9 September 1996

The Secretary
Financial System Inquiry
Treasury Building
Parkes Place
Parkes ACT 2600

Dear Sir,

SUBMISSION TO THE INQUIRY

1 Introduction

We are pleased to present this brief submission on a number of areas where we believe segments of the Australian community are exposed to the risk of financial hardship due to poor system design or non-existent or inappropriate regulation.

Our comments are restricted to those areas where we have direct exposure through our work as consulting actuaries in the general insurance and health industries.

At first glance these areas may be "on the fringe" of the inquiry's Terms of Reference. However it seems inevitable that the developing structure of Australian society will demand a quantum change in financial systems in the next century. We believe the future financial structure will include our "areas of concern" as key components. Clearly the inquiry will be interested in planning adequate systems to accommodate these developments.

We have identified five sub-areas in our broad fields of expertise where we believe discussion is warranted.

- health insurance - the current system is inherently unstable;
- medical indemnity "insurance" - a sub-industry with large levels of unfunded "liabilities";
- the interaction between state-based compensation and Commonwealth welfare programs - a classic case of "hand-washing" of responsibilities;

- the operation of lump sum tort-based damages in liability insurance matters - inviting double-dipping into scarce resources; and

- the Insurance Act solvency requirements - better than previously, but still inappropriate.

We now provide a brief summary of each of these issues. If required, we would be more than willing to attend on the inquiry to discuss any of them in greater detail.

2 The health industry

The recent premium increases in Australian health insurance have led to the announcement of a Government inquiry into the industry.

In our opinion these price increases are a natural result of an inherently unstable system, which will inevitably self-destruct in the near future (within ten years).

The problem

The instability arises from the combination of three incompatible features of the system:

- community rating;

- a voluntary system; and

- a risk/utilisation profile which is heavily correlated with age and gender.

This means that consumers can *choose* when it is appropriate to be a member of a registered health benefit organisation ("health insurer"). Clearly aged members of the community and those with expected high utilisation (e.g. females of child-bearing ages) would be expected to be more attracted to health insurance; membership profiles reflect this expectation.

Of course there is also a component of members, presumably risk-averse, who are prepared to retain membership on the basis of "true" insurance. This group is highly correlated with income - i.e. they can afford the cost of their insurance.

However the selective nature of membership leads to higher cost members, and hence the need to increase premium rates. The "true members" are more likely to drop out on the basis of reducing value of the higher premium, and the risk profile of the membership deteriorates even further. Without intervention, this spiral will continue until even the high-risk members cannot afford the cost, and the system will disintegrate.

This trend has been evident for the past five to eight years, and is evidenced by the increasing proportion of health insurance which is paid from the so-called *reinsurance account* - (i.e. the pooled fund for high-cost members) - this account now pays more than 50% of hospital costs, and is increasing at about 2% per annum. Of course this will continue to increase as the "baby-boom" population enters more advanced age.

The problem is exacerbated by a national health bill which is growing at 3% per annum faster than inflation and 2% per annum faster than GDP - our research suggests that the components of the real growth are:

- the growing population (about 1% p.a.);
- the ageing population (about ½% p.a.); and
- increased utilisation, mainly resulting from technology advances (the remainder of about 1½% p.a.).

This growing health bill is currently funded as follows:

Sources of funding for Health industry	1993/94	
	$bn	%
"Invisible" funding		
Federal funding	13.4	39.2
State Government funding	6.8	19.9
	20.2	59.1
"Visible" funding		
Private health insurance		
Individuals	4.1	12.0
Medicare levy	6.0	17.5
Accient compensation	3.0	8.8
e.g Workers Compensation/CTP	0.9	2.6
Total	34.2	100

The trend is this split has been for increasing percentage contributions by private individuals and the Commonwealth, and the reverse for State funding. Clearly reducing participation in health insurance exacerbates these trends.

The solution

Of course as with any systemic problem the solution is far from easy, but it must begin with an admission that the current system cannot survive. Moreover, the logical consequence of the forces underlying its instability is the gradual development of a large unfunded liability, representing the health costs of the advanced age of our current workforce.

As with any such *distant* liability, the natural funding mechanism is a cohort saving process, in which each generation saves for its own costs. This is especially important in times of changing demographics, as in Australia at present, with a large baby-boom bulge and below replacement fertility rates.

Therefore the easy answer is that we should all start saving for our advanced age health costs. However there is a proportion of the current active and retired workforce which clearly cannot produce adequate levels of these savings, and a further proportion of disadvantaged Australians who will never have the access to adequate income to produce them.

Therefore there is a need for a phased-in savings program to fund the cross-generation subsidy and at the same time meet the future requirements of the current younger-age workforce.

We believe the answer lies with a combination of:

- continued contributions of consolidated revenue for the purposes of "safety-net" funding of disadvantaged Australians and funding the cross-generational unfunded liability. Our research suggests that about half of current health expenditure is on people aged 50 and over, at 4.2% of GDP - this will stay at about 4% of GDP for the next decade, and then gradually decline; and

- an increasing proportion of personal savings for the remainder of the population. This may take the form of a variety of models, including direct insurance, health savings plans, compulsory superannuation-linked contributions.

The structure and regulatory system for this second tier of "savings" will be crucial to its success. We believe introductory discussions should be initiated immediately, and would be pleased to participate in them.

3Medical indemnity

The system of professional indemnity "insurance" for health professionals has been the subject of a recent review by the Department of Health and Family Services (the so-called Tito Review).

