered by its policies might be carried out under the NHS, and so attract cash benefits.

B3.10 The range of variations in the premiums charged by different companies, by types of plan and scale (reflecting hospital banding and similar differentials), is shown in Table B8 (on page 22). It will be seen that even between plans in similar categories there are wide differences in price. These largely reflect variations in the cover provided - such as

whether there is an excess clause under which patients have to pay (for example) the first £100 of any claim.

TABLE B8 - PMI: RANGES OF PREMIUMS

<i>Type of plan</i>	<i>Single person aged 30</i>		<i>Family, 2 adults, 2 children</i>	
	<i>Scale 1</i> <i>£ per month</i>	<i>Scale 3</i> <i>£ per month</i>	<i>Scale 1</i> <i>£ per month</i>	<i>Scale 3</i> <i>£ per month</i>
Comprehensive (13 policies)	40-163	26-55	119-568	76-159
Standard (17 policies)	20-82	25-38	63-220	63-103
Budget (16 policies)	14-50	11-27	42-152	34-78

Source: *Money Management*, December 1995

Note: Scale 1 or 3 largely reflects differences in the banding of the hospitals concerned.

Sales of PMI

B3.11 It has been estimated that around 60% of the 3.4 million PMI subscribers (see Table B4) are covered under company schemes. Their premiums average about £400 a year. The remaining 40% of subscribers pay individually or under voluntary group schemes, with premiums averaging some £650 a year.⁷

B3.12 Perhaps some 10%-15% of the 1.3 million or so policies held by individual subscribers lapse each year. Assuming that the overall market is growing slightly, annual sales of new PMI policies to individuals might total about 170,000 a year (according to an estimate made by a leading PMI company). Nevertheless, it has been suggested to us that perhaps as many as half of these sales might reflect existing PMI policyholders switching to other policies - mostly 'trading down', from comprehensive to standard, or from standard to budget.

B3.13 Such switching is facilitated by the fact that PMI contracts are renewed annually. Aggressive companies with low-premium policies can readily target existing customers of companies charging higher premiums.

B3.14 Concern has been expressed about salesmen from the now closely-regulated life-insurance sector entering the PMI market. There is considerable scope for 'churning' individual plans from one provider to another. In the case of company policies, although there is vigorous competition among the PMI providers, switching generally does not disadvantage individual members of such schemes since their cover normally remains unchanged. But the position is different for policies held by individual private subscribers. Those who have medical conditions which have developed during the period with one company are covered at no extra cost if they renew their policies with the same

company. But, should they move to another PMI provider, they could find that they have lost such cover. The Association of British Insurers (ABI) is aware of this potential problem and has issued an information sheet to its members (see paragraph B3.23).

B3.15 Direct promotion by the providers' sales teams, by means of press or television advertising, or mail shots, account for 90% or more of PMI sales to individuals. By contrast, sales to companies or other corporate purchasers are generally made through brokers. This market is very competitive.

B3.16 The factors that people considered important when buying PMI were studied in a Mintel Survey of May 1995. This differed from the NOP survey quoted in paragraph B2.7 because it concerned choice *between* policies, and respondents were 'prompted' by being shown a list of factors and asked to select which they considered to be most important. The factors selected first by respondents included the following:

all costs covered	36%
no hidden costs	19%
instant treatment	13%
emergency cover	8%
support for partner and children during hospital stay	7%

Users of PMI

B3.17 As has been previously noted, while there are about 3.4 million subscribers to PMI plans, the total number of persons covered, including dependants, is around 6.4 million. The figures reproduced in Table B9 show that most of them are concentrated in the southern part of Great Britain.

B3.18 Other surveys have indicated that the take-up of PMI is generally highest among professionals, employers and managers, and lowest among manual workers. In terms of social classification, there is a concentration in the AB groups, where take-up is about twice that in the group C1, which in turn is twice that in the group C2. Percentages in the D and E social groups are at very low levels.⁸

B3.19 Such studies tend to confirm the views of the industry analysts Laing & Buisson and the Consumers' Association's *Which?* magazine that PMI is still largely a luxury product. A recent study has indicated that the privately insured tend to be better off, better educated, and middle-aged.⁹

TABLE B9 - PMI: PENETRATION BY REGION

<i>Region</i>	<i>Percentage of population covered 1994 estimate</i>
Outer London	20
Other South East	19
London	16
East Anglia	12
South West	10
West Midlands	10
East Midlands	9
North West	9
York & Humberside	7
Wales	5
Scotland	5
North	4
Whole of Great Britain	11

Source: *Private Medical Insurance Market Update 1994*, Laing & Buisson.

B3.20 Initially, the purchase of PMI cover is most commonly made by, or for, people in the 18-34 age group, although it is those in the 45-54 age group that have the highest level of holdings. It has been suggested that only 4% of people over 65 hold PMI plans.¹⁰ This does of course partly reflect the fact that group cover provided by employers normally ceases at retirement. But many schemes offer continuing cover at rates that compare favourably with those that would be offered to individual subscribers joining a scheme at the same age. More importantly, however, subscribers who continue to purchase cover from the same PMI provider generally find that pre-existing conditions are not a bar.

Redress

B3.21 Depending on which company they are insured with, individual policyholders can refer any complaints they may have to either the Insurance Ombudsman or the Personal Insurance Arbitration Service (PIAS). The latter scheme, run by the Chartered Institute of Arbitrators, requires both sides to agree to be legally bound by the arbitrator's decision. A decision by the Ombudsman, on the other hand, is not binding on the consumer, who remains free to take the case to court. At the OFT, we are currently looking at ways to improve consumer redress mechanisms generally, taking account of points raised at the OFT-sponsored symposium on this subject in September 1995, and any relative

advantages or disadvantages there may be for particular PMI holders will be examined in that context.

Regulation

B3.22 PMI companies are regulated by the Department of Trade and Industry (DTI), which pays particular regard to solvency issues.

B3.23 At present, however, there are no regulations that specifically apply to the presentation and sale of PMI policies. The Association of British Insurers (ABI) has prepared guidance material, *Selling of Private Medical Insurance to Individual Purchasers*, which is reproduced in Annex 1. This covers recruitment of intermediaries, their training and competence, explanation of products to customers, processing of information, complaints procedures and monitoring.

B4 PRESENTATION AND COMPARISON OF PMI PLANS

B4.1 Our enquiries into the PMI market have alerted us to several features that raise questions - beginning with the way policies are presented.

B4.2 Addressing the Laing & Buisson conference on 4 October 1994, Peter Owen, Group Chief Executive, PPP, said, 'Products need to be simple, without small print, and they need to provide the customer with choice based on quality information'.

B4.3 We would certainly endorse these aims, and the unstated, but presumed, aim that the way PMI plans are presented should be readily understood by a wide range of people. In practice, however, the following findings suggest that they are not being achieved.

- A Gallup survey for Prime Health in June 1995 indicated that 75% of consumers thought that the small print of PMI policies made them difficult to understand.
- A survey carried out by the Hospital Management Trust in late 1995 (and presented during the course of our enquiry), showed that patients had a poor understanding of PMI. A large proportion believed that policies covered a range of costs that are, in fact, rarely protected. These included: the fees of private GPs, 36%; the cost of drugs at home, 43%; the treatment of chronic conditions, 28%; and psychiatric consultations, 33%.
- In 1994, a Mintel publication, *Personal Protection - An Overview*, noted: 'Product differentiation has been a marketing tool for the providers but a major effect on potential buyers has been to make it increasingly difficult to choose the most suitable plan'.
- PMI policies currently presented 'a minefield of comparisons', according to a headline description of an article by Peter Dalby, of Prime Health, in *Health Insurance Monitor*, August 1994.
- On 21 September 1995, the *Financial Adviser* said, 'The exclusion of these policies from regulation means that little has been done about standardising policies'.

A common format of benefits

B4.4 One shortcoming in the way PMI policies are presented is the lack of any consistency in the listing of benefits and terms by different providers. One research company commented to us that each firm had its own 'house style'. This made it very difficult to draw a direct comparison between the various plans on offer, even for professional analysts compiling product databases.

B4.5 In order to compare how benefits are listed we took policies from six of the PMI companies. The results are set out in Table B10. This showed that:

the main cost items (hospital charges and fees to specialists) are generally listed first, although in one case 'other' items (such as NHS cash benefits and private ambulances) were given precedence;

the third major cost item (out-patient fees) was listed in various positions - sometimes after 'other' items;

the listing of day-care charges was inconsistent, sometimes being listed with in-patient charges, sometimes separately;

items like prostheses/appliances and oncology were listed in some plans but not in others;

a wide variety of 'other' benefits were listed in more-or-less random order.

B4.6 Consultants and hospitals have commented that they can no longer keep track of what particular policies cover and what they do not. One hospital group suggested that there should be a common format of benefits and we believe that this would be a very helpful advance.

Identifying 'common core benefits'

B4.7 Even if benefits were set out in a common format, the variations in their numbers and mix would still make choices between different plans very difficult. In order to make a better assessment, commentators - and ultimately consumers - might well benefit from knowing the average value and range of values of each benefit and the likelihood that it might be triggered. Fortunately, from this point of view, some benefits are more important than others, and for them there is more commonality between different plans than might appear at first sight.

B4.8 The general make-up of claims throws useful light on the importance of particular benefits. PMI companies have indicated that hospital costs - covering such things as accommodation, theatre, dressings and drugs - account for some 55%-60% of total claims, while fees to surgeons, anaesthetists, and other personnel account for 20%, out-patients for 15%-20%, and 'other benefits' (termed 'bits and pieces' by one provider) for perhaps another 5%-10%.

B4.9 Behind such overall costs there are wide differences in the costs of individual claims and the numbers of claims. For example, while the *cost* of out-patient treatments may account for only 15%-20% of the total costs of all claims, the *number* of out-patient claims could represent as many as 80%-90% of the total number of claims overall.

Indeed, most out-patient treatment is high volume but low cost, with an initial consultation often costing about £70, and follow-up costs £40-£50.

TABLE B10 - PMI BENEFITS: ORDER OF LISTING IN SIX SAMPLE POLICIES

	<i>Sample policies</i>					
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>E</i>	<i>F</i>
Hospital:						
accommodation/nursing	1	1	5	1	1	1
theatre	2	2	7	2	3	3
surgical dressing/drugs	3	4	6	3	4	2
diagnostics	4	3	9	4	10	7
prosthesis/appliance	5	-	8	5	5	-
Fees:						
surgeons	6	5	11	8	6	4
anaesthetist	7	(5)	12	9	7	5
physician	8	(5)	13	10	9	6
Oncology	9	-	-	11	-	-
Out-patient fees:						
radiology, etc	10	6	14	17	15	11
therapists	11	(6)	(14)	(18)	15	13
Day care:						
various charges	12-16	(11)	(-)	(1-5)	2	(1-7)
specialists' fees	17	(11)	(-)	(6-7)	(4-6)	12
Other:						
nursing visits	18	-	-	-	-	-
private ambulance	19	15	2	12	16	8
home nursing	20	14	3	16	12	10
overseas travel	-	7	4	-	21	-
emergency accident	-	8	-	-	-	-
dental	-	10	-	-	18	-
parental accommodation	-	12	10	6	13	9
maternity cash	-	13	-	15	-	-
NHS cash benefit	-	16	1	14	18	-
health screening	-	17	-	-	-	-
out-of-scale benefit	-	9	-	7	8	-
Day-patient cash	-	-	-	13	-	-
GP's minor surgery	-	-	-	-	17	14
Chiropractor, etc	-	-	-	-	20	-
Hospice care	-	-	-	-	-	15
Physiotherapy	-	-	-	-	-	16

Source: Sample policies chosen by OFT

Note: Bracketed figures indicate general rather than specific mention.

B4.10 A comparison of different plans shows that almost all of them fully refund the cost of the bulk of the main benefits - that is, hospital accommodation, theatre, dressings and drugs, and the fees of surgeons and other specialists. (While BUPA does indicate limits on specialists' fees, these are said to be aimed at keeping such fees down rather than restricting the treatment available to policyholders).

B4.11 Given such a degree of consistency on most major items, one approach would be to identify 'core benefits' that are common to all plans. On average, these might well account for perhaps 75% of the costs of claims. Similarly, 'common core exclusions' could be drawn up.

Comparing plans through 'non-core benefits' and premiums

B4.12 At present there are no approaches which make it easy to compare the value for money represented by different PMI plans: what benefits can be purchased for the various premiums charged. One solution might be to remove 'common core benefits' and 'common core exclusions' from the comparison, so that the analysts - and potential purchasers - could focus on differences in 'non-core benefits' and whether what was offered justified the differences in premiums charged.

B4.13 Such non-core benefits would typically include any 'extras' in hospital benefits, out-patient benefits, and the considerable variety of 'other' benefits. For each of these benefits estimates might be developed on the lines illustrated in Table B11.

TABLE B11 - PMI: ESTIMATING LIKELY NON-CORE BENEFITS

<i>Benefit</i>	<i>Average cost of each episode*</i> £	<i>Likely annual frequency†</i> %	<i>Estimated annual benefit</i> £
Hospital extra	500	0.02	10.00
Out-patient services	60	0.75	4.50
Parental accommodation	100	0.001	0.10

Source: OFT - illustrative figures based on data supplied by various PMI providers

Notes: * The *range* of costs of each episode could also be shown.

† The frequency is likely to differ according to age.

B4.14 Some plans may well set limits or conditions on particular benefits - which could even include certain core benefits. In such cases, the 'estimated annual benefit' might have to be reduced according to the effect this might have.

B4.15 For each plan the 'estimated annual benefits' would then be made up of the common core benefits and the estimated total non-core benefits. The value for money of particular plans could then be compared as shown in Table B12.

TABLE B12 - PMI: COMPARING DIFFERENCES IN LIKELY BENEFITS AND PREMIUMS

<i>Plan</i>	<i>Total annual estimated benefits</i>	<i>Annual premiums</i>
A (budget)	Common-core benefits + £20	£300
B (standard)	Common-core benefits + £80	£400
C (standard)	Common-core benefits + £130	£400
D (comprehensive)	Common-core benefits + £250	£800

Source: OFT - the figures are purely illustrative

B4.16 In this illustration budget Plan A would offer little extra benefit above the common core benefits. Paying another £100 in annual premiums under standard Plan B would gain only £60 in likely benefits. But standard Plan C could offer better value in comparison with Plan A, with a further £100 in premiums buying a likely £110 in annual benefits. Comprehensive Plan D would involve much higher outgoings, but with extra benefits relatively much lower.

B4.17 Every prospective policyholder would still have to weigh up the balance of particular benefits and the likelihood that they might be triggered according to personal circumstances. Nevertheless, this illustration indicates one possible approach to the provision of a common form of measurement against which analysts and consumers could make much more informed comparisons of the plans on offer. It might well be possible to devise other, more effective methods, and we hope that the PMI industry may be able to work out a 'best approach' to the problem. The ABI may be able to facilitate such a process, and the Department of Health might also assist, since its responsibilities for promoting and protecting the health of the population lead to a consequent interest in the provision of value for money in all health services.

B5 UNDERWRITING

- B5.1 There are a number of different ways in which providers underwrite their PMI policies.
- B5.2 Where schemes are negotiated with companies, they are normally arranged on a group basis. Those individuals who take out cover under such schemes are not normally separately underwritten.
- B5.3 Most policy plans for individuals adopt one of the two methods described in the following sections - 'full underwriting', or the 'moratoria approach'. Around half the plans on offer adopt full underwriting, while slightly fewer adopt the moratoria approach. There are a few which insist on full medical reports.

Full underwriting

- B5.4 With full underwriting, would-be policyholders are asked to make a declaration which generally requires them to set out their past illnesses and medical treatment. The insurers use this statement to determine whether they need to seek permission to ask for a GP's report or require a medical examination (at a cost of £24-£36, which they meet themselves). On the basis of these checks, they then inform prospective purchasers what exclusions would apply to any policy they might buy.
- B5.5 Exponents of full underwriting point out that it provides both potential policyholders and insurers with a fairly certain picture of what will be covered by the policies on offer. Individual consumers can then judge whether to take out a particular plan in the light of that knowledge, while an insurer will not be faced with the costs of negotiating the extent of cover at the point of claim.
- B5.6 Critics maintain that some consumers fill in medical declarations inadequately, having forgotten about visits to doctors or simply not understanding their potential importance. In such cases individual policyholders might learn that a particular treatment would not be covered only through checks at the pre-authorisation stage - or when they make a claim.
- B5.7 There is clearly an argument that all prospective policyholders should at least have their medical records checked. A standard form might be developed for GPs or other medical advisers to set out an assessment of their patients' state of health for medical insurance purposes. Nevertheless, such a requirement would inevitably involve extra costs and delays, and it is not clear that this could be justified by the levels of refusals of cover that currently result from inadequate declarations.

The moratoria approach

- B5.8 Under the moratoria approach, consumers do not even have to make a medical declaration. Typically, such plans state that treatment for any relevant 'pre-existing'

condition will become eligible for benefit two years after the policy has been taken out, provided that, in the interim, the policyholder has not consulted a doctor about that or any related condition, nor otherwise sought advice about it (including check-ups), nor taken medication for it (including drugs, medicines, special diets or injections). Advertisements highlight the absence of medical checks or questionnaires.

