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EDITORIAL

IT was Santayana who said that those who do not remember the past are condemned to relive it. So in order to protect our present and future readers we will report a segment of actuarial history which may not be well-known. Our readers will make their own judgments and maybe the Program Committee will find the recital of some help.

Thirty years before the founding of the Actuarial Society in 1889 there took place in New York *The First American Life Underwriters' Convention.* The term underwriter for this meeting was not confined to our friends of the National Association of Life Underwriters or even to home office life underwriters. The meeting was described as "a convention of persons engaged in the business of life insurance" and this turned out to include not only agents and actuaries but even presidents and members of the Insurance Press.

No time was lost in getting the meeting started with the appointment of a Committee on Permanent Organization which, after a recess, produced a report including among other items a recommendation that all votes in the Convention be by Companies and another recommendation that a Committee on Vital Statistics be appointed.

The President addressed the Convention and said that he hoped that it was generally understood that, when the Convention finally adjourned, gentlemen would be as free, each to conduct the business of life insurance according to his own view, as before it assembled. This was supported by the Vice-President and the Committee on Permanent Organization. The speakers were all very careful to emphasize that the Convention was only an *advisory* not a *dictatorial* body and this was before the day of anti-trust. The final item in the first day's proceedings was to appoint a Committee to arrange for a dinner the next evening.

The next day's proceedings sound familiar. "The Convention assembled at 11 o'clock. Half-an-hour having been devoted to conversation, business was resumed . . ."

The report from the Committee on Vital Statistics was in the nature of a special plea by the Chairman, Sheppard Homans, for statistical contributions from the companies represented in order to establish a mortality table reflecting the experience on assured lives in the United States.

One item from the Report of the Committee on Legislation is as follows:

> "But any system of legislation which interferes with the legitimate business of life insurance and dictates or attempts to nullify rules and regulations which Life Insurance Companies see fit to incorporate into their plans of operation, and which are in conformity with their charters, we regard as pernicious . . . "

Space does not permit of giving more excerpts from the Report of the Convention save to mention that the dinner arranged for took place. About 100 delegates and invited guests were present and there were no fewer than fifteen toasts.

So ends the skeletonized report of the proceedings of the First American Life Underwriters' Convention. Maybe there was a second convention but that will have to wait for another occasion. Historically we may well conclude that the sound principles enunciated at this 1859 Convention still obtain.

A.C.W.

TO BE CONTINUED

Editor's Note: This article is submitted by the Committee on Health and Group Insurance. Comments will be welcomed by the Committee and by the Editor.

An Overview of the Health Care Delivery System

by Frank E. Finkenberg

This article presents a view of health care as an economic system, suggests a framework for classifying current criticisms of the system, and offers references for further reading. It was prepared with the encouragement of the Continuing Education Committee on Health and Group Insurance. The views expressed, however, are the author's own.

The market for health care is an unusual one. Most economic markets serve their purposes well if goods and services are produced in quantities people are willing to buy, but health cannot be bought and the market place deals in certain diagnostic and corrective procedures designed to maintain and restore health. Prior to widespread public and private health care insurance, that is, roughly until World War II, the health care market was indeed determined by the amount of services individuals were willing to pay for, and the system worked reasonably well, for those who could afford it.

Looking back we might say that many of the services provided had little impact on health before the general availability of antibiotics and other medical and surgical advances of the middle third of this century. But improvement in health was historically not the sole function of the physician and the hospital. They exercised a caring function, making the patient as comfortable as possible and assuring the patient and family that everything possible was being done. Society was little concerned with gauging the return on money spent in the health care system, which was largely made up of private transactions. The system was roughly in balance since there were only two parties involved — the patient and the doctor.

The growth of third party payments in the system of personal health expenditures (from 36.7% in fiscal year 1950 to 67.5% in fiscal year 1976), while serving the social goal of making health

(*Continued on page 3*)

To Be Continued

(*Continued from page 2*)

care available to the vast majority of Americans, also set the stage for disequilibrium. The physician continued to control the utilization of most medical care services. His education and training encouraged him to provide "the best" medical care, which was often translated "the most." The patient incurred if anything only a small fraction of the cost of care. The trend of physicians toward specialization accelerated, as the cost of a consultation was not generally borne by the patient. The growth of medical technology was also greatly assisted, as new devices and procedures found a ready market. For his part the patient was encouraged to seek even manginally useful medical care, because the apparent cost to him was low, or zero.

