Governance Discussion for National Disability Care & Support Scheme

Insurance Council of Australia

August 2010

9 August 2010

Mr John Driscoll
General Manager Policy – Consumer Directorate
Insurance Council of Australia Ltd
Level 4
56 Pitt Street
SYDNEY NSW 2000

Dear John

Governance discussion for National Disability Care & Support Scheme

You have asked us to assist the Insurance Council in relation to the Productivity Commission inquiry into the proposed National Disability Care and Support Scheme (NDC&SS). In particular, you asked us to provide you with our views on issues in respect of scheme governance, and efficiency. This report sets out our views

Yours sincerely

Ian Burningham Geoff Atkins

Fellows of the Institute of Actuaries of Australia

Finity Consulting Pty Limited
ABN: 89 111 470 270

www.finity.com.au
www.finityconsulting.co.nz

Sydney
Level 7, 155 George Street
The Rocks NSW 2000
Ph: + 61 2 8252 3300
Fax: + 61 2 8252 3399

Melbourne
Level 6, 30 Collins Street
Melbourne VIC 3000
Ph: + 61 3 8080 0900
Fax: + 61 3 8080 0999

Auckland
Level 27, 188 Quay Street
Auckland 1010
Ph: + 64 9 363 2894
Fax: + 64 9 363 2895

Governance discussion for National Disability Care & Support Scheme

Part I Executive Summary

1 Purpose and Scope

Finity Consulting Pty Limited (Finity) has been retained by the Insurance Council of Australia (Insurance Council) to provide support in relation to the Productivity Commission (the Commission) inquiry into the proposed National Disability Care and Support Scheme (NDC&SS).

The purpose of this report is to provide our views on governance and efficiency issues for the NDC&SS.

This paper and any conclusions drawn are the views of Finity, and will not necessarily be consistent with the views of the Insurance Council or its individual members.

2 Governance

A significant element of governance for insurance schemes is financial sustainability.

This includes a focus on:

- Short term financial management, and
- Long term sustainability.

The Board of NDC&SS should have full authority to manage the scheme:

- In our view this is best dealt with outside the mechanics of Government or Government departments.
- The Board should give advice and recommendations to the relevant Minister.

A clearly defined approach to financial decision making is required, with clearly articulated standards. These should cover areas like:

- Financial management
- Decision making responsibilities and processes
- Minimum capital levels relative to benefit promises.

While these elements do not guarantee protection against poor outcomes, they go some way to creating a sound environment to mitigate that risk.

3 Efficiency

The Insurance Council also asked us to provide our views on the question of efficiency for a scheme like the NDC&SS. This is in response to a specific question to the Insurance Council from the Commission:

> *"what elements of scheme design do we consider would drive the types of claim behaviour which would maximise the efficiency of the scheme"*

It is important to have a clear view of what is meant by "efficiency". It could be any of:

- Economic efficiency
- Operational efficiency
- Some other measure?

In our view a form of economic efficiency (allocation of resources) is most appropriate. In the context of a social insurance scheme, we take this to mean:

> *providing appropriate benefits to people who need them, and not to people who don't*

In this context, we believe that a number of elements can influence scheme efficiency:

- Eligibility (who can receive entitlements)
- Benefit design (how much of what can they receive)
- Organisational culture (what is the focus of staff)
- Dispute resolution and appeal procedures.

We include two case studies in the body of or report which highlight the importance of these elements.

4 Distribution and Use

We understand that the Insurance council may wish to provide a copy of the report to the Productivity Commission. Permission is hereby granted for such distribution on the condition that the entire report, rather than any excerpt, be distributed.

Additional limitations are detailed in Section 6 of the Detailed Findings. If the reader should have any questions or need any clarification about our views, the reader should seek answers to their questions from Finity.

Part II Detailed Findings

1 Purpose and Scope

Finity Consulting Pty Limited (Finity) has been retained by the Insurance Council of Australia (Insurance Council) to provide support in relation to the Productivity Commission (the Commission) inquiry into the proposed National Disability Care and Support Scheme (NDC&SS).

The purpose of this report is to provide our views on governance issues for the scheme.

This paper and any conclusions drawn are the views of Finity, and will not necessarily be consistent with the views of the Insurance Council or its individual members.

2 Background

The Disability Investment Group (DIG) was established in 2008 to explore innovative funding ideas to help people with disability and their families. The DIG reported to the Federal Government in September 2009, and recommended a national scheme to cover the cost of lifetime care for disabled Australians.

