



idee per il libero mercato



Old Age Care

An additional challenge

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- ❖ In describing the public scheme of welfare regarding health, the word **insurance** is often used: the **Bismarck** system is defined as a **social insurance** mechanism versus the **Beveridge** model which is based on an **universal** system.
- ❖ **Health insurance** is therefore commonly placed **at the core of the social mission/role** of insurance.
- ❖ This expression is **ambiguous**, as often happens when the term “**social**” is used.
- ❖ It is not wrong (and has a positive value) if we understand it to mean that **the insurance market can meet important and relevant needs** of human beings. This is indeed the case for **pensions**: the more important the need, the more **market-driven mechanisms** can be used to meet it.

The role of private insurance



- ❖ The roles of the insurance sector may be /are **different**:
 - ◆ Distributor of policies;
 - ◆ Request /claims manager;
 - ◆ Provider of (long term) guarantees, retail or wholesale, including in the assistance sector;
 - ◆ Health services provision management.

Can private insurance companies insurance health risks?



- ❖ **Market mechanism** and **competition** can be generated by the presence of **other private players in healthcare** with the **right incentives**, like HMOs in the USA: the intermediation between demand and supply of services provider in the management of claims are relevant but the **specific contribution of insurance** can be found in the **risk carrying and management**.
- ❖ The **role of risk-carrier** creates a fundamental role for **prevention**, that will be essential to **govern long-term expenditures**.
- ❖ The main connection between health needs and the operation of insurance can be found in a specific feature of insurance itself: the **long-term horizon** - in one of my work I attempted to show that the long-term perspective is indeed **the feature that most contributes to making the insurance business different**, much more than the other usually quoted traits (e.g. financial cycle).

The economics of health insurance



- ❖ **In health insurance the risk is economically manageable when it is a long-term risk**, we are far from the moment in which the contractual relationship ends, and the contractual relationship is medium- to long-term: a one year contract with an ill, old person is not insurance, is the provision of medical services!
- ❖ **The main tool for managing this feature is a statistical/actuarial mechanism** – in a world of limited information this is **imperfect by definition** and this create the **necessity/possibility to reward the risk** with a premium for the system to be **sustainable in the long term**.
- ❖ This is particularly true for the management of long-term care issues, no technical reason for which NH system has excluded LTC from the reform area: **the technicalities of insurance** (segregated funds, reserves, capital allocated) **are essential for credible long-term promises**.

Long term care - focus



- ❖ **Big risk, low frequency:** in this case **insurance works much better** than with high frequency a small risk, where individual speculation is the rule.
- ❖ In addition the **individual cost is relatively low** and the **value of psychological guarantee is high**, even though the **perception** of this is **not particularly high** in most people (except people living alone) and **85% of expenses** for LTC is **out of pocket** (the highest segment!).
- ❖ The **stability** of numbers also tends to be good in time – **proven manageable risk** in insurance terms.
- ❖ The **relation with pensions provision** can be relevant and must be exploited. Pension funds is the optimal provider in the phase of payment of the pension, the **contractual relationship is similar**, the **statistical correlation** to be assessed and exploited.
- ❖ We are a bit **more skeptical on the role of health funds** in this sector, especially in the “decreto Sacconi” context: the 20% limit is applied to dental care which is the typical short term expense preferably managed on a service mechanism than within an insurance scheme (very high frequency).

The Italian case



- ❖ The **expense will increase** from 1,8% to 3,3% GDP for LTC reason – clearly relevant for the economic system;
- ❖ There are **success stories**: Associazione Pastore and national insurance association contract (ANIA).
- ❖ **ANIA:**
 - ◆ Operates since 2005;
 - ◆ Segregated fund with collective capitalization mechanism;
 - ◆ 0,5%, 130 euros per employee;
 - ◆ 12.2k euros per year in case of claims;
 - ◆ Whole-life insurance;
 - ◆ 43,000 people involved.
- ❖ **Associazione Pastore:**
 - ◆ Operates since 1990;
 - ◆ Technically stable;
 - ◆ Yearly insurance;
 - ◆ 30,000 people involved;
 - ◆ Managed through insurance companies balance sheet with collective capitalization;
 - ◆ 206.6 euros per employee.

Lessons to be learnt



- ❖ The **guarantee works well for big groups without moral hazard**, but this **does not imply that it must be created by law**.
- ❖ The **market has created a standard** (definition of what is the **claim** is more or less the same all over the world) **by itself**.
- ❖ The **individual coverage** seems to have **less technical potential** but can be **useful** anyway for people not reached by collective mechanism.
- ❖ The **longevity challenge** per se seems to be an issue more for **pensions** than for LTC: the **increase of life expectancy is less exponential** than for healthy people.

Health insurance – NH case



- ❖ The **NH system** is the **test / experiment** through which health insurance is going **on a large scale**.
- ❖ **Profitability** for insurance **debatable**, long term issues.
- ❖ “Obbligo a contrarre” [**mandatory insurance**] on both sides is a question mark, **usually not working well** (Italian **motor insurance**).
- ❖ Price and package defined by law to be **carefully reviewed, standard minimum package**.
- ❖ The fact that **everyone becomes insured** is relevant, introduces a **cross-selling potential** (in Italy this is already substantially true thanks to motor insurance)
- ❖ The future **adjustment** of the system on the basis of the experience is **essential**, certainly a step ahead.

Conclusions



- ❖ **Insurance companies are natural players in the health market:** public regulation can forbid, prevent, tolerate, accept, bias or encourage this, but the natural situation is of a **strong connection between health and insurance**.
- ❖ In the real world this link has been translated in many activities and roles, the ones related to **risk** are the **specific contributions of insurance** to the systems.
- ❖ The **public system** in general tends to introduce a **bias towards preferred political outcomes:** collective schemes are deductible while individual ones are not, dental expenses versus others.
- ❖ What the **insurance** system can do and does is **strongly influenced by regulation**.
- ❖ In any case **the market for health insurance is growing everywhere**.
- ❖ Even in an underdeveloped health insurance market these activities are relevant and **more than 1,5 million people** receive services from insurance in the health sector.
- ❖ In general this market is **often not profitable** and this is a clear issue for successful **long-term development**.
- ❖ **Long-term care issues are different** and must be **managed separately** but are more, not less **insurance-specific**.