



SOCIETY OF ACTUARIES

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Letter From the Editor

by Ross Winkelman

A common refrain among health actuaries and others working in health care is that the practice of medicine is fragmented and inconsistent. As an example, caesarian rates in Italy are very high at about 40 percent of births and lowest in Nordic countries at around 14 percent. Significant variations exist across the United States. Interestingly, Italy and the Nordic countries are routinely regarded as having some of the best outcomes—clearly, this variation has more to do with financing and practice patterns than evidence based medicine. This is a critical discussion because inconsistencies can result in poor outcomes and wasted resources. However, I'll leave that discussion to more qualified individuals.

In thinking through this issue and reviewing other actuaries' work, it struck me that this discussion is also appropriate for the actuarial profession. Given the same set of data and information (i.e., the same patient), should two qualified actuaries arrive at similar answers (treatment), and should those answers be communicated in a consistent manner? The struggle, like it is in medicine, is to try to achieve consistency based on best practices while not prescribing approaches that cannot consider all of the specifics of all of the various situations. The Actuarial Standards of Practice (ASOPs) are the tool that the profession uses to achieve a measure of consistency. The Actuarial Standards Board (ASB) establishes the ASOPs, and the ASB's stated goal is for the ASOPs to "identify what the actuary should consider, document, and disclose when performing an actuarial assignment." Interestingly, this does not mention results, which is arguably what really matters.

Should we consider setting a higher goal for the ASOPs—namely that two qualified actuaries, given the same set of information and assumptions, should reach a similar conclusion? Some circumstances might support this type of a shift in the ASOPs (rate filings with fully credible experience come to mind) while others might not (long term health care cost trends based on the discussion in this issue!). The basic question that we need to collectively answer is what is the best way to improve our identification and compliance with best practices? Maybe modifying the basic purpose of the ASOPs is not the answer because of their binding nature. However, I think it is important that we seek out new ways to improve the quality and consistency of our work—just like we ask the medical community to do the same. ■



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