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The Rear View Mirror

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1 Introduction

I have been asked to take a look back into History, and to see whether there are lessons which have a bearing on health care provision and insurance today.

What are the lessons of the past and how far back should we look? The earliest reference I could find of the rich and healthy making provision for the weak and sick was in the book of Deuteronomy in the Old Testament. I am not going back that far.

But I do want to spend a few minutes talking about 1912 and then 1948, but to spend most of the time on health care products and insured schemes over the last 20 - 30 years.

Why was 1912 significant? It heralded in the Old Age Pension Act, which granted non-contributory pensions from age 70 from 2s. - 5s. a week subject to a means test.

In 1912 compulsory sickness insurance under the national health insurance scheme was introduced for employed people between 16 - 70. The scheme was administered by the Friendly Society movement and many existing societies set up new sections or became 'approved' societies. Some larger industrial insurance offices set up countrywide 'approved' societies.

Individuals were free to choose their approved societies, and societies could select their members, but could not refuse anyone because of age. The main benefit was a weekly sickness benefit and a flat contribution was paid weekly by people of all ages. A government subsidy was given to fund the Friendly Societies and make up the balance of contributions.

So, what was so special? Well, the co-operation of the State and the private sector to provide a national scheme. This was many years before Stakeholder concepts were established for pensions and is the type of arrangement that is being advocated by some people for health care and medical services in the future.

A national insurance scheme for unemployment was also introduced in 1912, but medical costs were not covered by the national scheme. People joined on a voluntary basis for membership of provident associations, Saturday clubs and hospital schemes to get some measure of insurance cover, or else they relied on charity.

This largely remained the position until the National Insurance Act 1946, which came into force in July 1948. This laid out the basis of our current State systems. In addition to social insurance benefits (retirement, sickness, unemployment etc) medical costs were covered by the National Health Service. All schemes were centrally administered and the co-operation with the private sector was discontinued.

Approved Friendly Societies ceased to have a central role and the many provident associations combined together to become the British United Provident Association (BUPA), though a few associations continued alone. The role of the associations had changed and they now offered an alternative to the NHS. A person could voluntarily join and when care was needed he could elect to take private treatment rather than NHS treatment. With all other benefits, sickness, disablement, unemployment etc a person could take an additional cover from the private sector - if he could find an insurer willing to take the risk.

With unemployment insurance there was no market except for Loss of Licence type cover and more latterly cover for loans and hire purchase arrangements. This creditor business is now a good market for some niche players.

The NHS now provided free medical services. The political thought at the time was that if the NHS gave treatment free people would get treatment earlier and public health would

improve, and the population would be fitter. The cost to the NHS would then decrease. Some hope! The demands on the service have steadily increased year on year, charges for some services had to be made and the NHS has continuously been under resourced. That is still the position today. Compared to other European countries our health service is second rate and you know all the criticisms - waiting lists, rationing, refusal of expensive drugs etc. This is not altogether surprising since we pay far less as a percentage of GDP on medical services than other European countries - roughly 30% lower than other Europeans and about 50% lower than they spend in USA on medical care.

2 Private Medical Insurance

After 1948 the provident associations like BUPA continued to give an alternative service and slowly insurers began to issue private medical insurance. The early versions were modelled on the provident association covers but because the premiums were relatively high some sought to issue 'budget' products where the cover was restricted or the policy holder was expected to use the NHS if treatment was reasonably available.

The attraction to the insurers lay in the Group market. Many employers, especially those with white-collar workers, started to include medical cover in their benefit packages. The concept was extended to blue-collar workers. PMI ceased to be a benefit for the reasonably affluent and became wide spread.

How did the insurers fare? - well, not very well in terms of profits because of:

1 Inflation in medical costs - cost of drugs and treatment escalate continually and rise faster than RPI.

2 People's expectation of the type of care they need increases continuously - people want expensive treatments and efforts by insurers to keep costs down and to control the type of treatment have not been really effective.

3 Claims Control. In some cases insurers became just payers of bills with little scrutiny.

These are the lessons, but the main lesson is to avoid under pricing, particularly in the Group market. Group business is attractive, but it is highly competitive. Some offices desire to get business on the books leads to unsound and plain silly quotations. This happens in PMI. It also happens in Income Replacement and Group Life covers as well.