- B5.9 From the insurer's point of view, this approach has the attraction of making for a more readily saleable product. Clients can be signed up on the spot without having to wait for medical declarations to be completed and scrutinised or for any further checks to be made of medical records or conditions. There is also less opportunity for prospective purchasers to have second thoughts.
- B5.10 In some circumstances, there may also be advantages for consumers. For example, would-be policyholders would know that, although cover against the recurrence of a condition that had only recently been diagnosed and treated might well be refused by an insurer operating full underwriting, it would automatically become available from one adopting the moratoria approach, provided that there were no further problems for (commonly) two years.
- B5.11 It might also appear that, because of the inevitable additional costs that arise from the initial assessment and checks necessary under full underwriting, policies sold under the moratoria approach would be inherently cheaper. We discussed this point with a major PMI provider who had used both approaches. We were told that no precise comparison could be made on the basis of the available figures. Nevertheless, the indications were that, although the moratoria approach was cheaper initially, the savings were more than offset by higher costs incurred when claims were made, and the insurer needed to be satisfied that presenting conditions were covered.
- B5.12 There are, however, several major drawbacks for consumers in the moratoria approach.
- B5.13 For example, there is no opportunity to reconsider whether to take out a policy in the light of any exclusions that might be imposed following the completion of a medical declaration or other medical checks. Consequently purchasers run the risk of paying largely 'wasted' premiums if they are told of a key exclusion only at the time of claim.
- B5.14 Similarly, consumers may be uncertain, or simply not understand, whether a particular claim would be covered, particularly when a condition had not been explicitly diagnosed. 'A sore throat six months ago could mean that a tonsillectomy in a year's time may not be covered, if the sore throat was connected to the later diagnosed condition'.¹² Such uncertainties and misunderstandings may well come to light only at the time when medical treatment is required - hardly the ideal moment.
- B5.15 Consumers with pre-existing conditions (PECs) might be misled by such sales talk as: 'Even PECs eligible after two years'; and 'Cover available for people who had been declined under full underwriting methods' (quoted from 'Prime Health' paper presented

at SMI Conference, 29 November 1995). In reality, few of those with pre-existing conditions may be able to fulfil the typical moratoria terms in paragraph B5.8. Similarly, statements like 'cover available' for people rejected by other companies do not make it clear how restricted or illusory that cover might be.

B5.16 There is also a danger that, in order to survive the moratoria terms, consumers with pre-existing conditions might take the medically undesirable step of not seeking advice or treatment if that condition should flare up within two years of their having purchased a policy.

B5.17 It is perhaps not surprising that, although the moratoria approach makes it easier to sell policies, it also generates complaints and dissatisfaction at the point where consumers come to claim. Indeed, two major PMI companies have told us that they intend to abandon this approach *because* of the large number of complaints it generates. We believe that other companies should follow their example. This would not preclude companies applying moratoria to specified conditions of which they become aware during underwriting.

B6 INCREASES IN PREMIUMS

- B6.1 One very important, but not widely publicised, feature of PMI is that its costs and the premiums charged have consistently risen faster than the retail price index (RPI). These increases are frequently, and unhelpfully, described as 'medical inflation'. In practice the price rises can be attributed to a number of factors, but analysis is not helped by the lack of published information. According to one leading health insurance analyst, between 1975 and 1994 benefits paid per subscriber increased at an average real rate (that is, at a rate above RPI) of 4.5% a year. 'It is not possible from published information to separate out the impact of hospital unit costs, doctors' fee rates, and claim rates. It is widely recognised among insurers, however, that increased claims frequency has been the main reason why PMI cost inflation has run ahead of the RPI in the past and this continues to be the case now'.⁵
- B6.2 We decided to look more closely at the level of PMI inflation and the reasons for it. We found that, in real terms over the period 1989-94, PMI premiums per subscriber had risen by 4.2% a year - which would appear to be broadly in line with the 'historical' rate of 4.5% referred to in the preceding paragraph. But such increases are averaged across schemes for both companies and individuals. In addition, the trading down in policies that has evidently occurred in recent years has further tended to mask the full extent of increases in premiums of given plans.
- B6.3 Overall, spending within the NHS covers a far wider range of facilities than any PMI policy. There are no detailed analyses of NHS expenditure available against which the services provided by the majority of PMI policies can be matched. Drawing a direct parallel between PMI premiums per subscriber and increases in NHS costs would therefore be misleading. Nevertheless, some broad comparisons can be made. We have no reason to think that the underlying costs faced by private hospitals differ significantly from those faced by the NHS. It appears that, in real terms, spending on PMI premiums per person covered has been rising at around 2%-2.5% faster than expenditure on NHS acute hospital services.

Increases in premiums in selected individual plans

- B6.4 Companies provided us with details of their actual premiums over the period 1990-95; these are shown for selected plans in Table B13 (see page 36). The first six plans had similar premiums in 1990, as did the next two at lower levels. The increases shown are for a 30 year-old - although there were similar increases for a 50 year-old. It should be borne in mind that the increase for any individual policyholder will be significantly greater over this period if his age triggers an age-related uplift in premiums.
- B6.5 The table shows that premiums for these individual plans increased by 10%-16% a year in cash terms - or 6%-12% a year above RPI, and 5%-10% a year above the Average Earnings Index (AEI). In sum, however, the *actual* increases for individual

TABLE B13 - PMI: INCREASES IN PREMIUMS FOR 30 YEAR-OLD 1990-95

<i>Plan</i>	<i>End of 1990 £</i>	<i>End of 1995 £</i>	<i>Overall increase %</i>	<i>Annual increases</i>		
				<i>Cash %</i>	<i>Above RPI %</i>	<i>Above AEI %</i>
A	270.24	453.75	69.0	10.9	7.3	5.6
B	270.20	479.09	77.3	12.1	8.4	6.8
C	279.00	460.88	65.2	10.5	6.9	5.3
D	258.80	525.51	102.5	15.2	11.4	9.8
E	241.40	408.94	69.4	11.1	7.4	5.8
F*	230.72	405.10	75.6	11.9	7.0	5.4
G	181.32	292.86	61.5	10.0	6.4	4.9
H	181.20	375.29	107.1	15.7	11.9	10.2
I*	318.20	576.00	81.0	12.6	8.9	7.3

Source: OFT - based on data supplied by various PMI providers

Notes: RPI Retail price index

AEI Average earnings index.

* The figures shown for these plans are for 1989 and 1994.

Insurance premium tax came into effect on 1 October 1994 at a rate equivalent to 2.5% of the value of premiums received.

plans have been well above the *average* rise in PMI premiums overall. There is no reason to believe that these plans are atypical. The apparent discrepancy has almost certainly been caused by 'trading down' (with a greater proportion of subscribers opting for cheaper plans) and lower rates of increase on group policies. Between 1989 and 1994 average premium increases for company schemes were 7% and those for other PMI policies 11.5%.

B6.6 We asked companies for their views on the factors behind the increases in premiums for a given level of cover. Their responses varied, with different providers suggesting that higher incidence of claims accounted for 40%, 60%, or 66% of the total increases in premiums.

The incidence of claims

B6.7 One major insurer gave us, in confidence, figures for the incidence of hospital admissions per thousand subscribers to one of its main products. Between 1990 and 1995, the

admissions incidence went up every year, albeit at a progressively slower rate. Over the period as a whole the total rise was 42%. Plainly, the figures will have been influenced by changes in the portfolio of subscribers - older subscribers, for example, are likely to need treatment more often - but they do strongly suggest an increasing propensity to claim on policies.

- B6.8 The rise in the number of claims per subscriber was attributed in part to alleged cost-shifting by the NHS. It was suggested to us that GP fundholders were encouraging patients to make greater use of their PMI plans. It was also suggested that the NHS were transferring in-patient emergency admissions to NHS pay-beds where possible. But no firm evidence was presented to support such claims.
- B6.9 It was also suggested that, over time, policyholders had become more aware of their ability to make claims. Some were eager to make use of medical advances; others might simply seek value from their plans by demanding treatment for marginal conditions.
- B6.10 The expanding range of treatments available in private hospitals was put forward as another influencing factor. This made private treatment a viable option in some situations where it would not have been before.
- B6.11 A further possible consideration is that specialists who work with private patients may have adopted different standards, and are more willing to consider surgery or similar treatment.
- `Regardless of waiting times, however, purchasers will continue to be attracted to PMI because of the relatively stringent criteria for entry onto NHS waiting lists.'⁷
- B6.12 Such differences in standards might arise from GP fundholders economising with their funds. Alternatively, there could be an over-readiness on the part of GPs to refer patients and on the part of consultants to provide PMI-paid treatment. One industry analyst has pointed to statistics showing that, while only 11% of the population are covered by PMI, some 20% of all operations, and 30% of hip operations (a leading elective procedure), are carried out privately. The same analyst has suggested that there is considerable disagreement among surgeons about five of the ten most common operations - dilatation and curettage (D&C), wisdom teeth, tonsils, hysterectomies, and glue ear. Professional opinion differs on whether these operations should be carried out at all and, if so, on which patients and at what time. Some studies have concluded that, among the less common operations, a significant proportion of heart surgery and joint replacement operations have been unnecessary or inappropriate.² It has been suggested that PMI holders might even need to be protected from inappropriate operations.¹³ On the other hand, another study¹⁴ found no difference between surgeons working in the public and private sectors in Britain in their willingness to refer patients for hysterectomies.

B6.13 US experience illustrates the problems arising with payments by third-party insurers. `A patient and doctor may choose hospitalisation and surgery, which are completely covered by insurance, to treat a condition, even though the condition could be treated at least as well with far less expensive drug therapy, for which there is little or no insurance coverage. A recent study by the National Center for Policy Analysis estimates that this effect unnecessarily increases national health spending in the USA by about 16%, or about \$140 billion a year'.¹⁵ The environment, however, differs from that in the UK, where it is still the public sector that sets the prevailing standards of medical practice.

Increases in costs

B6.14 In addition to the increased incidence of claims there may be increased costs per claim. Again, a major insurer has supplied figures showing that the average cost per hospital admission rose by 28% between 1990 and 1995, an average increase of 5% a year. This is significantly ahead of the Retail Price Index, which increased by 18.2%, an average of 3.4% a year, over the same period. Several reasons have been suggested for such cost increases.

- The `complexity mix' of PMI cases has altered. More complex operations now account for a higher proportion of costs.
- Costs in relation to out-patient treatments have increased. This can partly be put down to the greater use of more sophisticated diagnostic equipment.
- The fees of surgeons, physicians and anaesthetists have also risen. Following recommendations made in the 1994 Monopolies and Mergers Commission (MMC) report on private medical services, the British Medical Association's guidelines on consultants' fees were dropped. The MMC had concluded that, under the guidelines, fees were higher and rose faster than would be the case had those guidelines not existed.
- A possible over-expansion in private hospitals has resulted in low occupancies, high overheads, and hence high costs.
- Many hospital costs are wage-related, and increases tend to reflect the Average Earnings Index rather than RPI - although this would, of course, be offset by improvements in hospital productivity.
- The introduction of the Insurance Premiums Tax of 2.5% in 1994 produced a one-off increase in costs.

B6.15 None of the PMI companies suggested that PMI inflation would reduce significantly. One anticipated that it would continue at slightly below recent levels.

Warnings about PMI premium increases

B6.16 Despite the fact that, historically, PMI premiums have gone up by an average of some 4.5% a year - even making allowance for the mitigating effect of trading down - there has apparently been no suggestion that prospective policyholders should be warned about apparently inevitable increases in real terms.

B6.17 It may be argued that PMI contracts are renewed on an annual basis, and that policyholders are free to switch to other policies if they so wish. But the increases in PMI premiums are general, although - as Table B13 shows - they vary from company to company over a period. Furthermore, individual policyholders with existing medical conditions (who may represent between one-fifth and one-third of a particular provider's policyholders, depending on their age profile) are effectively 'trapped' with their existing companies because they would generally not receive cover for those conditions if they tried to switch to another company.

B6.18 The fact that, for many individual plans, PMI premiums have risen by 6%-12% a year above RPI argues strongly in favour of giving some warning. As previously indicated, we do not believe these plans are atypical; rather the overall average increase has been reduced by the effect of trading down.

B6.19 Such a warning might take the form of statements and illustrations on the following lines:

first, a general statement explaining that because of claims incidence and cost increases PMI premiums for individual plans had increased significantly faster than RPI;

secondly, a statement of the increases in premiums for each plan over the previous five years, both in cash terms and above RPI; and

thirdly, an illustration of how actual premiums would rise over the next five years both in cash terms and in real terms above a projected RPI, assuming the same rate of real increase as in the previous five years.

Particular problems of the elderly

B6.20 The forecasts shown in Table B14 (see page 40) suggest that the over-65s will account for nearly 18% of the UK population in the year 2021, compared with about 16% in 1996. The very elderly (85+) are expected to account for a slightly growing proportion of the UK population over the next 25 years.

B6.21 Even though the elderly account for only about 16% of the UK population, it has been estimated that 65% of all days spent in hospital are by people over pensionable age.¹⁶

B6.22 The extra costs and higher numbers of claims from the elderly is reflected in premiums, which typically might rise from £400 at age 30, to £600 at age 50, and to £1,200 at age 70 at current premium rates. The higher premiums for the elderly are in part offset by the tax relief of 25% available for those over 60.

TABLE B14 - PROJECTED AGE STRUCTURE OF UK POPULATION: 1996-2021

<i>Age</i>	<i>1996 000s</i>	<i>2001 000s</i>	<i>2011 000s</i>	<i>2021 000s</i>
0-15	12,298	12,521	11,887	11,472
16-44	23,857	23,851	22,976	22,187
45-64	13,323	14,003	16,079	16,374
65-74	5,056	4,872	5,428	6,404
75-84	3,132	3,270	3,304	3,915
85+	1,066	1,202	1,445	1,627
<i>Totals</i>	58,732	59,719	61,119	61,979

Source: *Personal protection - An overview*, Mintel, 1994

B6.23 But the real premiums of the 'future' elderly can only be seen after taking PMI inflation into account, as shown in Table B15.

TABLE B15 - PMI INFLATION: EFFECT ON ANNUAL PREMIUMS

<i>Annual premiums</i>	<i>PMI annual real inflation rates (above RPI)</i>			
	<i>0%</i>	<i>3%</i>	<i>6%</i>	<i>9%</i>
At age 30	£400	£400	£400	£400
At age 50	£600	£1,084	£1,924	£4,363
At age 70	£1,200	£3,914	£12,343	£37,691

Source: OFT projections

B6.24 This shows that someone aged 30 in 1996 might typically pay annual premiums of £400, while someone aged 50 would expect to pay annual premiums of £600, and someone aged 70 would pay £1,200. Such premiums are paid for those age groups now, and presumably would continue at those levels in 1996 money values if PMI inflation did not exceed RPI.

- B6.25 If, however, PMI premiums were to increase at 'only' 3% a year above RPI (well below historical levels), then at age 50 a policyholder who had subscribed in 1996 at age 30 would find himself paying £1,084 in real terms (before taking RPI increases into account). By age 70, he would be paying £3,914 instead of the 'expected' £1,200 (again before taking RPI increases into account).
- B6.26 If PMI premiums were to go up at or above the actual real rates of plans over the last five years, then the actual premiums payable would be much higher - for example, £1,924 instead of £600 at age 50 with PMI real inflation at 6% a year, and £37,691 instead of £1,200 at age 70 with PMI inflation at 9% a year.
- B6.27 Of course, most people who benefit from PMI do so through company schemes. On reaching retirement they, too, would face very high premiums were they to seek individual PMI cover. Average earnings, and hence occupational pensions, may also grow faster than RPI, but it seems unlikely that they will grow as fast as PMI costs have done over recent years. Nevertheless, unless PMI inflation is substantially curbed, very few of the elderly will be able to afford to continue holding PMI policies - certainly not without trading down very considerably.
- B6.28 More generally, any product whose price goes up faster than average earnings over a long period plainly faces problems. It will become less and less affordable, and either its specification will have to be continually reduced or its market will shrink. There is a limit to the extent to which the specification of PMI plans *can* be reduced without their losing their attraction. The companies providing them thus face obvious problems which to some extent they share with other health providers. In the next chapter we discuss how these are being tackled.

B7 MANAGED CARE

B7.1 All Western healthcare systems face the same basic problem: the ability of medicine to help patients exceeds the ability of society to pay for that help. If every doctor were to offer every patient the best care that money could buy for them, the total costs would far exceed what the economy could stand. Consequently, independently of normal inflation, every healthcare system struggles with rising costs and has to try to contain them in some way. While PMI is similarly affected, certain features exacerbate the problem. They include particular incentives to make greater use of the product and higher costs, and many PMI providers have responded by taking various steps towards providing 'managed care'.

PMI incentives

B7.2 A range of different parties have incentives to make use of PMI.

- Policyholders believe that they have 'paid twice' for medical care (taxes plus PMI premiums), and want to see some return for their extra 'investment'. They may insist to their GPs that they should see a private consultant and GPs have no strong reasons to deny such a demand. In addition, when being treated, they may well press for the best technology options if they are made aware of them.
- Consultants have an 'incentive to trade': indeed most consultants benefit significantly from undertaking work paid for by PMI.
- Private hospitals and NHS hospitals with private-patient units stand to benefit from the PMI policyholders directed to them.