The Australian Government has asked the Commission to *"consider how a national disability scheme could be designed, administered, financed and implemented"*.

The Productivity Commission issues paper identifies *Governance* as a specific area of interest (Section 12 of the Issues Paper May 2010).

In this paper we provide some views on issues relating to the governance of *insurers*, and *insurance schemes*. This assumes that the likely financial approach to the scheme will have strong elements of insurance (we note that a no fault insurance model is one of the key models to be assessed by the Commission).

The Insurance Council also asked us to provide our views on the question of efficiency for a scheme like the NDC&SS. This is in response to a specific question to the Insurance Council from the Commission:

> *"what elements of scheme design do we consider would drive the types of claim behaviour which would maximise the efficiency of the scheme"*

These views are drawn from our experience with the private insurance sector, as well as experience and observations with Government insurance schemes. There are areas of governance identified in the issues paper that we have no experience of, and make no comment on. In addition to our general views, on insurance governance, we also provide some views on specific questions raised by the Commission in the Issues Paper.

3 Governance framework

Discussion of governance in the context of insurance schemes starts with a relatively simple but important proposition:

> ***Insurance is a promise.*** It is a promise to meet commitments, now and in the future, should something bad happen to you that the insurer has agreed to cover

There are critical elements to meeting this promise:

- Willingness to pay, ie a continuing attitude and culture that results in fair and appropriate dealing with claimants.
- Ability to pay, especially the financial ability to meet the long term promises.

Over the long term, this requires the scheme be run "efficiently" to ensure financial sustainability. We comment more on efficiency later, but in this context we believe it means paying the right amount for the right services to the right people who need them.

Financial ability to pay requires:

- *sound short term financial management* (expense control, fraud prevention, claim adjudication, prudent investment and the like) – which a competent CFO should be expected to deliver, and
- *sustainable long term management* – a more subtle activity that extends over many years – entitlement design, expectation management, funding discipline, ability to deal with political issues, ability to recover from a downturn in fortunes.

In this context governance really means the framework for oversight of an insurance entity (either a scheme or an insurance company), to ensure its long term ability to meet consumer promises – avoiding the things that can go wrong.

Governance is important for sound financial management in the short term, but absolutely critical for sustainable long term management.

3.1 Insurance governance structures

In the voluntary private insurance sector, governance is largely commercial in approach. APRA (the prudential supervisor) sets standards and actively supervises against those standards.

The approach taken by APRA is fairly consistent with ASX best practice guidelines and would be familiar to anyone who has worked with corporate governance in the last decade. In some areas the APRA approach is more specific because of particular features of the insurance industry.

In a social insurance context (whether government run or compulsory and therefore government controlled) governance is a more subtle and difficult matter.

While the kind of problems that can arise in social insurance are quite similar to private insurance (as described in the next section) it is harder to define the best governance arrangements to deal with those problems in terms of:

- Prevention of financial sustainability problems arising
- Mitigating potential problems as they are identified
- Recovery from adverse situations without destroying the scheme, and
- Reputation risk (particularly arising from views on financial management).

The typical modern approach taken by government owners of insurance schemes in Australia is to look carefully at what APRA has done, try to understand what parts of that have worked well and what have not, and adapt those principles to their own arrangements.

In our experience it is very important that governments *adapt* the APRA approach to their own circumstances, rather than just copying APRA.

3.2 What things can go wrong in insurance?

The truly serious problems arise when the cost of the promises is greater than the sustainable ability to fund those promises. While not universally adopted, it is now widely accepted that a 'fully funded' basis is superior in this regard.

A helpful way to think about what can go wrong is to look at actual past examples. A useful reference point that we found is a paper presented to a National Competition Policy workshop from 1998 (see Appendix 1). While that workshop focused on CTP, and the common law aspects in particular, the governance examples remain relevant. There are other examples, including more recent ones, but because these crises often have political connections it is rare to find them analysed from an objective viewpoint.

Generalising from these and other examples, we have identified four underlying or 'root cause' reasons why those responsible for an insurance scheme may not achieve sustainable long term management:

- Ignorance – they do not know what the right things are, or do not know there is a problem.
- Ideology – their personal beliefs about what is the right thing for the entity are contrary to the economic requirements for sustainability.
- Malice – self interest, negligence, fraud or corruption leads them to not do the right things, and

- Interference – an ultimate controller (ie government) prevents them from doing the right things for its own (political) reasons.