The number of people covered for PMI is between 6½ and 7 million and this figure has been fairly static in the 1990s. The growth came in the 1980s and growth now appears to have levelled off. There is a trend for some people to come out of cover and privately fund their own medical costs. This may be due to the increasing premium scales with age and the cost at the older ages. However, the overall market on PMI insurance has probably reached the maximum. If nothing else changes then it probably has plateaued.

However, there are many complaints with the NHS system. Some people complain it is inadequate, and the money taken out of tax for medical costs is insufficient. On the other hand people do not want to pay higher taxation. So a wider debate is necessary on the relationship between private sector provision and State provision. It is a political debate. Some people would argue that people should have the right to pay extra contributions and benefit from a higher standard of service - the type of service they get in some continental European countries. They argue that only by allowing people to make greater contributions will significantly more money be brought into the system.

Others object and argue that this type of development would introduce a two tier welfare system and the poor would be given an inadequate service even though they are just as sick and just as deserving of treatment.

I don't want to enter this debate now, and the debate is also about money, contributions, funding, rationing, standards of care using resources etc. The debate, if it happens, needs to

be an intelligent one backed up by facts and good estimates. On some of these issues actuaries could make a considerable contribution. I think the Actuarial profession ought to be preparing for this debate and we should be doing some ground work now so that the profession can make a significant contribution in the future. We should at least be outlining the options and be up to date with experience in other countries with different social welfare systems.

3 Income Replacement Insurance (PHI or Income Protection)

Sickness and disability insurance was also taken over by the State in 1948. In addition, those unqualified for benefit as of right were helped through National Assistance to provide for the basics. Many of the approved Friendly Societies declined in number, but most keep going on a much-reduced scale. Insurance Offices had not been prominent in sickness insurance even though two insurers had been writing it since the beginning of the century. But during the 1960s there was an influx of offices moving into the market with individual plans and later group plans. It was very difficult to fix a pricing basis as there was no data available except for the Manchester Unity experience. The office I was with adopted a scientific basis - Friends Provident's rates plus 1s. 6d. More adventurous offices started with Friends Provident's minus 1s. 6d, others were somewhere in the middle.

Fortunately, Friends Provident rates were sound and the business through the '60s and 70s was generally profitable and the policy conditions were fairly tight. At that time the market showed reasonable profits and reasonable growth with much of it coming through the Group market.

However, in the 80's offices tried to stimulate growth by reducing premium rates, weakening occupation definitions, higher benefit levels (relative to salary), and they included insurability options. There was very little claims control. If the claimant's GP certified that he was sick then insurers paid without question. On individual contracts premium rates were generally guaranteed, but later 'flexi' contracts were introduced.

Steadily over the 1980's and the early '90's incidence rates increased, duration of claims lengthened and recovery rates fell. Losses were being made, especially on Group and the sad fact was some offices were unable to measure the profitability or otherwise of their portfolio except on a very crude basis. Later some offices found they had made severe losses because their valuation bases were inadequate.

If there is one lesson from the past, it is do not enter any line of business unless you can sensibly monitor it and measure the profits or losses.

Over the '90's to overcome the loss situation offices tried to:

1 Improve underwriting expertise - it was realised that income replacement was a different risk from life assurance underwriting.

2 Ask proper questions on application forms - offices began to ask more questions on people's finances and occupation, not just health questions.

3 Independent medical examination - insurers ceased to rely solely on the claimant's GP.

4 Avoid price wars - it is better to temporarily withdraw from a market rather than write losses.

5 Impose sensible policy conditions - offices restricted some of the wildest options. One office had advertised it was unique in having no restrictions or conditions - it is now closed to business.

6 Claims' management - offices began to manage their claims more actively, getting an inspector to call to make an assessment, keeping in touch with claimant, especially if he has gone past the period when he would have been expected to have recovered. We do not necessarily handle claims sufficiently well as yet but the practice is improving. We also have to recognise that people are more prepared to claim benefit and say they are totally

incapacitated when they only have minor medical conditions. This also happens in the State Scheme.

It is good to see the dialogue developing between the private sector and the DSS on claims handling methods and improvements in management systems.

The bulk of IR business is in the Group market. Individual business has failed to reach its potential with new sales reaching between 150 and 200,000 over the 1990's. During this period profits were thin.

4 Critical Illness

Critical Illness, on the other hand, has been a success story. From its birth in the 1980's to the present when 800,000 new individual contracts are issued the growth has been very strong, though there are signs that it might be reaching a peak at below a million new policies.