B7.3 Some PMI providers have taken steps to limit fees to consultants, and to move towards various forms of managed care. Others have introduced 'no claim' discounts, and have given policyholders the option of paying lower premiums if they agree to meet any excess on their claims.

Managed care in the USA

B7.4 In the USA, PMI plays a considerably greater role, since it covers a much wider range of medical treatment - not simply acute and elective treatment as in the UK. Nevertheless, the US experience should inform discussion about medical care within the UK. In the USA, there is currently a substantial public debate about the shortcomings of the traditional 'fee for service' approach of third-party payments by insurance companies and government agencies. The cost explosion in medical healthcare in the USA over the past 30 years has been attributed to the 'perverse, cost-increasing incentives of third-party coverage'. It has been claimed that:

healthcare providers have indulged in a 'medical arms race', searching for ever-more expensive technology, even if it produces only minimal increases in benefit;

patients and doctors have chosen services with greater insurance coverage even though alternative services with less coverage may be at least as effective and less expensive overall; and

a costly bureaucracy of medical reviewers has developed to check often mainly small claims.¹⁵

B7.5 Managed care influences the utilisation and cost of healthcare services, and measures their performance. A managed care healthplan might have such features as:

integration of financing and management of services with their delivery to an enrolled population;

provision of a comprehensive range of services at a predetermined price;

contracts with provisions to share financial risk or to incentivise the delivery of quality, cost-effective services;

financial incentives to members to use plan providers and follow plan procedures; and

an information system capable of monitoring and evaluation patterns of members' use of medical services, and the cost of those services.¹⁷

B7.6 The basic aim is to limit patients from over-consuming and providers from over-supplying. Another potential and positive feature of managed care is the general raising of quality of care.

B7.7 In some form or another, managed care now dominates the US scene. There are two main forms.

- Health Maintenance Organisations (HMOs) have three characteristics: an organised system for providing or assuring healthcare delivery in a geographic area; an agreed set of basic and supplemental health maintenance and treatment services; and a voluntarily enrolled group of people.
- Preferred Provider Organisations (PPOs) enable employer health benefit plans and health insurance carriers to contract to purchase healthcare services for members from a selected group of participatory providers.

B7.8 There are, however, no easy answers. It would seem that such managed care organisations readily attract criticism, like the traditional fee for service mechanisms

whose incentives they seek to reverse. It has been claimed that 'Managed Care's method for reimbursing doctors pits financial interest of the physician against the medical interest of the patient'.¹⁸ Doctors are often paid on a 'capitation' basis - according to the number of patients on their lists, regardless of whether those patients receive any treatment. Consequently, if a patient is referred for expensive treatment, the cost is potentially met out of the doctor's own pocket. In addition, bonuses are paid to those doctors who are deemed to be the most cost-effective.

- B7.9 That said, it is inevitable that, if costs are to be contained, the self-interest of patients must be counterbalanced in some way. Clearly, at the point of need, all patients may see it as being in their interest to consume as much care as may possibly help them. But, as previously noted, no system could withstand the unconstrained demand of every patient.
- B7.10 The criticism of managed care organisations has led to the creation of 'medical savings accounts' alternatives, which do not involve PMI. These enable consumers to save to purchase whatever medical care they wish. At the same time they can insure against the risk of requiring very expensive treatment. This amounts to self-insurance, but with some laying-off of the larger risks.

Managed care in the UK

- B7.11 In contrast to the USA, most European countries have historically placed much greater emphasis on publicly-provided healthcare. Formal managed care has featured much less. Nevertheless, there are now several moves towards the provision of managed care systems in the UK. Indeed, within the NHS itself there are elements of managed care with the health authorities effectively acting as HMOs, but with their finance coming from taxation rather than contributions from members as in the USA. Fundholding GPs have been described as, in effect, miniature HMOs.¹⁷
- B7.12 In the context of PMI, some plans have long embodied constraints that amount to forms of managed care - implemented through their pre-authorisation requirements, the nomination of preferred providers, and a restricted choice of hospitals. Various hospitals have drawn our attention to the uncertainties that inevitably arise with disputes over pre-authorisation; according to one of them, there are problems in 25%-30% of such cases. Difficulties are caused by the necessity for pre-authorisation not only in connection with the basic treatments claimed, but also for extras like special nursing, the use of ITUs, and the provision of certain drugs.
- B7.13 Apart from implementing simple cost-containment measures, PMI providers have been exercising greater control over how and by whom particular conditions are treated.
- BUPA has formed clinical consensus panels to discuss 'best clinical practice' in the busiest specialities, such as psychiatry, oral surgery, obstetrics, gynaecology and orthopaedics. The performance of consultants is subsequently monitored against these guidelines.¹⁹

- Other PMI companies have adopted 'case management practices' where they seek to agree the treatment and cost of more complicated cases with consultants and hospitals. Pilot projects are also in hand to exercise wider controls over consultants.
- CIGNA has sought to introduce techniques involving preferred providers, utilisation management (to prevent unnecessary hospital admissions, and to oversee the length of stays in hospital and the intensity of treatment), and care management (to control costs and the quality of care through the constant review of complex, high-value cases).²⁰
- Foundation Health has established a network of consultants (Mednet), with agreed clinical schedules for between 20 and 30 of the most common procedures. Such arrangements already apply to company plans but Foundation Health is also piloting individual plans with similar schedules.

B7.14 Consultants in the UK have given such steps a mixed reception. Many believe that they would excessively restrict clinical freedom. For doctors, the implications of managed care have been described as an attempt to control costs by modifying their behaviour, placing the emphasis on their relationship with insurers and HMOs rather than with patients, and setting clinical guidelines and protocols to reduce costs. Clinical decisions would be influenced by financial considerations, while aggressive contracting and utilisation controls would be set in order to reduce premiums.²¹

Clinical protocols: case management practices

B7.15 While the various steps being taken by PMI companies to agree protocols or to insist on certain practices with consultants and hospitals parallel similar developments in public health systems, they are probably being pressed more forcefully. There are a number of good reasons for establishing such ground rules.

- The use of particular procedures varies widely between different doctors, and between different areas. In the period 1984-90, the rate of prostate gland removal varied by a factor of more than 20 between individual US states.²² In 1989/90 the rate of D&C in Britain was about one-seventh of that in the USA, while there was a variation factor of 2.7 between districts in the Oxford region alone.²³
- The way in which particular procedures are performed also varies. Again, in the hospital districts covered by the Oxford region, the proportion of D&Cs performed as day cases ranged from 22% to 82%.
- Such variations may have considerable cost implications. Comparisons between in-patient and out-patient curettage procedures in the USA have shown a 10-fold difference in costs.

- In addition, successful treatment and the avoidance of complications can have a major impact on costs. In medicine as elsewhere, 'right first time' is generally the cheapest way. LDS Hospital in Salt Lake City improved the timing of administering antibiotics to surgical patients. The post-operative infection rate dropped from 1.8% to 0.4% - which was estimated to produce savings of some \$500,000-\$750,000 each year.²²

B7.16 The actions being taken by PMI providers have therefore the potential simultaneously to improve patient care and reduce costs. But it is equally possible that different standards will be adopted, not only among PMI providers but by consultants and hospitals working within the various NHS authorities and trusts. Reference has already been made (in paragraph B6.11) of the possibility of different standards of entry being adopted for treatments funded by PMI or the NHS.

B7.17 It is surely vital that the different protocols and practices being developed should be drawn up within a coherent framework which covers the NHS authorities, the PMI providers and private hospitals. This suggests that there should be some overseeing body, possibly under the Department of Health. It is also essential that professional bodies, especially the Royal Colleges, should be fully involved.

B7.18 If there are significant differences in the protocols or practices adopted by different bodies, every effort should be made to bring them to the attention of those within the medical industry, commentators, and (ultimately) consumers. One way this might be achieved would be to publicise both the performance targets set and the actual performance against target achieved by every NHS authority and PMI provider, following a common format to allow comparisons to be readily made.

GP referrals

B7.19 Protocols or best practices may curb the costs of particular procedures, and affect the number of operations. But some commentators suggest that increases in PMI premiums are primarily caused by the rising number of PMI claims, and these could continue unchecked unless controls on referrals by GP gatekeepers are introduced.

B7.20 Within the NHS system, such restraints already exist through the level of funding available to GP fundholders, and through the targets set for other GPs by District Health Authorities. At present however, there are no such controls over GP referrals of PMI patients, and this may be an important factor in the reportedly different standards between the NHS and PMI.

B7.21 PMI providers recognise this, but find it frustrating. 'I predict that insurers will continue to wrestle with possible ways of tying GPs into the managed care process and that this will be mostly futile.'²⁰ Indeed, PMI companies are considering how they could set up their own GP networks. Presumably such GPs could be paid on a capitation basis,

perhaps with incentives to discourage their making more referrals than laid down in pre-determined norms.

B8 CONCLUSIONS AND RECOMMENDATIONS

- B8.1 PMI makes a significant contribution to the financing of healthcare in the UK. Nevertheless, it generally covers only acute and elective conditions. These typically range from the removal of tonsils to hip replacements and coronary bypass operations.
- B8.2 PMI appears to receive a number of positive signals from the NHS - through the existence of significant waiting lists for elective conditions, through the incentives for fundholding GPs to direct PMI policyholders away from the NHS, through the substantial extra incentives for consultants to take on private work, and through the links between the NHS private-patient units and PMI.
- B8.3 In terms of numbers of subscribers however, the PMI market has been fairly static for some five years, despite the wide variety of plans now available. The ownership of PMI plans still appears to be focused on senior employees and professionals, while its sociographical coverage is concentrated particularly in the South East. It has been suggested that a substantial proportion of the annual sales of individual plans involve existing policyholders trading down to less costly plans.
- B8.4 We have looked in particular at individual PMI plans and have found some problematic features. Many actual and potential problems arise from the fact that PMI brings together two topics - health and insurance - which are each quite complex enough on their own. Nevertheless, much can be done to improve the information available to consumers, so providing a sounder basis on which they can decide whether to purchase PMI and, if so, select which plan is best suited to their needs.

Presentation and comparison of plans

- B8.5 Different plans are presented in different ways, and it is difficult - if not impossible for those outside the industry - to compare them in terms of value for money.
- B8.6 **We recommend that:**

PMI plans are presented in a common format and (like other contracts) in plain and intelligible language;

an approach be developed to enable a ready comparison to be drawn between plans (one possible approach, based on 'common core benefits' and comparison of extra benefits with premiums is set out in Chapter B4).

Underwriting

- B8.7 The underwriting of individual PMI plans does not involve a particularly rigorous approach. Even 'full underwriting' relies heavily on self-declaration by prospective policyholders.

- B8.8 The moratoria approach was devised to provide 'an easier sell'. But, for consumers, it involves a number of actual or potential drawbacks. For example, exclusions may well not come to light until a claim is made, making it impossible to judge whether a particular policy offers value for money. Consumers may also be subject to misleading sales claims, while they are given a clear incentive not to seek medical advice during the moratorium period. In addition, the general arrangements result in more problems and administrative costs for consultants and hospitals.
- B8.9 We recommend that PMI providers should abandon the moratoria approach to underwriting.**

Increases in PMI premiums for individual policies

- B8.10 Over the past 20 years or so, average PMI premiums have risen at about 4.5% a year above the RPI without comment and with little observable reaction from the market. These average increases, which cover premiums for both individuals and companies, reflect a measure of trading down and mask much higher rises in premiums for particular plans.
- B8.11 Our investigation has shown that, in recent years, actual increases for nine plans for individual subscribers, offered by seven PMI companies, averaged 10%-15% a year in cash terms, or 6%-12% a year above RPI. Over the longer term, increases at these levels, even allowing for some trading down, appear unsustainable.
- B8.12 Discussions with companies about the factors lying behind such increases have revealed somewhat different views on the relative importance of incidence of claims and increases in costs. The incidence of claims was variously claimed - though without evidence - to have risen for the following reasons: cost-shifting from the NHS by GP fundholders; a greater general awareness of what medical treatments were now available; the eagerness of policyholders to get a return from their premiums; and, possibly, the readiness of consultants to provide treatment on a private basis.
- B8.13 A number of different reasons for rising costs were also put forward: the greater complexity of operations; the use of more sophisticated diagnostic equipment; increases in fees for specialists and in hospital costs; and the Insurance Premiums Tax.
- B8.14 Companies gave no indication that there might be any significant reduction in the rate of increase in PMI premiums; yet, at the same time, there was no suggestion that prospective or actual PMI policyholders should be warned of likely increases.
- B8.15 We recommend that there should be a warning about likely increases in PMI premiums, perhaps in the following terms:**

a general statement explaining that, because of the incidence of claims and increases in costs, PMI premiums for individual plans had risen significantly faster than RPI;

a statement of the increases for each plan over the previous five years, both in cash terms and above RPI;

an illustration of how actual premiums would rise over the next five years, both in cash terms and in real terms over a projected RPI, assuming the same rate of real increase as in the past five years.

B8.16 New entrants to the market could also issue warnings about increases in PMI premiums, referring perhaps to past levels of increases averaged across the industry.

B8.17 The elderly already face great difficulties in paying PMI premiums. This reflects the risks and costs of their treatment. If likely increases in these premiums are also taken into account very few of the 'future' elderly will be able to afford the much greater PHI premiums indicated by present trends, even allowing for a general rise in their overall standard of living.

Managed care

B8.18 'Managed care' is a general description of a variety of mechanisms originating in the USA and intended to reverse the incentives to over-claim and over-treat that arise through third-party payments like PMI. A managed care health plan might have such features as: a range of services at predetermined prices to an enrolled population; contracts with providers of quality and cost-effective services; financial incentives to members to use the plan providers and to follow plan procedures; and an information system to monitor and evaluate use of services, their position and their costs.

B8.19 Like the 'fee-for-service' mechanisms it sought to curb, managed care in the USA has its critics - notably because it may offer doctors paid on a capitation basis incentives to avoid expensive treatments whose cost is effectively met out of their own pockets. Some commentators advocate medical savings plans which cut down the involvement of third parties, and enable consumers themselves to decide what to pay on much medical treatment.

B8.20 Managed care is being introduced in the UK in a variety of forms, which commonly feature the use of clinical protocols or case management practices. While these may well be effective in curbing the costs of treatment, there is a risk that multiple standards could develop of which commentators and consumers are largely unaware.

B8.21 We recommend that all protocols or care practices should be drawn up within a common framework, under the guidance of an industry body and the Department of Health. NHS bodies and PMI companies should publicise their protocols on best

practices, in common formats so that comparisons can be readily made. The Royal Colleges should be invited to sponsor consensus conferences to help refine these protocols, and both NHS bodies and PMI companies should be encouraged to publish output and outcome targets and results achieved.

B8.22 While the establishment of such protocols may curb the costs of treatments, further action will be needed if the incidence of claims is to be curbed. The PMI providers are already looking at ways in which GP referrals to consultants might be controlled. Here again, there is a danger that differing standards could be introduced, hidden from public view.

B8.23 In assessing the value for money offered by PMI, individual would-be policyholders should take various factors into account. These include:

PMI's restricted coverage, focusing on acute and elective conditions;

the importance they attach to such subjective factors as greater comfort and privacy, and relations with consultants rather than perhaps with more junior doctors;

prospective waiting times for NHS treatment, and any significant differences in access to NHS and PMI treatment lists;

their personal spending priorities, bearing in mind that premiums are likely not only to increase with age but will also reflect general increases in PMI costs.

B8.24 Once a decision to purchase PMI has been made, the choice of a suitable plan should be made on as informed a basis as possible. We look to the establishment of a common format for benefits, and a readily accessible means to compare the benefits and premiums of different plans. Independent assessments by expert analysts of any differences between different PMI providers' clinical protocols or managed care practices would also help to inform that choice.

PART C: PERMANENT HEALTH INSURANCE

C1 INTRODUCTION

- C1.1 Permanent Health Insurance (PHI) is not perhaps the best way to describe a product whose purpose is essentially to provide or extend sick pay. It is an income-replacement policy, but one which replaces income lost only as a result of sickness or continuing disability. It thus supplements whatever individual policyholders may receive from employers or the state.
- C1.2 Most policies provide benefits only after a policyholder has been unable to work for a defined period. This so-called 'deferred period' may be set anywhere between four and 104 weeks.
- C1.3 In practice, PHI is a complex and highly variable product. For example:
- benefits vary considerably between companies;
 - the deferred period also varies;
 - the definition of disability which triggers payment varies;
 - premiums may be renewable, reviewable or guaranteed (see paragraph C3.1);
 - some policies also include an investment element, on a unit-linked or a with-profits basis.
- C1.4 In trying to pick their way through these complexities, individuals thinking of purchasing PHI have to make a number of difficult decisions. One of the most crucial is deciding how much of their income they should protect. To date, a typical PHI policy may have paid 75% of pre-disability income *less* other benefits available from employers or the state (although recent tax changes may affect the position - see footnote on page 58). For regular salary-earners, estimating their likely future income may be comparatively easy. For those who are self-employed, whose employment is irregular, or who earn a significant amount in bonuses, it is more difficult. Since any pay-outs under a PHI policy will be based on *actual* income only, they may find that they have overinsured and a proportion of their premium payments will have been wasted.
- C1.5 Prospective policyholders should also consider how much benefit they may receive from other sources should they be disabled. Where sizeable sums are available, there might be little point in their buying PHI.
- C1.6 In addition, they should look carefully at how policies define a 'disability' which triggers payment. Some policies base this on an inability to follow one's *own* occupation, others

on an inability to follow *any suitable* occupation - and there are differences of detail even between broadly similar definitions.