Because hospital reimbursement by third parties removed a key restraint on charges, these institutions were free to bid for professional staff and prestige in their communities by offering the most up-to-date complex facilities, without regard for the potential oversupply of such facilities or the real need for them.

Other trends in society have contributed to imbalance in the health care system. Financing of health care through employment is now the modal form, having been greatly accelerated by the exemption of employee benefits from the World War II wage freeze. Thus there is another layer of insulation between the patient and the cost of medical services. If the insurer is the third party, the employer is a fourth party, absorbing most of the premium cost. Until quite recently, employers were generally not in sympathy with insurers' efforts to control costs, since these actions were taken after the services were provided, and generally resulted in merely transferring costs to the employee, leading to substantial employee dissatisfaction. The growth of private insurance, especially through employer groups, was greatly encouraged by the income tax laws. The federal treasury in effect was partially funding most privately financed health care arrangements adding a fifth party and further diluting incentives for cost containment.

Another trend tending to increase disequilibrium in the health care market is the increasing propensity to litigation, reflecting a philosophy that plaintiffs deserve to be compensated for any adverse medical outcome. Reacting to this, providers have utilized more and more diagnostic procedures, allowing standards of medical care to be defined by what is necessary to construct a good defense in case of a malpractice suit.

The conquest of infectious disease (largely due to improvements in living standards rather than medical care) has also impacted the imbalance in the health care market. Chronic conditions, especially diseases of the aged, have assumed much greater importance. Treatment of these illnesses is at the same time more costly and less effective than treatment of infection. Overall demand is increased as more people are spared an early death from typhoid or diphtheria, but exposed later in life to the ravages of cancer or cerebrovascular disease.

The system harbors no easily labeled villains; it is responding to built-in incentives and to social trends. Criticisms of the system often focus on symptoms rather than problems. Valid criticisms can be placed into three categories:

(1) *The system is out of control.* This underlies criticisms of medical care inflation, of the proliferation of technology, of too many hospital beds or too many specialists, and of overutilization of services. The theme is that the system contains a built-in bias to provide an ever-increasing volume of services at an ever-increasing cost.

(2) *The increasing volume of services has little measurable impact on health.* This criticism, while it ignores the comforting, caring, and reassuring functions of medical care, is an attempt to find some level of medical services that is justifiable by an objective standard. It implies that medical care, unlike television sets or soft drinks, has no intrinsic value, but must be measured by results. This may be too severe a test.

(3) *The system permits and encourages an uneven pattern of access to medical care.* Under this heading are included all criticisms of financial and cultural barriers to medical care, geographic maldistribution of medical resources, and concern regarding management and continuity of patient care. Financial barriers to care, largely interpreted as unavailability or excessive cost of medical care insurance, is the greatest criticism of the system in the public mind, perhaps because the solution seems so obvious. All that is needed is to supply government funds to insure those who cannot otherwise afford it, or alternatively, have the government finance health care for all. Such actions, in the absence of solutions to other problems, would merely further aggravate the system's lack of balance.

Change is certainly needed in the health care delivery system. It is likely that important changes will occur within the next two years. Whatever the nature of the changes they will have positive and negative impacts on our society, our economy, and our health.

For those who would like a better understanding of the system and the prospects for change, the following suggestions for further reading are offered:

Executive Office of the President. Council on Wage and Price Stability. *The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Put it Together?* December 1976. 195 pp.

John G. Freymann, M.D. *The American Health Care System: Its Genesis and Trajectory.* Medcom Press. 1974. 398 pp.

Victor Fuchs. *Who Shall Live? Health, Economics and Social Choice.* Basic Books. 1974. 168 pp.

Health Insurance Institute. *Major Issues in the Financing and Management of Health Care.* 1976. 34 pp.

Scientific American. September 1973. Special issue: "Life and Death and Medicine".

Anne R. Somers and Herman M. Somers. *Health and Health Care.* Aspen Systems Corporation. 1977. 528 pp.

U.S. Federal Trade Commission. *Competition in the Health Care Industry.* Papers and proceedings of a conference held in June 1977. □

Actuarial Meetings

Mar. 7, Actuaries Club of Hartford
Mar. 8, Nebraska Actuaries Club
Mar. 9, Actuarial Club of Indianapolis
Mar. 9, Baltimore Actuaries Club
Mar. 14, Twin Cities Actuarial Club
Mar. 15, Seattle Actuarial Club
Mar. 15, San Francisco Actuarial Club
Mar. 21, Chicago Actuarial Club
Mar. 30, Boston Actuaries Club