3.3 Governance mechanisms

There are some specific governance mechanisms for insurers that can assist with mitigating the risks identified. These mechanisms have also been successfully adapted to Government insurance schemes in various jurisdictions. These include:

- Decision making
- Financial management/monitoring
- Reporting.

We comment on each of these below.

3.3.1 Decision making

Legislation

The legislation governing the scheme should be clear about the importance of long term sustainability and should recognise the balance between desirable benefits for claimants and the ability to pay for those benefits.

Objectives should be clear and specific, and identify where responsibility for key decisions vest. In our opinion key financial decisions should vest with the Board, and be outside the political framework.

Board structure

An insurance scheme should have a Board of Directors, distinct from its Management (although the CEO may be a member of the Board). The Board should not be a 'stakeholder' or representative board with members representing the interests of (or worse still appointed by) various stakeholder groups. It may be appropriate to consider an 'advisory council' to ensure the Board can receive the views of stakeholders.

The Board should have a typically commercial make-up with a mix of relevant skills and experience. Individuals with directly relevant experience (usually gained from a stakeholder perspective) are helpful, but only if those individuals are able to properly distinguish their role as a Director from their stakeholder interests.

It is notoriously difficult to find and maintain suitable Boards for government entities, so the more the criteria and process for appointment are agreed, the better. While Directors almost certainly must be appointed by the responsible Minister, it is important to guard against 'politically friendly' appointments.

True power with Board

The difficulty of managing the 'benefits vs costs' balance over a period of decades is a challenging one, and made more so when political issues influence the approach.

It is best, therefore, that the Board is given genuine responsibility for actively managing this balance. While the Board will (usually) not be in a position to make its own decisions about benefit entitlements, and will (mostly) not be able to unilaterally set revenue amounts, unless the sustainable management challenge is clearly owned by the Board good governance is not institutionalised.

One implication of this is that micro decision making by responsible Ministers and micro management by a Government Department needs to be minimised. While a level of Government scrutiny is required (and indeed a helpful part of the governance framework) it should be limited to major (possibly social) issues and, in particular, focused on whether the Board is fulfilling its responsibilities.

Two useful ways to assist with this objective are:

- Decisions that must be taken by Government (or a Minister) should explicitly require the Board to give advice and a recommendation to the Government first.
- To require directions by the Minister to be explicit and to be tabled/reported on.

3.3.2 Financial management/monitoring

Prudential standards

Once the legislation is established, much of the scheme governance requirements can be articulated in a series of financial management policies (similar to prudential standards in the APRA regime). These written policies (while often only guidelines and principles) provide a helpful discipline for scheme management, board and government alike, and can be audited against if necessary.

These often include standards covering:

- Required capital levels
- Premium setting polices
- Risk management
- Fit and Proper appointments (as part of overall governance).

Actuarial advice

For any insurer or insurance scheme, especially those with long term benefits, the role of the actuary is a key one in financial sustainability. APRA has codified the 'Appointed Actuary' role for private sector insurers, and while all government funds use actuarial advice in one way or another, there is no consistency in the roles and responsibilities.

The Actuary is a technical adviser (perhaps akin to the engineer on a construction project, or the Chief Medical Officer in a hospital). They are not in charge, do not make many (if any) decisions themselves, but are critical expert advisers that must be appropriately involved and whose input must be taken seriously.

They are typically Board appointments, have minimum specified role responsibilities and are seen as 'independent'.

Independent Audit

An appropriate audit function is always an important element of governance. The financial audit is not difficult (once the role of the Actuary is established and understood) and government audit offices can be expected to be competent for this role.

When it comes to performance audits or other special purpose audits, most often the government audit office does not have the appropriate skills and experience, and some form of external contracting works best. This is often the case for example for internal audit functions.

Risk Management

One of the financial policies (or prudential standards) should require the entity to undertake enterprise risk management. Rather than being specifically mandated the precise form and nature should be up to the Board to control, and there needs to be an occasional independent assessment of this function.

3.3.3 Reporting

Forward looking

An important element of reporting for an insurance scheme includes a forward looking assessment of its financial position (for insurance companies regulated by APRA this is called a financial condition report):

- This often includes an assessment of whether prices are sufficient to meet future benefit expectations.
- It also includes an assessment of the future capital position.
- While reported to the Board, it is available to the prudential regulator or in this case the relevant Minister.

Transparency

There is a difficult balance to be found between the benefits of transparency and public access to information, and the benefits of confidentiality of certain aspects of scheme management.