C1.7 It is perhaps not surprising that the sales of PHI to individuals have been falling, despite its potential attractions - particularly the measure of protection it gives against long-term disability. Our investigation has indicated that some doubtful promotional and underwriting practices have been introduced. Moreover, a substantial proportion of policyholders appear to be paying for benefits which they will never be able to receive in full.

C1.8 Like Part B of this report dealing with PMI, this part deals almost exclusively with policies that have been purchased by individuals. Nevertheless, it should be borne in mind that some 60% of those who are covered are protected by group policies - and the most vociferous of disappointed claimants fall almost exclusively in this category.

C1.9 Among the problems that are encountered, there are three that stand out:

difficulties in making claims when employment has ceased, possibly through ill health;

difficulties in obtaining redress; and

inadequate knowledge of the terms and conditions of policies.

C2 THE PHI MARKET

Sales

- C2.1 Of the estimated 2.5 million people who are protected by PHI, roughly 60% are covered by group policies and 40% by individual policies.
- C2.2 Around 50 companies currently sell PHI policies to individuals. Overall, the number of sales fell from 160,000 in 1991 to 117,000 in 1995. In 1995, the leading individual PHI providers were Black Horse Life (17,748 sales), Allied Dunbar (10,828), Lincoln National (10,100), Norwich Union Healthcare (9,300), and Sun Alliance Medical Sickness (9,278).²⁴
- C2.3 Although the majority of PHI sales are made by the providers' own direct-sales staff, an increasing proportion (44.3% in 1995) is being sold by independent financial advisers. The average annual premium for an individual PHI policy in 1995 was £319, while the average sum insured was £8,443.²⁴

Premiums

- C2.4 As Table C1 shows, the premiums charged vary considerably between companies, and by the age and profession of the policyholder.

TABLE C1 - PHI: VARIATIONS IN PREMIUMS

	<i>Male clerk</i>		<i>Male self-employed restaurant manager</i>	
	<i>Age 30</i>	<i>Age 50</i>	<i>Age 30</i>	<i>Age 50</i>
Monthly premiums:	£	£	£	£
range	10-66	23-103	15-75	37-292
average	18	41	32	77

Source: *Money Management*, November 1995

Note: The premiums shown are based on a 26-week deferred period, and are for level benefits of £20,000 a year to age 60.

- C2.5 In addition, there are 'budget' plans of limited duration. For example, a PHI policy lasting for five years would typically have premiums about 33% lower than standard.

The loading of premiums

C2.6 For the purposes of PHI, occupations are generally classed on the following lines.

- 1 Clerical, administrative, or other similar non-hazardous occupations.
- 2 Occupations where some degree of risk is involved - such as supervision of manual workers, totally administrative job in an industrial environment.
- 3 Occupations involving regular light to medium manual work but no substantial hazard which may increase the risk of sickness or accident.
- 4 High-risk occupations involving heavy manual work.

C2.7 Premiums are 'loaded' according to the occupation classification (which means that higher occupational risks attract larger premiums), although the steepness of the loading varies between companies.

TABLE C2 - PHI: EXAMPLES OF THE LOADING OF PREMIUMS BY OCCUPATION FOR A MAN AGED 30

Annual premiums for:	<i>Occupational classification</i>			
	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>
Allied Dunbar	£71	£162	£214	-
Canada Life	£83	£95	£117	£161

Source: *Planned Savings*, May 1995

Note: Annual premiums are based on a 26-week deferred period, and provide for a benefit of £200 a week to age 60.

C2.8 For women, there are very substantial additional loadings. Premiums range from 25% to 65%, and average about 50%, above those for men.

C2.9 Changing circumstances may lead to the reclassification of particular professions. For example, some companies have placed teachers into higher risk-rated classifications following a rise in stress-related illness in the profession.

Underwriting

C2.10 The PHI approach to underwriting is more rigorous than for PMI, reflecting the fact that insurers have greater sums at risk. Moreover, as many as 25% of applicants for PHI are turned down or have their cover restricted on medical grounds - compared with the rejection of only 5% of applications for life insurance. Nevertheless, some companies have introduced the questionable 'moratoria approach' to underwriting (see Chapter C5).

Claims experience

C2.11 It has been reported that some 25% of claims are rejected,²⁵ typically because the disabilities in question do not persist beyond the deferred period (which, depending on which option has been selected, may be variously for the first 4, 26, 52 or 104 weeks of disability), or because an applicant's income is too small to support a claim. A benefit may be payable only if the income is above state benefit levels.

C2.12 Disabilities that commonly lead to claims are set out in Tables C3 and C4.

TABLE C3 - PHI: DISABILITIES LEADING TO CLAIMS

<i>Disability</i>	<i>Claims in force 31 Mar 1995 %</i>	<i>All claims 31 Dec 1994 to 31 Mar 1995 %</i>
Back/permanent total disability	17	17
Circulatory	17	15
Mental	16	11
Bone	8	12
Neurological	7	4
Arthritis	7	5
Others	28	36
	100	100

Source: 'M&G Survey', *Health Insurance Monitor*, October 1995

TABLE C4 - PHI: DISTRIBUTION OF DISABILITIES BY OCCUPATION

<i>Disability</i>	<i>Managerial/ professional %</i>	<i>Self-employed %</i>	<i>Manual %</i>
Musculo/skeletal	17	39	47
Circulatory	21	13	19
Mental illness	24	19	12
Others	38	29	22
	100	100	100

Source: 'M&G Survey', *Health Insurance Monitor*, October 1995

C2.13 Some PHI policyholders have expressed concern that certain companies consider claims too unsympathetically. The companies, for their part, suggest that claims are becoming more frequent and payments more prolonged, and that fraudulent or improperly extended claims are expensive not only for the industry but also for innocent consumers. Perhaps with this in mind, PHI companies have sought to ensure that they maintain contact with claimants. One large group PHI company has introduced a free 'disability counselling' service. While its stated aim is to help claimants make the most of opportunities to improve their circumstances, it may well also assist the company to ensure that any claims it pays out continue to be genuine. Less subtle methods of checking on claimants include unannounced visits by PHI company staff and the use of private investigators.

Redress

C2.14 The number of complaints about PHI referred to the Insurance Ombudsman rose from 19 in 1991 to 192 in 1994. In about one-third of the latter cases, the Ombudsman favoured the complainants. Those making claims under group policies have, however, encountered difficulties in having their cases heard by the Ombudsman. For his part, the Ombudsman has stressed the importance of employers taking out group cover for their employees on terms which enable claimants to pursue their claims directly. The Personal Investment Authority (PIA) Ombudsman has now taken over responsibility for PHI cases.

Regulation

C2.15 Where there are investment elements incorporated in a PHI product these are already regulated under the Financial Services Act. The PIA has indicated that further regulation for PHI products is being considered.

C3 THE COMPLEXITY OF THE PRODUCT

Premiums

C3.1 Premiums for PHI products come in a number of different forms:

most may be reviewed after a period of five years (or a shorter period);

some may be reassessed and renewed after, say, one year or five;

a few are charged on level or guaranteed terms.

C3.2 Some policies are marketed purely on a protection basis, while a number offer a partial refund of the premiums paid if no claims have been made during a specified period. As indicated in paragraph C2.15 however, the premiums for some products incorporate an investment element. When such a policy is surrendered, or matures, the holder may receive a pay-out - if generally a small one.

C3.3 What usually happens in practice is that policyholders pay into an investment fund from which their premium payments are withdrawn as required. The procedure may be structured to offer tax advantages, but in any event it will generally help to smooth the normal rise in premiums as policyholders get older. Any final pay-out is based on the total payments made over the years plus the return on the investment, minus the cost of cover. As such, it is highly sensitive to fluctuations in the investment market and the level of charges. If investment performance net of charges is particularly bad, premium payments may have to go up in order to compensate.

C3.4 Only in the case of sales through brokers and IFAs is it likely that the importance of different levels of charges will be brought out. For the 65% of sales made directly by PHI providers themselves, consumers may not be aware of the importance of charges and consequently they may not shop around for low-charge products.

Benefits

C3.5 Although premiums may be directly related to the possible pay-out of a specific financial benefit - £15,000 a year, for example - any benefit that *is* eventually paid will depend on what the policyholder in question was earning before being disabled. PHI policies limit the benefit payable, generally to an amount which, when added to receipts from state and employer payments, totals no more than a set percentage of previous income (see paragraph C3.7), so that the insured has a direct incentive to return to work.

C3.6 A major survey of PHI policies from 46 companies (the Kluwer survey)²⁶ has indicated that:

four companies would pay benefits of more than 75% of pre-disability income;

11 provide for 75% of pre-disability income (with two imposing further conditions);

four provide for 75% of the first £45,000, and then for one-third of any income over £45,000;

nine provide for 75% of the first £45,000, and then for some proportion (other than a third) of any income above £45,000;

15 provide for some percentage (55% to 80%) of some other sum (from £42,000 to £60,000), with further conditions in some cases;

three provide for different terms, a flat rate per month, for example.*

C3.7 The great majority of PHI policies seek to relate payments directly to previous income, although the way this is measured may vary. Most companies take state benefits into account, but some do not. Companies also differ in the way in which they treat unearned income - such as dividends or interest received - some discounting, say, the first £5,000. In addition, there are differences in the way that, for PHI purposes, they establish the income of policyholders who are self-employed. Most companies will average net profits as agreed for tax over a period, perhaps three years, in order to take account of the relationship between a proprietor's health and profitability.

C3.8 We do not know whether individual policyholders fully understand the significance of such variations when they choose to purchase a particular plan, or whether they appreciate the effect that their choice may ultimately have at the point of claim. Nevertheless, at first sight it does appear that some, at least, are likely to be adversely affected by inappropriate policy choices.

Definitions of disability

C3.9 Most of the 46 companies covered by the Kluwer survey²⁶ define 'total disability' in broadly similar terms, which can be summarised as follows:

being totally unable through illness or accident to follow one's own occupation, and not following any other for profit or reward.

C3.10 Nevertheless, more than one-third of companies define the term differently:

* Note: Following tax changes which took effect in April 1996, recipients are generally no longer taxed on benefits paid out by individual PHI plans. (Previously, such income had been taxable from 12 months after the disability.) We understand that, as policyholders will be able to keep most of their benefits as disposable income in future, PHI providers are considering reducing the percentage of pre-disability income to be covered by their policies.

five companies apply the condition shown in paragraph 3.9 for two years only, and then substitute 'any reasonably suitable occupation' for 'one's own occupation';

six companies apply the more stringent 'any reasonably suitable' condition after two years only for those in certain occupations; and

six companies apply the more stringent condition immediately.

C3.11 There is, of course, a subjective element in any ruling about whether disability makes a claimant 'totally unable' to follow a particular occupation, or what might constitute 'any reasonably suitable' occupation. Practices may vary between companies.

C3.12 We therefore recommend that the industry should produce a standard definition of 'total disability'.

Other conditions

C3.13 Other policy conditions can vary considerably between companies, as a summary in the Kluwer survey²⁶ makes clear.

- **AIDS and HIV** - All 46 companies examined have restrictions but 'the wordings show little standardisation'. Seventeen companies exclude disability 'caused' by HIV infection. Fifteen companies have policies which lapse when HIV infection is established. Eleven companies specify that no benefit will be paid once HIV infection has been established but do not state that the contract will be terminated.
- **Deferred periods** - Most companies publish premium rates for deferred periods of 13, 26, and 52 weeks. About half the companies offer rates for a four-week deferred period, and nine offer for a 104-week period.
- **Escalation rates** - These are the rates at which payment may increase over a period of claim. The most commonly available rate is 5% a year, but rates allowable vary from 3% to 15%. Some policies allow increases in line with the RPI and others with National Average Earnings (NAE). A few policies do not provide escalating benefits.
- **Housepersons** - Many policies include cover for people who work as housepersons. Benefits payable to disabled housepersons vary, however, from £1,560 to more than £12,000 a year. Conditions are also set for payment, ranging from confinement to the house to inability to perform at least three or four basic activities.
- **Increase options** - Here the sums insured and the premiums may be increased. There are two basic methods.

In the first, the increases are specified in the original contract and operate automatically - although different companies follow different ground rules. Some provide for set percentage annual increases in premiums and benefits. Others specify increases in line with RPI or NAE, with or without specific percentage limits.

Under the second method, contracts may contain a periodic option to increase the sum insured and premiums by a given percentage. Typically, there might be options to increase the sums insured by 25% or so after three years or five years.

- **Linked claims** - A claimant may recover and return to work but subsequently suffer a recurrence of the same disability. Should that happen within a specified 'link period' then another deferred period will not be imposed. The length of such link periods may be 13, 26, or 52 weeks, depending on the policy.
- **Non-medical limits** - These are the sums to be insured above which companies *automatically* require would-be policyholders to undergo a medical examination. The limits vary between companies. For a 35 year-old taking out a policy with a deferred period of 26 weeks, the non-medical limits vary between £5,200 and £42,000.
- **Occupation** - Almost half the companies surveyed specify that the insurance cover they provide relates to the occupation originally underwritten. Should a policyholder change occupation, that cover will terminate unless the insurer is notified and terms to continue the policy are agreed. Other companies require no such notification, and relate disability to the policyholder's occupation at the time of disablement. In either case, whether advantage lies with the policyholder or the company would depend on the risk-rating and premium tests attached to the occupations involved.
- **Proportionate benefit** - Where a claimant takes up employment in an occupation different from that held at the time of disablement, the continuing benefit is usually reduced in proportion to the ratio of the earnings in the new job to those in the original job. Some companies allow for inflation. A few limit pay-outs of proportionate benefits to periods ranging from six months to two years.
- **Rehabilitation and partial benefit** - When a claimant is no longer *totally* unable to follow the original occupation and returns to work in a reduced capacity, the benefit payable is usually calculated in the same way as proportionate benefit. But some companies impose extra conditions or restrict such payments to a period of between 26 weeks and two years.
- **Residence** - Cover may be extended for residence in different countries. The Kluwer survey comments, however, that 'there are almost as many variations as there are companies transacting business'!

- **Unemployment** - More than half the companies examined provide no cover at all if a policyholder is not engaged in a remunerative occupation immediately prior to disability. Other companies' practices vary widely. Some continue to provide cover, but increase the deferred period. Others continue cover but impose a restricted definition of disability - this might for example, necessitate confinement to the house, or the inability to carry out at least three basic activities. Yet other companies continue cover for a limited period, although usually with a reduction in the maximum benefits.
- **Special features** - In addition, many PHI providers have three or four conditions that are either unique to themselves or limited to a very few companies. A hospitalisation benefit, a long-term care benefit, loaded premiums for smokers, and no additional loadings for women provide some examples.

Assessing the product and making comparisons

C3.14 Anyone who is considering whether to purchase a PHI policy is thus faced with a range of companies who impose a large number of varied conditions. The choice can be bewildering.

C3.15 Even the premiums payable have different names. Some policies have an investment element, in which case the charging policy and the investment performance of the insurer will be an important consideration. The benefits payable follow a similar pattern but here again there are variations which could be of crucial importance to individual policyholders. The disability conditions can be stringent, and there is little assurance that they will be interpreted consistently.

C3.16 Other considerations apart, increases in benefits insured and premiums can vary substantially between companies, as can escalation rates for claims in payment. Cover for periods of unemployment, where it exists at all, takes every conceivable shape. Conditions on residence and special features may also be important.

C3.17 Taking account also of the wide range of premiums charged by different companies, it is clearly not easy - and perhaps impossible - for consumers to make rational choices between the products on offer.

C3.18 Some commentators believe the very complexity of PHI products is a key factor in the falling sales that have been experienced in recent years.

‘PHI is a flawed product and will never appeal to the mass market unless some fairly radical changes are made.’¹¹

‘The conclusion has to be that the PHI product needs an overhaul.’²⁷

C3.19 There is obviously a balance to be struck between reducing confusion in the market and providing a range of products to suit individuals' needs and preferences. We judge, however, that at present the level of diversity is undesirably high.

A PHI `benchmark product'

C3.20 We were told that some PHI companies had met to discuss taking steps towards the standardisation of at least some of the many conditions that govern their products. The discussions had not progressed however because individual companies had not been prepared to concede that their own particular approach might not be the best.

C3.21 There might be increased customer confidence in PHI and the protection it offers, not least through the provision of the means to compare different products more easily, were the industry to devise a `benchmark product', setting out the main elements of PHI and defining the relevant conditions. As an illustration of the sort of thing we have in mind, such a benchmark might incorporate the following features.

- Premiums would be set for a five-year period, although providing for automatic increases in both premiums and benefits in line with NAE.
- Benefits payable under the policy would be limited to $x\%$ of pre-disability income, less state benefits.
- There would be a standard definition of `disability', and tests would be on a consistent basis.
- There would be a standard deferred period of 26 weeks (with perhaps also a standard period of four weeks for the self-employed).
- There would be no time limits on proportionate and partial benefits.
- Should a policyholder become unemployed, cover would continue for six months, but payments would be subject to a deferred period of six months or one year.
- Any claims in payment would rise each year in line with RPI.