It found a number of areas of concern in this system, but we would like to emphasise a number of problems arising from the lack of regulation of Medical Defence Organisations ("MDOs"), which provide cover for the majority of Australian medical practitioners. These are:

- MDO membership is *not* equivalent to insurance cover - MDOs retain the discretionary right to pay or not to pay claims submitted to them. In practice we believe claims are generally paid on behalf of continuous members, but difficulties arise when members change MDOs;

- while some MDOs have established subsidiary insurance companies subject to ISC regulation, these do not cover all the risks of the MDOs, and in practice only *reported* claims are covered. Other MDOs (the UK-based international mutuals) do not even have this level of comfort;

- as a result, there is a large unfunded IBNR liability in the system (estimated by the Tito Review in the $100 millions) - the issue is exacerbated by the very long tail of this type of insurance. If MDOs were required to report on an *occurrence* basis (which is how members seem to believe they are covered), we believe the industry as a whole would be insolvent; and

- we believe members of the MDOs are not generally aware that these problems exist, or their implications.

4 Accident compensation -v- Commonwealth programs

The issue of State versus Commonwealth responsibility for accident compensation systems and claimants is one which has been debated for many years, with no real resolution.

Compensation systems

In Australian workers compensation there are eight State and Territory Schemes plus those of Commonwealth employees and the Seamens' fund; total premium income is thought to be in the region of $4 - $5 billion annually.

For transport accident compensation there are eight State and Territory Schemes with an estimated annual premium income of about $3 billion.

Private insurers participate as *underwriters* in three of the transport accident compensation schemes and four of the workers' compensation schemes. They also participate as fund and/or claims *managers* in a further three of the workers' compensation schemes.

The nature of these schemes means that their liabilities are extremely long term (extending for the future lifetime of claimants who may be young children in

transport accident compensation and teenagers for workers' compensation). For the most part they are fully-funded or close to it (i.e. the schemes have investments which are regarded as adequate to meet future liabilities).

Government programs

The Commonwealth administers a variety of income support and welfare programs for people with disabilities. These are funded from consolidated revenue. For the most part access is restricted to people who do not have a claim on an accident compensation scheme.

In addition each State and Territory administers welfare programs, usually joint-funded, with similar access restrictions.

Problems with the system

The systemic problem in this arrangement is the lack of any clear definition of responsibility. Compensation programs vary in their level of coverage and access, introducing different levels of required government contribution by jurisdiction.

This results in State/Commonwealth and even intra-State disputes, and a poor utilisation of resources. It also inhibits innovative reform by those compensation schemes with restricted access, because this may increase their level of coverage and hence reduce government contributions in their jurisdiction.

We would welcome a clear definition of the environments and levels of coverage within which accident compensation schemes should operate, together with a clarification of State/Commonwealth responsibility in this area.

5 Lump sum damages

The previous problem is exacerbated by the existence in some accident compensation schemes of continued access to lump sum compensation under the common law system (amended by statute in some jurisdictions).

It has been shown by successive reviews (most recently the Tito Review) that lump sum compensation is rarely used for the purpose intended, is often prematurely dissipated, and results in double-dipping into increasingly scarce resources.

The typical scenario is where a claimant is awarded a lump sum for damages, including future loss of earning capacity and future costs of care. Once awarded, under common law the lump sum is the property of the claimant to be spent as desired. Once the lump sum is dissipated, the claimant is free to utilise the government programs described in the previous section. Commonwealth legislation designed to prevent this double-dipping is only marginally effective.

We would welcome a Commonwealth position which either directly eliminates this eventuality (if possible under the Constitution) or tightens the access to government programs, thereby effectively protecting the scarce resources available to non-compensable accident victims.

6 Insurance Act solvency requirements

The Insurance Act 1973 (as amended) provides the general regulatory framework for private insurers and reinsurers operating in Australia.

Inter alia, the Act specifies minimum solvency (capital) requirements for licensed insurers, being the greater of:

(a) 20% of net premium written in the previous year,

(b) 15% of the provision for outstanding claims, and

(c) $2M.

While we appreciate that the requirements are intended only as minima, our view is that the above formula is deficient in that it does not reflect the varying risk profiles for the different insurers.

In general insurers are subject to the following broad risks, namely:

- Inadequacy of provisions for outstanding claims.

  Here an appropriate capital requirement would be a percentage of the insurers provision.

- Inadequacy of premium rates.

  Here the appropriate requirement would be a percentage of "break-even" premium rates.

- Investment risk, where the capital requirement would be a percentage of asset values.

As such, a general formula for capital/solvency requirements would be of the form:

x% of outstanding claims

\+ y% of break even premiums

\+ 3% of asset values.

However, the values of x, y and z should not be identical for all insurers, but should be specific to their own business and associated risk profiles.

In essence, we are suggesting the introduction of the same form of "risk-based capital" requirements as now applies to US insurers.

Naturally, any such requirements would need to be easy to communicate, easy to apply and be administratively practical. As such, compromises from theory may be necessary.

However, we believe that the topic is sufficiently important that some effort be made to improve the existing requirements. The last time the Act solvency requirements were changed was **in response to** an insurance company failure (NEM). It would be preferable to attempt to prevent such failures **before** they occur.

The role of actuaries in general insurance has increased significantly in the past 10 years. However at present we are usually asked to advise only on balance sheet provisions for outstanding claims. Here we must consider the uncertainty in our estimates, and the question of prudential margins.

These questions should be seen in the wider context of the insurer's overall capital position. An insurer in a strong capital position has less need for balance sheet prudential margins, than one in a weaker capital position.

However we are almost never asked to comment on the insurers capital position.

The introduction of theoretically sounder requirements into the Insurance Act would, we believe, represent a step forward enabling proper comparison of insurer's financial positions.

7 Closing remarks

In this brief submission we have discussed a number of issues where we consider the broad Australian financial system is or will be under risk of tension.

Of course there are many other such areas, and each of those identified warrants closer discussion.

We would be pleased to participate in any discussion deemed appropriate by the inquiry.

Yours sincerely

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Partner

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