So, we should ask ourselves why Critical Illness is a success story and why is Individual Income Replacement is in the doldrums. One straightforward answer is that Critical Illness provides a large cash sum at a time when people perceive that they may need considerable financial support when they have a crisis in their life. Having the means to face an uncertain future is a great attraction since the future may mean a completely different lifestyle for the claimant. The message on Income Replacement is more muted - "Subject to rules and regulations the insurer provides you with an income that won't necessarily cover the extra costs of being disabled and won't make you feel better - and we will check up on you". The form of the Income Replacement policy today is essentially the same as the product that those two offices were issuing in the 1900's. Does we need a revamp? Should we offer a "make you fitter and back to work policy"? It can clearly be seen that an active claims management system improves the profits of a Disability Insurer. Should we expand on this and offer rehabilitation and recovery and then only pay a low income if disability become permanent. Should we build in specific care services for the disabled claimant - a defined programme of care to the claimant

to get him back to work and out of claim? Perhaps the insurance policy should be in two parts with different benefit conditions and level of benefits in the short and in the long term. There are two thoughts:

1 If active claims management reduces claims costs why not extend the principle to recovery? The overall premium level may need adjustment.

2 If the product design has essentially stayed the same over a 100 years, even though social and economic conditions have changed, then the product will eventually fail to meet needs and changes may be required. The product may need to be significantly simplified and changed.

Critical illness has been a marketing success and has been reasonably profitable, but it is not without its dangers.

There could be antiselection and we have seen some antiselection with breast cancers in females. There are also some highly contentious PTD claims. Of more concern is that screening improvements in diagnosis and genetic screening of vulnerable people may lead to earlier claims and a different claims pattern with a consequent need for premium adjustments, or a change in benefit conditions - prostate cancer screening is an example. New treatment and better management of medical conditions may require a change in the conditions on what is considered to be "critical". For example, undergoing angioplasty treatment does not appear a critical condition and may lead to 'windfall' profits for some people and a change in attitudes to claiming in general.

Prices of Critical Illness cover have held up well, but an ever present danger is excessive price cutting.

5 Long Term Care Insurance

Though Critical Illness has been a success another product where we are hoping for good growth, Long Term Care insurance has failed to get off the ground. Sales are

disappointingly low and declined even further when the Government was wondering what to do on the Royal Commission's recommendations. Now the position on social care and nursing care has been established, sales are picking up to the 1998 level, but I do not think any office is embarrassed by the flow of business. In the early 1990's it was thought this was a large potential market since the population was ageing, the number of people that would live to extreme old age and require nursing care would increase rapidly, while the Long Term Care provided by the State was generally considered to be inadequate.

So why did not the market life take off? Perhaps we were unrealistic in our assumptions about the size of the market. It now appears that the market may be restricted to a fairly narrow band - the middling rich - the very rich don't need the cover and the ordinary person cannot afford it.

Maybe the pricing is far too conservative. We have virtually no real data to use. Maybe we have to be conservative because of the premium guarantees some offices now give. When the contract was first introduced premium levels were not guaranteed. Then guarantees were given on single premium contracts without extra cost even if future experience turned out to be worse than expected. In some cases now the practice has spread to annual premium contracts.

Offices then have a dilemma:

1 Charge heavily for the guarantees, and then people cannot afford the product, or

2 Charge lightly for the guarantees and run the risk of massive losses if the experience is worse than our present guesses.

On the whole subject of guarantees I think that we should be careful of granting any guarantees on premium rates on any health care product, e.g.

a) With Long Term Care we just don't know the present experience and even less of the future;

b) With Critical Illness for the reasons I outlined before changes in screening, diagnosis and genetic testing could change the rate of claim;

c) With Income Replacement it is not the disease pattern will change, but people's attitudes to claiming will change. The attitude to claiming has changed in the past and is certain to do so in the future but the extent is unknown.

We run serious risk of losses on these 3 contracts and I hope offices' reserves are strong enough to cover a setback.

6 Conclusion

I would like to end on a theme I outlined on PMI insurance. I said that some people think that the NHS is failing and some new thinking is required. The existing structure has been unchanged in principle for 50 years. There needs to be an accord between the private and the public sectors so as to give the public a better service.

The same is true on incapacity benefits, disablement benefits and as now becoming apparent on Long Term Care. When the debate on the shape takes place then I hope that the Actuarial Profession will learn the lessons of the past and be able to make an informed and intelligent contribution to the debate.