C3.22 Such a benchmark would be designed purely as a protection product, and so it would not provide any element of additional bonus from investment performance.

C3.23 Once a standard basic product on these lines had been devised (with appropriate premiums determined by market forces), commentators, advisers and consumers would be better placed to judge whether any variations from it - which provided for investment returns, for example - would justify the extra premiums charged.

C4 PROMOTION METHODS

C4.1 Promotional literature on PHI produced by some companies appears to be potentially misleading. In particular, statistics from government sources are quoted in ways which may exaggerate the case for taking out PHI.

The chances of being off sick and of dying

C4.2 `Recent DSS statistics show that working men aged 20-65 are over seven times more likely to become incapacitated and be off work for more than six months than to die during those ages.' In support of this claim, the company making it provided Department of Social Security statistics showing that, in 1990, 671,000 men between the ages of 40 and 64 were off sick for more than six months, whereas 62,320 in the same age group died in that year.

C4.3 Taken at face value, the company's statement is true. If, however, anyone were to draw the inference that an average man was seven times more likely *to need PHI* than to die, that would be false, for the following reasons.

- Of the 671,000 men who were off sick, some 309,000 were in employment immediately prior to claiming benefit, 48,000 were self-employed, 310,000 were unemployed, while the status of the remaining 4,000 is unknown. As most policies require claimants to be in employment on disability, nearly half those off sick would simply not qualify for PHI.
- Some of those who were in work before becoming disabled would have had incomes insufficiently above the state benefits to get much of a return from PHI.
- About 50% of employees are covered by long-term Occupational Sick Pay schemes. In many cases, benefits are payable for more than a year, in others until retirement.²⁸

Being off sick during your working life

B4.4 `During their working lives, one in five people will be unable to work due to long-term sickness for a period of longer than three months.' Again, taken literally, this may well be true. But the inference that there is a 1 in 5 chance of needing to claim on a PHI policy would almost certainly not be true.

- Policyholders might not be in employment immediately prior to disability, and if so would probably not qualify for PHI benefits.
- The period of illness may well fall entirely within the deferred period which, in the case of the company quoted, `is normally 26 weeks'.

- Policyholders might have an income insufficiently above the state benefit levels to get much of a return from PHI.
- Depending on their age group, blue-collar workers are 50%-70% more likely to have a long-standing illness than white-collar workers, but premiums for such workers are often unaffordably high.¹¹
- About 80% of employees will receive short-term Occupational Sick Pay from their employers, in addition to Statutory Sick Pay, for the first 28 weeks of a disability.
- About 50% of employees would also be covered by long-term Occupational Sick Pay schemes.

C4.5 While statements like those quoted may well be accurate in a literal sense, they could mislead readers when directly coupled to a sales message in the context of a PHI brochure. In particular, the DSS statistics on which they are based apply to *all* workers whereas about 85% of PHI policies are sold to occupational groups 1 and 2. These groups are composed largely of white-collar workers who run a lower-than-average risk of becoming disabled. Those with higher risks would frequently not be able to afford PHI. Such statements also ignore how PHI policies interact with state and employer sick pay schemes.

C5 THE MORATORIA APPROACH TO UNDERWRITING

- C5.1 As indicated in paragraph 2.10, PHI providers take a rigorous approach to underwriting, and around 25% of proposals are rejected or subject to special conditions.²⁵
- C5.2 It has been claimed that the demanding underwriting process, which may sometimes involve delays of between three to four weeks, is one of the factors responsible for the fall in PHI sales over recent years. There is little hard evidence to support the claim, yet two companies have decided to short-cut the procedure by adopting the moratoria approach to underwriting.
- C5.3 As discussed in Part B, in connection with PMI, under the moratoria approach policyholders do not have to undergo advance medical checks. Any claim they might make, however, would be rejected if treatment for, or advice about, the condition in question, or a pre-existing related condition, had been given within a set period before the claim was made (typically two years).
- C5.4 From the insurer's point of view, this approach makes for a product that is much easier to sell. But from the consumer's viewpoint it has significant drawbacks.
- C5.5 Given the high proportion of proposals rejected under 'normal' underwriting, it follows that with the moratoria approach a similar number of policies could effectively be terminated at the time of claim. Many policyholders might then discover that they had been paying premiums which were virtually valueless.
- C5.6 In addition, consumers may not understand the approach, or they might be unclear whether any possibly related condition could exclude them from benefit. It is very likely that such uncertainties would be resolved only after a disability had arisen - hardly the time to inform policyholders that they will not get the support they had counted on.
- C5.7 With PHI, the potential problems are more severe than under PMI. When PMI policyholders' claims are rejected they would normally have to fall back on the NHS or - provided they could afford it - meet the cost of the treatment required out of their own pockets. While that may mean delay, further expense, or treatment under less satisfactory conditions, it is likely that they will ultimately be treated. For PHI subscribers, however, rejection of a claim after they had suffered a disability could affect their standard of living for many years. Where PHI is concerned therefore, the moratoria approach appears to be a particularly poor deal for consumers.

C6 OVER-INSURING

C6.1 One curiosity of PHI is that policyholders' premiums commonly provide for a potential benefit which is greater than that paid out at the time of claim.

- In the UK perhaps 30% to 40% of PHI claimants have their insured benefits reduced by at least some degree. A fact which is rumoured to have been noted by the OFT in their ongoing investigations into healthcare and is one which, somewhat surprisingly, has not received any significant attention in the press.²⁹

C6.2 This phenomenon of over-insuring arises because premiums are related to a benefit which is typically calculated as 75% of expected income less state benefits. In simple terms, if a policyholder's expected annual income was £19,000 and annual state benefits were £3,000, then the annual insured benefit would be 75% of £16,000, that is £12,000.

C6.3 In practice, the policyholder's expected income often turns out to be less than had been assumed.

- It may simply have been set at too high a level when the policy was purchased. Both the salesman, with commission levels in mind, and the customer, misguidedly, might make an optimistic guess at future income - 'typically the insured's income is not checked at outset, and is only queried when a claim is made'.³⁰
- Uncertainty about future income is perhaps strongest among the self-employed, and among those whose income is very dependent on bonuses and overtime payments. Indeed, the self-employed present a particular problem because of the incentive for tax purposes for them to minimise their declared income, whereas for PHI purposes the maximum income is more beneficial. The position is not helped by the differing views taken by insurance companies about what should be counted as 'income' for the self-employed. In a survey of 34 companies, 13 did not separately define the term for self-employed people, nine used 'net relevant earnings', two used 'net profit', and three based their definitions on recent earnings at different periods.³¹
- Many policies have built-in annual increases of, say, 5% in premiums and benefits assured. If the policyholder's income does not in fact rise as fast as the built-in additions, over-insurance will result.

C6.4 The sums involved in 'extra' premiums for over-insurance may be substantial. If say 35% of the estimated 1 million individual holders of PMI were paying premiums of £300 a year of which £75 was in over-insurance, then some £25 million a year may be paid in 'wasted' premiums. If there is also some over-insurance in group PHI the total of wasted premiums would be higher still.

- C6.5 One insurance company commented to us that it was 'disturbing that many people are paying premiums for benefits they can never receive'. Other insurers spoke of efforts to improve consumer understanding, but in general we found that there was no great concern among insurance companies about over-insuring.
- C6.6 When pressed, insurers did speak of possible annual checks but with little enthusiasm. Nevertheless, such checks, and a possible refund system, would seem to be a fairer way of dealing with customers.
- C6.7 At present it seems that a policyholder's income may often be checked only at the time of claim, with perhaps a 1 in 3 chance that benefits paid for will be adjusted downwards on pay-out. But if actual income proves to be *higher* than estimated income, the benefits paid out are not increased. In sum, the arrangements amount to a one-way benefit for the insurers, arising from the insured having paid superfluous premiums. Of course, it may be that this over-insurance is reflected in a lower level of premiums for all subscribers, but at very least this redistributive effect is somewhat haphazard in its effect on individuals. In general terms it will tend to benefit those with predictable earnings growth and penalise those whose earnings are more erratic. Such people are also likely to have less access to other forms of protection such as sick pay from employers.
- C6.8 Can such outcomes be avoided? The first line of defence must be a proper fact find when policies are sold. In addition, annual checks of the benefit insured against the benefit payable could doubtless reduce the volume of over-insurance. Nevertheless, many consumers might find it difficult to make the necessary adjustments without advice, while advisers might not be keen to take steps that could reduce their commissions.
- C6.9 A further possibility would be to build into policies periodic reviews of past insured benefits against payable benefits, with consumers being told that proof of past income could result in refund of benefits. The fairness of such a refunding scheme could well improve the attractiveness of PHI.

C7 CONCLUSIONS AND RECOMMENDATIONS

C7.1 'Permanent Health Insurance' is a misnomer for a product which is really an income protection plan on disability. As such, the product has clear attractions, perhaps particularly for the self-employed, and for those whose employers do not offer long-term protection.

Complexity of the product

C7.2 Yet sales of individual PHI plans have fallen. One concern, widely expressed, is that the complexity of the product may deter consumers. With variations in types of premiums, benefit terms, and disability definitions, and variations in a dozen other points of potential importance, PHI is not easy to understand, and PHI products are virtually impossible to compare. PHI thus presents a sharp contrast to the simpler, and generally better-selling, life-insurance products.

C7.3 We recommend that the PHI industry, possibly through the ABI, produce a standard definition of 'total disability' and also take steps to draw up a standard PHI 'benchmark product', with the key features clearly and simply described. Any additions that were made to such a product by individual companies could then be compared against any resultant extra premiums.

Promotions

C7.4 Statements like 'more people are off sick long-term than die', or that 1 in 5 or 1 in 6 'will be off sick long-term', may imply, misleadingly, that there are similar chances that you need and will receive PHI protection. In practice, the chances could be much lower if you are a white-collar worker or if state and employer protection is taken into account.

C7.5 We recommend that questionable promotions like '1 in 5' be dropped, and that instead PHI providers should make more efforts to explain how PHI interacts with state and employer sick pay schemes.

The moratoria approach to underwriting

C7.6 As in the case of Private Medical Insurance, the moratoria approach to underwriting provides insurers with an 'easier sell' but has drawbacks for consumers. These are much more severe than with PMI. With perhaps 25% of PHI proposals being rejected under 'normal' underwriting, the moratoria approach means that a significant proportion of those consumers who are affected will pay wasted premiums, and will suffer the loss of potentially large financial cover at the onset of a disability.

C7.7 We recommend that the moratoria approach to underwriting be dropped for PHI.

Over-insuring

- C7.8 One feature of PHI is that the benefits that are paid out may well be less than the anticipated benefits that have been paid for. This shortfall arises because policyholders' actual incomes frequently do not meet earlier expectations. Whether this is because such expectations were pitched too high or because realistic forecasts remained unfulfilled, the arrangements invariably favour insurers, and the insured end up having paid large sums in wasted premiums. Not surprisingly, perhaps, PHI providers appear to have done little to make the arrangements fairer.
- C7.9 Shortfalls might be reduced by annual checks of actual incomes against expected incomes. Nevertheless, greater fairness could be seen to be achieved through the introduction of periodic reviews that made provision for the refund of overpaid premiums.
- C7.10 **We recommend that the PHI industry, possibly through the ABI, should tackle the problem of over-insuring, through which the PHI providers collect excess premiums. There should be a proper fact find when policies are sold. In addition, annual checks could reduce shortfalls, but a system for refunding such premiums could be a fairer solution.**

PART D: CRITICAL ILLNESS INSURANCE

D1 INTRODUCTION

- D1.1 Critical Illness Insurance (CII) provides for the payment of a lump sum on the diagnosis of a critical illness (such as cancer, a stroke, or heart attack) or when certain medical procedures are carried out. Some policies provide for payment on diagnosis of any of eight critical illnesses or conditions. Others provide for payment on as many as 32 conditions.
- D1.2 CII is a product first developed in South Africa in the 1970s. At around the same time attempts in the UK to sell insurance against cancer were largely unsuccessful, evidently because, although they were afraid of contracting the disease, people did not want to be reminded of it. There was, however, much less resistance in 1986 when CII policies were introduced to the UK - more broadly based and with a new name.
- D1.3 The case for taking out CII depends on an assessment of three factors: first, the likelihood of contracting a critical illness; second, the chances of surviving that illness; and third, the consequences of the illness for the individual's personal finances.

Contracting a critical illness

- D1.4 In their promotional literature, providers of CII commonly quote statistics like the following.³²
- A man aged between 20 and 40 who is in good health has a 1 in 7 chance of suffering a heart attack, a 1 in 11 chance of developing cancer, and a 1 in 4 chance of developing a critical illness before reaching the age of 65.
 - A woman aged between 20 and 40 has a 1 in 5 chance of contracting a critical illness before the age of 65.
 - Every year in the UK more than 130,000 people suffer a stroke.
 - Every year 150,000 people have their first heart attack.

Surviving a critical illness

- D1.5 CII policies generally require policyholders to survive a critical illness either for 14 or 30 days (depending on the condition, and the chosen policy). The longer they survive, the longer the period of potential financial need will be. Some relevant figures can be given.

- Of every 100 individuals who have a heart attack, 78 will reach hospital alive, and 57 will be alive a year later.
- 35% of men and 46% of women who contract cancer will be alive five years later.
- Almost 70% of stroke victims survive for at least 12 months.

Possible difficulties for CII providers

- D1.6 Changes in medical practice have increased the frequency with which the procedures specified in CII policies are carried out. In the case of some conditions this has led to earlier and more perceptive diagnosis. These developments have prompted some commentators to question whether CII will continue to be viable if cover is not restricted to those whose life expectancy *is* likely to be seriously compromised in a given situation.
- D1.7 Plainly, there are significant difficulties in achieving such a restriction. In recent years, the perception of CII as providing cover only for terminal or life-threatening conditions has become muddled. Marketing has increasingly emphasised survivability, while product design has multiplied the number of conditions listed for cover. On occasion, CII seems to be presented as being somewhat akin to PHI, with a cash lump sum - financed by investment - providing disabled policyholders with a form of income replacement.

D2 THE CII MARKET

Sales

- D2.1 Overall, the total number of individual CII policies in force in 1994 was around 650,000. Sales of such policies rose sharply from 132,000 in 1991 to 302,000 in 1995. There are now more than 60 companies in this market. In 1995, the highest sales were achieved by Standard Life (30,251), Scottish Amicable Europe (29,467), Allied Dunbar (29,224), AXA Equity & Law (26,270), and Barclays Life (24,702).²⁴
- D2.2 Group sales of CII were much lower, and only 64 new group schemes were set up in 1995. In this part of the report however, as in other sections, we are primarily concerned with policies sold to individual consumers.
- D2.3 More than two-thirds of CII sales in 1995 were made by the providers own sales teams, with an estimated 31% being sold through independent financial advisers (IFAs).²⁵ That proportion had, however, risen from 14.9% in 1993. Like other life products, many policies are now sold with mortgages, the aim being to complement traditional life cover.
- D2.4 The average sum assured for new sales in 1995 was £40,023. That is lower than the comparable figures for 1994 (£43,880) or 1993 (£44,896). The reduction reflects the increasing proportion of sales made as a rider to endowment policies, where the sums assured are generally lower.²⁴

Purchasers

- D2.5 About 67% of CII purchasers are in the ABC1 social groups. (These groups themselves account for 45% of the population as a whole.)
- D2.6 Some companies suggested to us that fear had been an important factor in the purchase of CII, although sales promotion was now placing greater emphasis on coping with survival of a critical illness. Nevertheless, the questionable practice of selling through fear evidently continues.
- `While selling by fear should not be condoned, research commissioned by Guardian Financial Services in 1994 showed that IFAs who have been successful in selling critical illness do consider fear as a major persuasion factor in the selling process, enabling clients to relate to financial problems associated with a critical illness and the first-hand experience of those who had seen a close relative or friend who has suffered such an illness. Statistics on the incidence of illness such as cancer, heart attacks and strokes are readily available and can form the basis for successful mailshots and sales aids'.³³
- D2.7 Others indicated that selling on fear had switched off many consumers in the past, and that a combination of factors now lead to CII sales. These are:

personal greed - you suffer the heart attack; you get the cash,

overcoming nightmarish problems - a cash lump sum is one of few silver linings if you suffer a critical illness, and

meeting a real need. Pegasus director, Dr Marius Barnard, eloquently argues that, as a medical doctor, he can repair a man physically, but only insurers can repair his finances.³⁴

D2.8 Viewed analytically, it is hard to see why a lump-sum payment at the point when illness strikes should be the right solution to many consumers' needs. These will in fact vary depending on circumstances.

- In some cases (such as terminal cancer), life expectancy may be very limited. For many the principal concern will be the position of dependents after death, and their needs might best be met by a conventional life policy.
- In others (such as strokes) the need may be for long-term care, which might be better met by an LTCI policy.
- In yet others (such as heart attacks) the main impact may be on earnings potential and might best be met by a PHI policy.

D2.9 It is very possible - though we have no direct evidence - that it is the very diversity of possible needs that makes CII attractive. A lump sum offers flexibility over a range of possible circumstances that consumers may mentally group together as similar threats.

D2.10 Most CII cover is sold as a 'rider' (an add-on) to life assurance or endowment policies. The sum assured - or, depending on circumstances, part of it - is paid out on the diagnosis of a critical illness or, where there has been no such prior diagnosis, on death. In 1995, 48.4% of new cover was sold as a rider to mortgage-related endowment policies, 3.4% as a rider to set-period ('term') life insurance, and 33.8% as a rider to open-ended ('whole of life') assurance policies. Stand-alone policies represented only 17.7% of new CII sales overall.³⁴

Premiums

D2.11 Premiums vary considerably between different CII plans, doubtless partly reflecting the differences in the cover they provide. They also differ according to the sex and medical condition of the individual policyholder and rise steeply with age.

TABLE D1 - CCI: VARIATIONS IN PREMIUMS

	<i>Monthly premiums for five-year stand-alone policies</i>			
	<i>Man aged 30</i>	<i>Man aged 40</i>	<i>Woman aged 30</i>	<i>Woman aged 40</i>
	<i>£</i>	<i>£</i>	<i>£</i>	<i>£</i>
Range of premiums	13-23	35-65	16-30	32-54

Source: *Health Insurance Monitor*, May 1994

D2.12 As Table D2 indicates, premiums continue to increase sharply after the age of 40. The levels of the premiums shown are guaranteed for a 10-year period and provide for £100,000 of critical illness cover.

TABLE D2 - CCI: TYPICAL INCREASES IN PREMIUMS WITH AGE

<i>Non-smoking man attained age</i>	<i>Monthly premiums £</i>
30	14.65
40	36.85
50	83.28

Source: A leading CII provider

Underwriting

D2.13 Companies told us that perhaps 10%-15% of applicants were rejected, although those under 40 not seeking high cover would generally face few problems.

Claims

D2.14 As Table D3 shows, two conditions alone, cancer and heart attacks, account for about three-quarters of all CII claims, while five conditions account for 94% of claims.

D2.15 About 20% of all CII claims are rejected. Where claims are made on grounds of total permanent disability, a stipulation of many CII policies, more than two-thirds of claims are rejected. A substantial proportion of claims result from a misunderstanding of the policy conditions which, in particular, often define 'total permanent disability' as being unable to continue *any* occupation, rather than the policyholder's *own* occupation. Clearly, consumers frequently do not appreciate this distinction.

TABLE D3 - CCI: PERCENTAGE OF CLAIMS BY CONDITION

<i>Condition</i>	<i>%</i>
Cancer	49.0
Heart attack	27.0
Stroke	9.0
Multiple sclerosis	4.7
Coronary artery bypass surgery	4.4
Other	<u>5.9</u>
	100.0

Source: Employers Re figures in *Health Insurance Monitor*, September 1995

Redress

D2.16 Policyholders can now pursue CII claims with the PIA Ombudsman, if they are unable to gain satisfaction from the relevant provider.

Regulation

D2.17 The PIA's consideration of possible regulation of PHI could presumably extend to CII.

D3 COMPARISONS BETWEEN CII PRODUCTS

- D3.1 As indicated in Table D3, five medical conditions account for more than 90% of CII claims. The National Federation of Independent Financial Advisers (NFIFA) has recognised the importance of a relatively small number of illnesses or procedures in this area by drawing up a series of standard definitions. These cover: cancer; heart attack; stroke; kidney failure; major organ transplants; and coronary heart bypass surgery.
- D3.2 Although CII claims are dominated by five conditions, the addition of others has become a common feature in many policies. Outside those conditions specifically defined by the NFIFA, they may include (in no particular order): multiple sclerosis; paralysis; paraplegia; loss of limbs; loss of speech; loss of sight; loss of hearing; aorta surgery; heart-valve surgery; AIDS through blood transfusion; AIDS cover for medical professionals; terminal illness (not specifically defined); Hodgkin's disease; burns; Alzheimer's disease; balloon angioplasty; benign brain tumours; coma; degenerative diseases; insulin-dependent diabetes; loss of independent existence; motor neurone disease; open-heart surgery; Parkinson's disease; rheumatoid arthritis; total permanent disability to follow one's own occupation; and total permanent disability to follow any occupation.
- D3.3 Consequently, as shown in Table D4, the number of conditions covered by the CII policies now on offer varies widely.

TABLE D4 - CII: NUMBERS OF POLICIES BY NUMBERS OF CONDITIONS

<i>Number of conditions</i>	<i>Number of policies</i>
0-10	11
11-20	16
21-30	26
31-32	12

Source: '1995 FPR health care survey', *Money Marketing*

- D3.4 When we examined this situation more closely, it became clear that even policies providing for the same *number* of conditions covered a differing *selection* of conditions. Thus the four policies offering cover on 10 conditions had only seven in common, while the two policies with 21 conditions had only 15 in common. The situation is further complicated by overlap between some conditions. Where total permanent disability is included, cover is available for at least the later stages of certain other conditions - such as motor neurone disease.

D3.5 Some providers and IFAs selling such policies readily acknowledged that the larger number of conditions designated is essentially a marketing gimmick, whereas others sought to defend the additions as a genuine extension of cover. Analysts plainly often felt frustrated and their comments were generally negative.

- `It is difficult to see what other new conditions can be added to critical illness policies without making them so complicated that policyholders become even more confused than at present.¹³³
- (In a CII survey) `We have deliberately not included any premium comparisons because increasingly these are becoming impossible on a true like for like basis.¹³⁴

D3.6 If the analysts find it impossible to compare products, we may assume that advisers and, more particularly, consumers can have little idea which product would represent a personal `best buy'. Yet premiums vary substantially - often for no obvious reason - and making the wrong choice could prove to be very costly in terms of higher monthly outgoings for less practical benefit. In these circumstances, it is difficult to accept that market forces could work effectively to eliminate those products which offer consumers poor value.

A CII `benchmark product'

D3.7 For marketing purposes, CII providers produce statistics on the chances of particular individuals getting cancer, suffering a heart attack or a stroke, or getting any critical illness before the age of 65. Consumer choice would be much improved if similar statistics were used to differentiate between the various CII products themselves.

D3.8 As a possible basis for comparison, a `benchmark product' could be drawn up based on the five or six conditions (cancer, heart attack, stroke, coronary artery bypass surgery, multiple sclerosis, and, perhaps, total permanent disability) which give rise to the vast majority of claims. The chances of these conditions being diagnosed could be shown for each and on an overall basis.

D3.9 Companies would price such a benchmark product according to their own actuarial assessments and according to their individual marketing aims.

D3.10 Where companies offered any products that varied from this benchmark - typically by making provision for other critical illness conditions - their sales literature could include a statement of the chances of incurring those conditions. Consumers could then make up their minds whether the perceived risks merited the additional premiums charged for an enhanced product. This would of course be a matter of individual choice; some consumers might be more concerned about particular conditions than their statistical incidence would suggest. This would allow for the fact that individual attitudes are often

moulded by personal experience, for example by having known someone who had suffered from one of the specified conditions.

D4 SALES ON AN ACCELERATION BASIS

D4.1 The bulk of CII sales are on an 'acceleration' basis. That means that they are linked with life cover in endowment, term, or whole of life policies so that a lump sum will be paid on either diagnosis of critical illness or death, whichever comes first.

TABLE D5 - CCI: SALES BY POLICY TYPE

<i>Type of policy</i>	<i>Sales</i>	<i>Average sums assured £</i>
Free-standing	53,661	52,030
Acceleration:		
term	10,321	86,249
whole of life	91,956	52,537
endowment	146,316	32,940
<i>Totals</i>	302,245	40,023

Source: *Healthcare Insurance Sales: Current Trends and Future Influence* - 1995 statistics, LIMRA and M&G

D4.2 For CII providers, and salesmen, the attraction of CII cover is that the premiums are typically two or three times higher than those for term insurance. Accordingly, a free-standing CII is a more profitable sell than traditional term insurance. But consumers do recognise the merit of life cover, whether this is in the form of an endowment policy, or is restricted to a set period or 'term', or is an open-ended 'whole of life' policy - under any of which their dependents are provided for. Salesmen therefore present the merits of CII and life cover for dependents within a single policy package. The premiums and commissions payable are, however, much higher than those on ordinary term policies, or those attributable to the life-cover element in other policies.

D4.3 The 'either/or' basis of such acceleration policies generally means that, should a critical illness be diagnosed, the whole lump-sum benefit is paid at that time. There is no restriction on how that money should be spent. Even pay-outs on mortgage-linked endowment policies may be retained for personal use, not necessarily used to pay off mortgage liabilities. But however a policyholder spends the lump sum - whether on medical or other support, or simply to enjoy what period of life may remain - then there will be no additional benefit payable to dependents at death. To obtain new life cover while suffering from a critical illness would be impracticable (although see paragraph D4.9). Anecdotal evidence suggests that many policyholders do in fact spend the money in ways which will benefit dependents, typically by paying off their mortgage.

D4.4 There does, however, remain a risk that two legitimate aims - protecting dependents and providing for a policyholder with a critical illness - will become confounded. In these circumstances it may well be dependents that suffer.

D4.5 Several companies have recognised this problem and have taken action to meet it, at least in part.

- `Some companies allow the sum assured to be split according to the policyholder's needs so that, for example, only 60% of the lump sum is paid out for a critical illness claim, leaving the other 40% in place as a death benefit . . .'²⁷

D4.6 The `acceleration' problem has been recognised in the USA, where acceleration of life insurance pay-outs is allowed not only for critical illness but also where a need for long-term care is established.

D4.7 In the USA, the National Association of Insurance Commissions has created an Accelerated Benefits Model Act 1991 to ensure the fair development, marketing, sale, and application of accelerated benefits policies. In particular, the Act requires:

disclosure, at the time of application, of any effect of the benefit payment on the policy's cash value, premiums, death benefit, and the like; and

the written consent of the beneficiaries under the life policy to any acceleration of the benefit.

D4.8 A survey of individual states showed that of the 38 that responded, 30 regulated accelerated benefits in a number of further ways.

D4.9 In Australia the acceleration problem has been tackled by allowing policyholders to pay an extra premium enabling them to `buy back' life cover usually in stages, beginning 12 months after a critical illness claim has been paid. Typically, policyholders who have received a CII payment for a condition which is not diagnosed as terminal may be offered the opportunity to purchase pure life cover of one-third of the amount paid out in the CII claim on each of the first three anniversaries of the CII payment being made. The 12-month deferral period on this option significantly reduces the additional premiums payable, as mortality rates for critical illness sufferers are particularly high during the first 12 months after claim. A similar approach has been adopted in South Africa.

D4.10 It appears that acceleration has been seen as a problem, and four approaches to tackling it have been identified:

selling CII and life cover separately;

providing split benefits on joint products - for example, 50% on the diagnosis of critical illness and 50% on death, or 100% on death where there has been no critical illness;

introducing an option to pay a higher premium to `buy back' life cover, as in Australia; or

requiring beneficiaries to consent in writing to any acceleration before any benefit is paid.

D4.11 Selling CII and life cover would be unattractive to salesmen - and to many product providers. More importantly, it would be more expensive for consumers and we do not believe that we would be justified in seeking to constrain the market in this way.

D4.12 The payment of split benefits may be attractive to some consumers, but others might find they had purchased a product which, in trying to do two things, did neither of them satisfactorily.

D4.13 We do not find the idea of beneficiaries' consent to any acceleration at all attractive. First, it runs counter to the normal assumption in UK law that someone of sound mind is free to dispense of their money as they think fit; it is up to them whether they spend it during their life or pass it on to their heirs. Secondly, it would put intolerable moral pressure on beneficiaries and hence on family relationships. (Particularly difficult problems will arise if the beneficiaries are minors where someone else will be forced to balance their interests against those of the policyholder).

D4.14 We believe that the Australian approach best meets the real needs of someone who has survived a critical illness - and perhaps has needed money to pay for their own care - to be able nevertheless to provide for their dependents. We recommend that this approach should be studied for adoption in the UK.

D5 CONCLUSIONS AND RECOMMENDATIONS

- D5.1 Although only five conditions account for some 94% of all CII claims, marketing considerations have led companies to leapfrog over each other by offering policies covering more and more critical conditions. Currently some policies offer cover for as many as 32 conditions, and conceivably more could be added.
- D5.2 Consequently, even the health industry's own analysts find it impracticable to make valid comparisons between CII products. In addition, the differing charges and allocation rates of surrender penalties of those products with investment elements serve to confuse the issue even further. Yet the premiums of the various products available differ widely, and consumers could easily end up paying much more for a product providing no significantly greater benefits than those of a cheaper policy.
- D5.3 **We recommend that the CII industry, perhaps through the ABI, should draw up a CII benchmark product based on the five or so conditions which account for 95% of claims. The chances of suffering those conditions separately and overall should be disclosed - as they frequently are for marketing purposes. Any variations from that benchmark product, for example by the addition of other conditions, could then be judged by comparing the stated chances of suffering the extra conditions, and the resultant increase in premiums.**

Separate or accelerated claims

- D5.4 Although about 20% of CII sales are on a stand-alone basis, most are tied to endowment, term or whole of life policies. Such 'accelerated' packages mean that the lump sum assured could be paid out when a policyholder is afflicted by a critical illness. Dependants might then be left without the life cover benefits they had expected to receive from the coupled insurance policy.
- D5.5 **We recommend that the CII industry, perhaps through the ABI, should recognise and address the problem of the loss of life-cover benefits for dependants when a critical-illness benefit is triggered within an accelerated policy. One solution might be to provide the option of a higher premium to buy back life cover, as in Australia. But, in any event, everyone taking out a CII policy should be made completely aware of the basis on which cover is provided, in particular the fact that payment for a critical illness will reduce or even eliminate the benefits payable at death.**

E: LONG-TERM CARE INSURANCE

E1 INTRODUCTION

- E1.1 Long-term care insurance (LTCI) was first introduced in the UK in 1991, shortly after the passing of the National Health Service and Community Care Act 1990, which was implemented in 1993. Already LTCI plays an important role in the debate as to who should pay for the long-term care needs of the growing very elderly section of the UK population. The purpose of this report is not to enter this debate, but to examine the value for money of LTCI for consumers.
- E1.2 Some five years after the introduction of LTCI, there are only eight companies active in this market, and sales have been low. There is an atmosphere of 'wait and see', not only to watch whether the products sell better, but also whether the Government will make the products more attractive, perhaps through 'partnership' initiatives. The consultation paper *A New Partnership for Care in Old Age*, launched in May this year, does indeed propose partnership initiatives and has gone some way towards informing consumers and the market operators. The proposals are, however, in tentative form and the situation will remain uncertain at least until any relevant legislation has been enacted.
- E1.3 This report looks at possible future care needs, the effects of the National Health Service and Community Care Act, the LTCI products on offer, and the factors which consumers might consider before purchasing LTCI. It considers in the light of such factors, what selling practices might be encouraged.

E2 CARE NEEDS AND PROVIDERS

*'Most people move fairly quickly from being well able to look after themselves to dying, but a significant proportion, between a third and a sixth, require some form of care.'*³⁵

Care needs

E2.1 The very elderly are expected to account for an increasing proportion of the UK population. The Government's consultation paper forecasts that by the year 2030 the number of people over 65 will be 50% greater than it is now, and the number of those over 85 will be 64% greater.

E2.2 The UK is not alone in having a growing elderly proportion of its population as shown by a comparison with other countries in the European Community (see Table E1).

**TABLE E1 - PERCENTAGES OF POPULATION AGED 65 AND OVER
IN SELECTED EC COUNTRIES**

<i>Country</i>	<i>1995</i> <i>%</i>	<i>Projected</i> <i>2020</i> <i>%</i>
Belgium	16.1	21.8
Denmark	15.3	18.3
France	14.9	20.6
Germany	15.3	20.6
Luxembourg	14.2	19.3
Netherlands	13.2	18.3
UK	15.8	19.2

Source: Eurostat

E2.3 The chance of a person being disabled increases significantly with age (see Table E2). (The chances of females being disabled and requiring care are higher. LTCI premium rates for women reflect this.)

E2.4 It is therefore not surprising that the likelihood of needing residential care rises with age. In England and Wales, 1% of 65-74 year-olds are in residential care, 5% of 75-84 year-olds, and 21% of those aged 85 or more.³⁶ Residential care is here defined as care in a residential home, a nursing home or a hospital. It does not include places in sheltered housing schemes or informal care provided at home by family or friends.

TABLE E2 - PERCENTAGES OF AGE GROUPS DISABLED

<i>Age range</i>	<i>% disabled to some degree</i>
16-59	6
over 60	36
over 85	78

Source: *Long Term Care for the Elderly*, ABI, 1995

Types of care

- E2.5 Most long-term care is informal care provided by the family and others close to those cared for. In 1985 it was estimated that 6 million people in Great Britain were involved in giving informal care, 1.3 million of them for over 20 hours a week.³⁷
- E2.6 Various concerns have been expressed about the continued provision of 'informal care' - that is, care by family or friends in the home. Some have argued that as women become increasingly economically active they are no longer able to play a traditional role as provider of informal care for elderly relations; some fear that divorces and single-parent families will weaken the family complex. But as some commentators point out, however, there is little evidence at present to support some of the more extreme predictions.
- E2.7 Formal care may take the form of day and domiciliary services (such as meals on wheels, district nursing, or day-centre places), or full-time residential care. 'Around 1 million people [in the UK] receive day and domiciliary services and around 500,000 people are in residential care, two thirds of them in residential care homes and one third in nursing homes. The National Health Service [in England] has around 55,000 beds for elderly people (including elderly people with mental illness)'.³⁶
- E2.8 The independent sector provides nearly 30% of the domiciliary care and just over half the residential care funded by social services authorities, and its share in both types of service is rising.³⁶ The NHS also purchases some places in independent nursing homes. In addition, some people arrange their own care, or it is arranged by family or friends on their behalf; this is most likely to be in the independent sector.

The costs of care

- E2.9 Within the UK, the costs of residential and nursing home care vary between regions. In November 1994 the average cost over the UK as a whole for a place in a residential home was £12,000 a year, but for London it was £16,000. The corresponding figures for nursing-home care were £17,000 a year for the UK overall and £21,500 for London.³⁸
- E2.10 The average length of stay in a residential home has been estimated at around three years. Nearly 25% of residents, however, are thought to stay for four years or longer. For

nursing homes, the average length of stay is estimated at around 1.5 years, with around 10% of residents staying for four years or longer.³⁶ No doubt these figures include some patients who progress from a residential home to a nursing home and whose total period in care is therefore quite long.

The National Health Service and Community Care Act

- E2.11 Before the National Health Service and Community Care Act came into effect, responsibility for publicly-funded long-term care was split between the NHS, local authorities and Social Security. The Act gave local authority social services departments the lead responsibility for assessing an individual's need for care, involving other agencies as appropriate, and then making suitable provision for that care, subject to budget limitations.
- E2.12 Where a social services authority provides someone with residential care, it must assess ability to pay for that care using government regulations and guidance embodied in the Charging for Residential Accommodation Guide (CRAG).
- E2.13 Almost all forms of income are taken into account in the assessment. Residents retain part of their income as a personal expenses allowance, the amount in most cases being £13.75 a week from April 1996. The assessment also takes account of the resident's capital. From 8 April 1996 no account is taken of capital up to £10,000. For capital between £10,000 and £16,000, an income of £1 a week is assumed for each £250 held. Capital over £16,000 is assumed to be wholly available to pay for residential care. The effect of this is that residents are expected if necessary to draw on their capital to pay for care until their capital is reduced to £16,000, and then to draw on it more slowly until it reaches £10,000. Thereafter it is disregarded.
- E2.14 When a resident owns his or her own home, this is included in the calculation of the available capital. The local authority must, however, ignore the value of property where it continues to be occupied by: the resident's husband or wife; a relative who is aged 60 or over, or incapacitated; or a relative under sixteen whom the resident is legally liable to support. In addition the authority has some discretion to ignore the value of property in other circumstances.
- E2.15 If a property does have to be sold to meet care costs, the local authority can place a legal charge on it if the sale is delayed. This means that any sums paid by the authority towards the contribution owed by the resident can be recovered when the property is sold.
- E2.16 To protect the authority against asset shifting, where assets are transferred by a patient to other individuals in the six months before that patient goes into care, local authorities may recover the assets transferred. Even assets transferred earlier may be pursued by local authorities if the reason for transfer can be shown to be avoiding contributions to care costs.

E2.17 In the following chapters we discuss the new proposals on which the Government is consulting, which would materially change the way in which contributions are assessed.

E3 LTCI PRODUCTS

E3.1 Despite the recent considerable interest in the private financing of long-term care, there are few different LTCI products available. LTCI is sometimes sold as a rider to some Critical Illness Insurance, but the main LTCI sales are of stand-alone products, either on a pre-funded basis or for immediate cover.

Pre-funded LTCI

E3.2 Pre-funded, or 'indemnity' LTCI is a way of sharing the costs of long-term care between those who prove to need it and those who do not. In this respect it resembles other forms of insurance such as fire insurance for homes. All those who take out indemnity insurance pay premiums, but only the minority who actually need care draw benefits. As a result, they pay less for their insurance than if they had to meet the whole cost themselves. Those who in the event do not need care have peace of mind about how they would meet its costs if necessary. Indemnity insurance is, however, available only where people are 'insurable risks' - where it is uncertain whether they will need long-term care.

E3.3 Six insurance companies currently offer pre-funded LTCI products. Two offer both regular- and single-premium products, and three regular-premium products only. One company has a product based on an offshore investment bond, with any benefits drawn down annually from the bond.

E3.4 Typical premiums payable by 55 year-olds to achieve cover of £1,000 a month are shown in Table E3.

TABLE E3 - LTCI: PREMIUMS TO ACHIEVE £1,000 A MONTH COVER

	<i>Monthly premiums</i> £	<i>Single premium</i> £
Man aged 55	62.06	10,584
Woman aged 55	72.41	16,885

Source: *Insurance Age Health Supplement*, September 1995

E3.5 Premiums to achieve the same £1,000 a month cover are significantly higher for older people (see Table E4).

TABLE E4 - LTCI: PREMIUMS AT AGE 70

	<i>Range of monthly premiums £</i>
Man aged 70	73-137
Woman aged 70	91-180

Source: *Planned Savings*, November 1995

E3.6 Payment of benefits under these products is typically triggered by inability to carry out two or three 'Activities of Daily Living' (ADLs), such as mobility, washing, dressing, toileting, or, in one case, according to a functional assessment scale. The coverage also varies with the particular products, with different emphases on residential, nursing home, and domiciliary care. Payments do not necessarily depend on the patient's going into residential care; they could for example, pay for nursing at home. Benefits are normally indexed for inflation. In some cases a choice of indexation methods is offered.

Immediate cover

E3.7 Four companies offer products providing benefits on an annuity basis. This means that a policyholder makes a single payment which provides a given level of benefit -usually for life. Table E5 gives some examples of the payments required to provide a benefit of £1,000 a month for someone in very poor health.

TABLE E5 - LTCI: PAYMENTS TO PROVIDE IMMEDIATE COVER OF £1,000 A MONTH

	<i>Level annuity basis £</i>	<i>Escalating at 5% £</i>
Man aged 60	34,523	37,552
Man aged 69	33,851	36,698
Woman aged 60	49,017	56,810
Woman aged 69	47,952	55,196

Note: The costs would generally be higher for individuals in better health, because of the likelihood that they would draw benefit for longer.

E3.8 All the tables indicate payments to provide cover of £1,000 a month for life. In fact, the cover required to pay nursing home fees in full would be greater, and perhaps even double in some regions (see paragraph E2.9).

Comparison of products

E3.9 As with the other more established health products, it is not easy even for analysts to compare different LTCI products, even though there are not many.³⁹

Possible other products

E3.10 One of the first LTCI products was linked with pension arrangements, with long-term care benefits being payable at a fixed age, such cover being financed by a reduction of some 10% in pension payments. Such arrangements were, however, opposed by the Government on the grounds that they made inappropriate use of pension tax concessions. *A New Partnership for Care in Old Age* does, however, contemplate variable pension schemes, which offer a smaller initial pension in return for a larger pension later on.

E3.11 Other alternatives, such as using the value of homes through Partial Equity Release schemes, have also been advocated. Major problems were experienced with equity release products in the late 1980s, but *A New Partnership for Care in Old Age* suggests that, with better techniques of risk management, they may be due for a revival.

E3.12 Practices in other countries vary considerably.

- In the USA the Medicaid budget has typically paid perhaps 80% of all nursing home costs, but Congress has presented plans to cut the Medicaid budget. LTCI has been available in the USA since 1987, and is sold by more than 100 insurers with around 1 in 10 of over-65s now having LTCI.
- Four US states (Connecticut, New York, Indiana and California) have established 'partnership schemes' under which those who finance part of their own care with the help of insurance receive some protection from means-testing for Medicaid. The terms of these schemes vary, and all are relatively young, the earliest having been established in 1992. Sales of approved insurance products have so far proved disappointing.
- In 1995, Germany introduced a state scheme for institutional care, based on funding from 1% of incomes (1.7% from July); those outside the state scheme must make private provision. LTCI either replaces state cover or supplements it, and some 400,000 top-up policies have been sold. This equates to one per 200 of the population.
- In the Netherlands people are entitled to long-term care in a nursing home by law, and perhaps as a result home care is less common. Only one insurer offers a home care policy and sales have been low.
- In Japan, long-term care is usually the responsibility of the family, and the first LTCI product was launched only in 1995.⁴⁰

Possible partnership schemes in the UK

E3.13 In *A New Partnership for Care in Old Age*, the Government proposes to adopt the US idea of offering some protection from means-testing to those who make provision for their own care through insurance.

E3.14 For pre-funded, or indemnity, insurance the Government is consulting on two options:

a scheme which would disregard an extra £1.50 of capital for every £1 of insurance benefit paid out; or

a scheme which would disregard an extra £1 of capital for every £1 of benefit paid out with an extra £15,000 of capital disregarded once the individual had funded his or her own care for four years.

E3.15 For immediate needs annuities the Government is again consulting on two options:

giving £1 of extra protection for every £1 received from the annuity; or

giving £1.50 of extra protection for every £1 received from the annuity, but deducting from this the purchase cost of the annuity.

E3.16 In each case, the policies would have to meet certain conditions, still to be set. The proposals would require primary legislation, and thus cannot take effect very quickly.

E4 BUYING AND SELLING LTCI

E4.1 In the UK both buying and selling LTCI are relatively novel practices, and there is much concern that many of those buying LTCI are particularly vulnerable people. Pressure groups such as the Continuing Care Conference, and an IFA-based group, have called for close regulation of LTCI practices. The Government has indicated that it does not propose to require that the new 'partnership' products themselves should meet special standards in the interests of consumer protection, but has asked whether further measures should be introduced to regulate the *selling* of these products.³⁶ We discuss our responses to these questions in Chapter E5.

Buying LTCI

E4.2 People considering whether to purchase an LTCI policy are likely to take the following factors into account.

- **Chances of requiring care** - According to an ABI-led delegation of LTCI providers, there was a 1 in 4 chance that a person aged 60 needs or would need care. At age 80 the chances rise to 7 in 10. The basis of these figures is not entirely clear and we do not know whether they are consistent with those shown in paragraph E2.4. The risks may vary with income: we do not know whether those able to afford LTCI now are more or less likely to need it in later life. It is however believed that women are more likely to need care than men, perhaps because they tend to live longer.
- **Availability of care from family or friends** - Informal care has accounted for about 80% of all care, and will continue to dominate care provision for many years. In a sense the best insurance against the costs of care is to have many children. Even so, as they grow older, people will may face advanced stages of physical or mental disability that would require professional care.
- **Differentials in the levels of care** - Whether a typical LTCI policy will result in higher standards of care is very much a matter of personal circumstances. It appears that, for all except the wealthy, standards of *nursing-home* care are very similar for those with or without LTCI. For *residential homes*, those with LTCI may have a slightly wider choice. This is particularly so in the South East, where the cost of some homes may be very high. Quality of care is, however, not always closely related to price. It is, of course, possible that the market will change in the future, perhaps with self-paying patients receiving better accommodation or care than the minimum. Most local authorities try very hard to provide *domiciliary care* to help people stay in their own homes, but some are less flexible than the best insurers. The most important factor is the local authority. In the best authorities, LTCI will not produce better care at any point; in the worst, it may.

- **Assets to protect** - Commentators have indicated that this is the key factor in LTCI. It is explicitly the main factor behind the Government's new proposals. If individuals have assets, such as a house, investments, and so on, to protect for their beneficiaries, and they cannot or are unwilling to pass them to those beneficiaries while they are still healthy, then LTCI may be an attractive purchase. If, however, they have no beneficiaries to whom they want to leave their assets then there appears to be no strong reason to purchase LTCI.
- **Affordability** - The levels of premiums have been illustrated in paragraphs E3.3-E3.8. For most people, LTCI would represent a very expensive purchase.

‘Only 5% of people will be able to afford standard LTCI products as they are currently produced.’¹⁴¹

‘The very large lump sum investments required for these plans are a massive impediment to sales.’¹⁴²

There may be occasions when in order to preserve assets to which they anticipate becoming beneficiaries, friends and relatives elect to help in meeting the cost of LTCI. Such assistance is most likely to be sought where an elderly person has significant capital, but little annual income.

E4.3 Taking account of these factors, the ‘typical’ purchase of LTCI might result from:

the purchaser not wishing to trouble relatives or not having a family able or willing to provide care;

the purchaser wanting to protect assets for beneficiaries;

the purchaser wanting to receive care at home for as long as possible; or

the purchaser being able to afford the premiums, whether with or without help from beneficiaries.

Selling LTCI

E4.4 Concerns over the selling of LTCI to elderly and vulnerable people led to the ABI drawing up a Statement of Best Practice, which was published on 24 July 1995 (see Annex 2).

E4.5 This statement provides useful guidance, but there are signs that even stated selling objectives are less than reassuring. For example, one LTCI manager suggests that two types of people offer the greatest opportunities for LTCI sales (and will therefore presumably be targeted).

- **Investment clients** - Presumably clients with substantial assets to protect and the means to afford the LTCI premiums.
- **60+ single or widowed individuals (predominately women)** - Here it was suggested that 'These individuals will want to be absolutely certain that they are buying insurance that will deliver when they need it most. So highlight the tangible benefits of what they are buying, such as the helpline, the care counsellor, the flexibility of the benefit payments'.⁴³

E4.6 But are the helpline, the care counselling and flexibility worth paying premiums of £1,000 or more a year for? The principal reason for taking out LTCI must surely be to protect assets for future beneficiaries. The needs of those beneficiaries will vary; the need to allow a son or daughter to be sure of remaining in a home previously shared with the policyholder will usually be much stronger than the need to pass an inheritance to a grandchild or a more distant relative. It remains the case, however, that - in physical rather than psychological terms - the people who gain most from LTCI generally do not include the policyholder.

E4.7 It has been reported that in the USA 'a significant proportion of contracts lapse before any benefits become payable. The American Association of Retired Persons has suggested that all contracts should provide certain minimum benefits on early termination. This question of surrender values for LTCI has become a major issue in the US market, but insurance industry practitioners in the UK do not appear to be giving it much prominence.'⁴⁴

E4.8 The possibility of high lapse rates with no surrender values indicates the importance of careful checking that the LTCI premiums are affordable, as well as checking the basic condition that assets need protection so that they could be passed to beneficiaries.

E5 SHOULD LTCI PRODUCTS BE REGULATED?

- E5.1 The Government has invited views on how long-term care products, and in particular products marketed under a partnership scheme, should be regulated. It has proposed that, to qualify for protection from the means test, partnership products should need to meet criteria set in legislation. We agree, and we do not comment further on this point.
- E5.2 The main point on which the Government seeks views is whether the *selling* of indemnity insurance products should be regulated. Annuity products are already subject to regulation under the Financial Service Act. Selling of indemnity products by brokers is regulated by a statutory Code of Conduct, but for other sales only voluntary codes apply.
- E5.3 *A New Partnership for Care in Old Age* points out that the costs of regulation are ultimately borne by the consumer. However, we consider that LTCI sales, whether part of a partnership scheme or not, do require statutory regulation. This is for several reasons.
- E5.4 It is quite apparent from this report and the consultation paper that long-term care products are complex and varied. At the same time, purchasers are likely to be particularly vulnerable, as they may be elderly, and will often be alone. Those close to them may feel inhibited by their status as potential beneficiaries. Increasingly, if the Government's desire to see people making long-term care provision from an earlier age is realised, products themselves may represent long-term commitments which require sound investment and safe management. Long-term care purchasers need 'best advice' more than almost any other group. They also need to be protected against the consequences of bad advice.
- E5.5 Long-term care insurance is an expensive product which is usually purchased when income is beginning to dry up, and mistakes can least be afforded. Purchase may be made in the form of large lump sums. At the time of claim, policyholders will usually have to be sufficiently disabled to fail three activities of daily living tests. They are unlikely to be in a position to complain effectively if it then turns out that their best interests have not been served or they have not been treated fairly. In the absence of a compensatory mechanism, it would in any event be too late to amend matters.
- E5.6 Where indemnity insurance is to form part of a partnership scheme, the need for regulation is even more apparent. When a policy is chosen which provides poor value for money, the loss in benefit carries with it a further loss in partnership credit.
- E5.7 Given the range and complexity of products, purchasers require advice about which product is most likely to meet their needs. If the industry has difficulties in comparing products as things stand (see paragraph E3.9), it is clear that sales forces will need professional training to sell products accurately. A full 'fact find' will be necessary to establish how the customer views residential as opposed to domiciliary care, what assets

it is desired to protect, whether additional capital or income is available to buy 'top-up' care, and so on.

- E5.8 We therefore consider that the selling of LTCI products, whether partnership or otherwise, requires regulation analogous to that under the Financial Services Act. Whether this can be achieved by some less onerous means than extending the Act is a point on which experts may advise. We note that the Personal Investment Authority is exploring the position, and that there is widespread support among insurers for greater regulatory control.
- E5.9 Regulation is not an option we turn to lightly. Nevertheless, even within an open and free economy there are times when the vulnerability of consumers is such that they need protection. This has been a factor in our consideration of the protection of pre-payments for funerals. Further, experience in markets such as endowment mortgages and pensions suggests that where consumers do not have financial expertise, and products are complex, the results of insufficient regulation may far outweigh the costs saved.
- E5.10 One particular point on which the Government seeks views is whether people who are sold products which purport to meet the partnership criteria, but do not, should receive special protection. It recognises that people purchasing policies 'would not necessarily have the expertise to determine whether the criteria had been met'. We agree, and consider that some protection is essential. This would, of course, be obvious mis-selling, and any regime analogous to the Financial Services Act should be able to deal with it without consumers needing to resort to the courts.

E6 CONCLUSIONS AND RECOMMENDATIONS

- E6.1 The proportion of the elderly in the UK and in other countries will rise over the next 25 years, and the need for long-term care will increase significantly. The National Health Service and Community Care Act has meant that the financial burden of providing such care may be shifted further from the public to the private sector. LTCI products should facilitate that shift, and the Government wishes to encourage them as a way of protecting assets.
- E6.2 The first LTCI products were introduced in the UK in 1991, but only a handful of companies have promoted LTCI products and sales have been very low, totalling between 15,000 and 20,000 by the end of 1995. Even though there are few products these contain significantly different features and analysts are already finding it difficult to compare them.
- E6.3 **We recommend that the LTCI industry, possibly through the ABI, should draw up 'bench-mark products', perhaps with one pre-funded and the other for immediate cover. The value for money of products with variations from the bench-mark product could then be more easily judged by comparing the premiums payable.**
- E6.4 The LTCI products currently on offer generally involve high regular or single premiums, but the 'partnership proposals' under discussion could nevertheless make LTCI attractive for more people.
- E6.5 In buying LTCI, key factors would appear to be the chances of needing long-term care, the availability or desirability of family care, a wish to protect assets so that they might be passed on to beneficiaries, and whether LTCI is affordable. It is not clear that such factors are emphasised in the selling process, and it is possible that with vulnerable individuals undue emphasis is placed on secondary features like the availability of a helpline or of care counselling.
- E6.6 **We recommend that sales of LTCI should focus on whether prospective purchasers have family care available, whether they want to protect their assets to pass on to beneficiaries, and whether the premiums required are affordable. Sales techniques should not focus on secondary features like helplines, or care counselling.**
- E6.7 **We also recommend that, for pre-funded LTCI, prospective purchasers should be given a clear indication of the likely surrender value if they prove unable to keep up the premiums.**
- E6.8 **We recommend that the selling of LTCI products should be regulated.**

PART F: SUMMARY OF RECOMMENDATIONS

F1 PART B: PRIVATE MEDICAL INSURANCE

F1.1 We recommend that:

PMI plans are presented in a common format and (like other contracts) in plain and intelligible language,

an approach be developed to enable a ready comparison to be drawn between plans (one possible approach, based on 'common core benefits' and comparison of extra benefits with premiums is set out in Chapter B4).

Paragraph B8.6

F1.2 We recommend that PMI providers should abandon the moratoria approach to underwriting.

Paragraph B8.9

F1.3 We recommend that there should be a warning about likely increases in PMI premiums, perhaps in the following terms:

a general statement explaining that, because of the incidence of claims and increases in costs, PMI premiums for individual plans had increased significantly faster than RPI;

a statement of the increases for each plan over the previous five years, both in cash terms and above RPI;

an illustration of how actual premiums would rise over the next five years, both in cash terms and in real terms over a projected RPI, assuming the same rate of real increase as in the past five years.

Paragraph B8.15

F1.4 We recommend that all protocols or care practices should be drawn up within a common framework, under the guidance of an industry body and the Department of Health. NHS bodies and PMI companies should publicise their protocols on best practices in common formats so that comparisons can be readily made. The Royal Colleges should be invited to sponsor consensus conferences to help refine these protocols, and both NHS bodies and PMI companies should be encouraged to publish output and outcome targets and results achieved.

Paragraph B8.21

F2 PART C: PERMANENT HEALTH INSURANCE

F2.1 We recommend that the PHI industry, possibly through the ABI, produce a standard definition of 'total disability' and also take steps to draw up a standard PHI 'benchmark product', with the key features clearly and simply described. Any additions that were made to such a product by individual companies could then be compared against any resultant extra premiums.

Paragraph C7.3

F2.2 We recommend that questionable promotions like '1 in 5' be dropped, and that instead PHI providers should make more effort to explain how PHI interacts with state and employer sick pay schemes.

Paragraph C7.5

F2.3 We recommend that the moratoria approach to underwriting also be dropped for PHI.

Paragraph C7.7

F2.4 We recommend that the PHI industry, possibly through the ABI, should tackle the problem of over-insuring, through which the PHI providers collect excess premiums. There should be a proper fact find when policies are sold. In addition, annual checks could reduce shortfalls, but a system for refunding such premiums could be a fairer solution.

Paragraph C7.10

F3 PART D: CRITICAL ILLNESS INSURANCE

F3.1 We recommend that the CII industry, perhaps through the ABI, should draw up a CII benchmark product based on the five or so conditions which account for 95% of claims. The chances of suffering those conditions separately and overall should be disclosed - as they frequently are for marketing purposes. Any variations from that benchmark product, for example through the addition of other conditions, could then be judged by comparing the stated chances of suffering the extra conditions, and the resultant increase in premiums.

Paragraph D5.3

F3.2 We recommend that the CII industry, perhaps through the ABI, should recognise and address the problem of a loss of life-cover benefits for dependants when a critical- illness benefit is triggered within an accelerated benefit policy. One solution might be to provide the option of a higher premium to buy back life cover, as in Australia. But, in any event, everyone taking out a CII policy should be made completely aware of the basis on which cover is provided, in particular the fact that payment for a critical illness will reduce or even eliminate the benefits payable at death.

Paragraph D5.5

F4 PART E: LONG-TERM CARE INSURANCE

F4.1 We recommend that the LTCI industry, possibly through the ABI, should draw up 'bench-mark products', perhaps with one pre-funded and the other for immediate cover. The value for money of products with variations from the bench-mark product could then be more easily judged by comparing the premiums payable.

Paragraph E6.3

F4.2 We recommend that sales of LTCI should focus on whether prospective purchasers have family care available, whether they want to protect their assets to pass on to beneficiaries, and whether the premiums required are affordable. Sales techniques should not focus on secondary features like helplines, or care counselling.

Paragraph E6.6

F4.3 We also recommend that, for pre-funded LTCI, prospective purchasers should be given a clear indication of the likely surrender value if they prove unable to keep up the premiums.

Paragraph E6.7

F4.4 We recommend that the selling of LTCI products should be regulated.

Paragraph E6.8

ANNEXES

1 ASSOCIATION OF BRITISH INSURERS: SELLING OF PRIVATE MEDICAL INSURANCE TO INDIVIDUAL PURCHASERS

Information sheet

Summary of specific points for the selling of individual and voluntary private medical insurance (PMI) contracts

Introduction

PMI is a relatively discrete segment of the general insurance market dealing with the sensitive area of individuals' health. For this reason, this Information Sheet has been prepared to summarise and amplify the specific requirements of the Code applicable to PMI.

The guidance under the Code recognises the different characteristics of certain classes of insurance. This specific PMI guidance has been prepared to ensure that the more particular needs of those buying PMI are met. It will be incorporated into the guidance manual prepared in support of the Code.

The main areas covered are recruitment, training and competence, explanation to customers, standards of documentation, complaints and monitoring.

General principles of the Code

The Code provides a framework of general principles within which ABI members and their intermediaries should sell general insurance products. ABI members accept responsibility for company employees and company agents. Independent intermediaries are responsible for the advice they give and action they take but are still required to comply with the Code. Registered brokers are covered by their own code of conduct. Copies of the Code are available from ABI.

The specific requirements of the Code vary according to the type of insurance and circumstances of the prospective policyholder. However, in all cases intermediaries will ensure as far as possible that the policy proposed is suitable to their needs and resources.

Intermediaries will give sufficient detail of the essential provisions of the cover afforded by the policy so as to ensure, as far as possible, that the prospective policyholder understands what he/she is buying.

All members of the Association are required to comply with the provisions of the Code. They should also ensure that all those involved in selling their policies are aware of it and require them to abide by the provisions. In 1997 Member Chief Executives will be required to sign an annual declaration of compliance.

Non-members of the Association are encouraged by the DTI to comply with the provisions of the Code.

Important and specific points for the selling of PMI

The following provisions set down the important and specific points for selling of PMI by intermediaries.

(a) *Recruitment of intermediaries*

Principle - Within the ABI Code there are general appointment criteria, some of which are applied at the discretion of the individual company. For private medical insurance it has been agreed to amplify these criteria in recognition of the sensitivity of the product and the number of intermediaries entering the PMI market. Insurers selling PMI will seek to ensure that all those whom they recruit, or with whom they enter into an agency agreement, are fit and proper people to be selling PMI to customers.*

This will mean:

- (i) That intermediaries (especially the individual intermediary) have no criminal convictions (save those that are spent under the Rehabilitation of Offenders Act), and there are no other grounds which may call their integrity into question. For example, the insurer should exercise reasonable discretion regarding outstanding County Court judgements.
- (ii) Checks should be made as to whether the intermediary has been the subject of action arising from the breach of rules or duty by a regulator, especially a regulator of financial services.
- (iii) That information on past and present appointments with other insurers eg information concerning an intermediary's financial indebtedness have been obtained from previous employers, or agency records scrutinised. Insurers receiving specific requests for references should make every effort to respond speedily and retain sufficient records of appointments and terminations in order that they may do so. If references are not satisfactory then the intermediary's employment or agency appointment in respect of PMI is to be refused or terminated forthwith.
- (iv) Particularly in the case of the intermediaries who are to hold money on behalf of the company or its customers or potential customers, consideration should be given to obtaining satisfactory references from bankers and, where appropriate, accountants or auditors.

(b) *Training and competence*

* The effect of this is that the insurer should be satisfied, on reasonable grounds, that the intermediary is of good character and of the requisite aptitude for the appointment and is not under such financial pressure as to be encouraged to mis-sell PMI products.

Principle - Whilst the ABI Code contains general provisions on training, to date there is no formal qualification specific to PMI. As those selling PMI should understand the particular and unusual characteristics of the product to enable the consumer to make an informed choice, insurers should ensure that all their intermediaries have the necessary training.

This will involve:

- (i) The insurer assessing the competence of potential intermediaries, having regard to previous experience, product knowledge and other agencies held. Where appropriate the insurer will provide training specific to its business.
 - (ii) Particular attention being given to ensuring that all intermediaries and relevant staff have a full understanding of the PMI products offered by the insurer.
 - (iii) Ensuring that the intermediary and relevant staff have a full knowledge of the provisions of the ABI Code, and the specific guidance in respect of PMI, and its implications. For new intermediaries, such knowledge should be tested prior to appointment.
 - (iv) In the case of inexperienced intermediaries, consideration of safeguards, eg providing that they will be accompanied in the course of their selling by a supervisor who has successfully undergone appropriate training in coaching, assessment, training skills and monitoring methods.
- (c) *Explanation to customers*

Principle - There are particular aspects of PMI contracts which need especially careful explanation. Insurers and their intermediaries will therefore take reasonable steps to ensure that a customer who purchases a policy understands its core provisions and that the policy being purchased is appropriate to their needs and resources.

In particular, a full and clear explanation should be given of:

- (i) The benefits payable under the policy (ie the benefit table), and any significant medical or technical exclusions or restrictions applying, which are included in and imposed by the standard terms and conditions, or by the underwriting of the individual application and affect the scope and coverage of the benefits.
- (ii) The possible implications involved in transferring business from one provider of PMI to another or of transferring from one type of PMI plan to another, such as new underwriting conditions on pre-existing medical conditions.
- (iii) The coverage or otherwise of pre-existing conditions.
- (iv) Arrangements for the making and paying of claims, and whether payment is made direct to the provider of services or to the insured.

- (v) The fact that premiums and coverage may vary on renewal.

This will mean that the above points are clearly and plainly stated, during the sale where appropriate or in the associated sales literature.

(d) *Processing of information*

Principle - As information collected in relation to the selling of PMI policies is often medical information, insurers will ensure that all information obtained from customers is treated as confidential and in accordance with the Access to Medical Reports Act 1988 and Access to Health Records Act 1990.

(e) *Complaints procedures*

Principle - PMI companies will have a suitable mechanism for the handling of complaints and will notify customers of the initial action they should take in the event of a complaint before a contract is concluded. PMI companies are also strongly recommended to join an independent arbitration or ombudsman service, details of which will be passed at an appropriate stage to complainants.

(f) *Monitoring*

Principle - Insurers will have appropriate procedures to ensure adherence to the principles of the ABI Code and specific requirements applicable to PMI.

This will mean that:

- (i) Companies either have appropriately senior staff designated to act as compliance officers or make it a responsibility of the appropriate line management to ensure the compliance of those for whom they are responsible.
- (ii) In the event of persistent or serious failure to comply with the provisions of the ABI Code by an intermediary, disciplinary action will be taken including consideration being given to the cancellation of the PMI agency.

2 ABI STATEMENT OF BEST PRACTICE: LONG-TERM CARE INSURANCE

Introduction

- 1 The following Statement of Practice concerns those insurance companies ('insurers') offering long-term care insurance policies effected in the UK. It supplements the standard ABI Codes of Practice and the relevant provisions arising from the Financial Services Act 1986.
- 2 Nothing in this Statement should be interpreted as conflicting with or overriding any rules arising from the Financial Services Act 1986 in respect of those long-term care insurance policies which are treated as investments for the purposes of the Act.
- 3 The Association strongly encourages and expects its members to observe the provisos of this Statement and to ensure that all those involved in selling their policies are aware of and are asked to abide by its provisions.
- 4 For the purposes of this Statement 'long-term care insurance' means insurance which provides benefits to meet the continuing cost of care of those unable to care for themselves and which is either triggered by the need for care or assessed by the need for care.

Selling and marketing principles

- 5 In addition to the principles set out in the ABI Codes of Practice and the relevant provisions arising from the Financial Services Act 1986, insurers agree to:
 - (a) Ensure that company representatives assess clients' needs for long-term care insurance with due regard to any financial provisions and strongly encourage independent intermediaries to do the same.
 - (b) Provide the prospective policyholder with details of the following main product features before the contract is completed:
 - (i) The amount of premium payable and the payment term. For a contract with escalating premiums the rate at which premiums will increase. The nature and extent of the insurer's right to review and revise the premiums payable, and the notice to be given in the event of any revision.
 - (ii) The amount of the insured benefit. Any escalation or other changes that might apply before a claim begins, when benefits will start and stop, and the rate at which they will increase after a claim begins.

Any restrictions on how much benefit is payable and the nature and extent of the insurers right to review and revise the benefit conditions.

- (iii) The disability definitions which trigger benefit payments and how claims will be assessed; all major policy exclusions, such as pre-existing conditions and disabilities not covered - particularly any exclusions applying to mental impairment. The nature and extent of the insurer's right to review and revise exclusions and/or definitions.
 - (iv) The extent of the insurer's right to cancel the policy (eg where the policy is annually renewable) and how such a cancellation may affect claims in payment.
 - (v) Whether any death benefit is payable and the amount of such benefit.
 - (vi) Whether any surrender value is payable or other benefit provided if the policyholder ceases payment of premiums and, if applicable, how such benefits are determined.
 - (vii) The tax treatment of benefits payable and that benefits paid may affect rights to State benefits.
 - (viii) The availability and duration of a cancellation period - see d below.
- (c) Ensure that all written material is clear and not misleading, and that statistics quoted in the marketing literature are relevant to the product being sold.
 - (d) Where there is no legislation or regulation covering the cooling-off period, insurers will provide for a minimum cancellation period of 14 days as measured from the receipt of the policy document.
 - (e) Ensure that long-term care insurance forms part of a formal Training and Competence Scheme for company representatives who are authorised by the insurer to sell such products and strongly encourage, including the provision of appropriate training material (where applicable), independent intermediaries to do the same.
 - (f) Ensure that company representatives and independent intermediaries are aware of any benchmark Activities of Daily Living (ADLs) in common use within the industry and have a comparison of the ADLs used in the contract within any such benchmarks.
 - (g) Recommend that policyholders take steps to ensure that appropriate relatives are aware of the existence of a long-term care insurance which could provide benefits in the event of the policyholder's disability including mental illness.

- (h) Provide the following additional safeguards for policies which meet immediate care costs:
 - (i) Where the purchase of the product involves the sale of property or the raising of a loan secured against a property, the client (or his representative) should be advised to consult his solicitor or other professional adviser before completing the contract.
 - (ii) A declaration to be signed by the client (or his representative) that the essential provisions of the contract have been explained.

Underwriting and claims

- 6 In addition to the principles set out in the ABI Statement of Long-Term Insurance Practice, insurers agree to:
 - (a) Ensure that there is access to an independent complaints or arbitration procedure in respect of disputed claims.
 - (b) Inform the client in writing of any alterations to the standard policy terms made as a result of the underwriting process.
 - (c) Assess claims promptly and efficiently, using suitably qualified or experienced resources, with due regard to the reasonable interpretation of the policy conditions.

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