To give one example, the Financial Condition Report prepared by the Appointed Actuary for an APRA regulated insurer is a strictly confidential document, although it is available to the auditor and the regulator. In the case of a scheme, consideration will need to be given to the confidentiality issues weighed against any public interest.

This is important because a great benefit of the FCR is that the actuary should consider a wide range of potential risks to the sustainability of the scheme and a 'warts and all' assessment is necessary for the management and Board to consider appropriate responses.

If, however, all these potential 'fears and concerns' are aired in public (such as by tabling in Parliament or under Freedom of Information) then there is a risk that the assessment may be less forthright, resulting in diminished benefit from the process.

4 Specific commission questions

We have provided views below on several of the questions (but not all) raised by the Commission in Section 12 of the Issues Paper.

1. *"Should government departments or an independent statutory body administer the scheme?*

   In our view an independent statutory body is preferred. An important part of governance for schemes like these is to "de-politicise" financial management and oversight.

2. *To* what *extent could one agency act as the fund holder and overall decision maker?*

   This is certainly possible – the TAC is an example where this works well.

3. *What is the scope for outsourcing various functions?*

   In our view there is reasonable scope to outsource identified functions. Certain functions (for example benefit design, financial oversight and monitoring) should not, however, be outsourced.

4. *What are the lessons from existing state and territory arrangements?*

   We have included as Appendix A a copy of "Understanding scheme failures", 1998. While over 10 years old, the lessons illustrated in this paper are still valid.

   Key themes include:

- Political influence over pricing leading to financial deterioration
- Community views on excessive premium levels can lead to design change.

5 Efficiency

5.1 Case study: NSW CTP – 1980 to 1986

An expanded case study on NSW CTP is included in Appendix A.

Pre 1987, benefits were provided under common law with few restrictions placed on these. Whiplash and minor claims increased rapidly (by 30%) from 1980-1986. Fraud was believed to be rampant. The scheme (administered by the GIO) attempted to manage cost pressures through settling claims quickly – this was ineffective.

Comments:

Eligibility:

- Fault based scheme, with an incentive for claimants to be "in" to receive benefits.

Design:

- Common law entitlement – not needs based.

Culture:

- A focus on speedy compromise resolution led to increased claiming behaviour.

5.2 Case study: NZ ACC 2009

ACC is a no-fault accident based scheme operating in NZ. Established in 1974, the scheme provides a range of income benefits, in addition to medical services, care and support. Throughout the ACC's history it has undergone periods of stronger financial management based on insurance principals, and more recently periods of looser financial management with a stronger social justice approach. The 2009 Annual report included this comment from the Chairman:

> *"The most significant feature of the ACC's situation at the end of 2008-2009 is that its financial position has become unsustainable"*

The reasons for this were attributed to (amongst other things):

- Insufficient levies (prices/premiums too low)
- Declining rehabilitation performance
- Increase in the scope of the Scheme and entitlements.

Comments:

Eligibility

- Definition of a covered "accident" is the critical boundary to manage sustainability.

Design

- Absence of litigation and very small lump sum payments has been helpful in controlling claiming behaviour.
- Changing the balance to be in favour of the claimant rather than scheme finances, with less push for return to work (or scheme exit) changed claiming behaviour considerably.

Culture

- Poor governance allowed premiums to be too low for too long while ignoring the growth in claims.
- The culture of the organisation supported the shift to claimants over scheme finances.

5.3 Case study summary

These case studies demonstrate a number of elements which we believe can influence scheme efficiency:

- Eligibility (who can receive entitlements)
- Benefit design (how much of what can they receive)
- Organisational culture (what is the focus of staff)
- Dispute resolution and appeal procedures.

The lessons from the case studies are summarised below.

Eligibility

- Clear articulation of boundaries and who is covered for what is critical.
- Ensuring that lawyers/courts are not overly involved in eligibility decisions is a must:
  - An adversarial approach can add costs and increase the speed at which experience deteriorates.

Benefit/scheme design:

- Understand financial incentives (avoiding perverse incentives from the schemes perspective).

- The provision of relevant services is more efficient than cash compensation.
- Clear guidelines are necessary with distinct roles identified for:
  - Strategic management of decisions
  - Needs assessment
  - Client advocacy
  - Decision making, and
  - Review and appeals.

Culture and dispute resolution

- A consistent application of judgement by staff is required (within a framework).
- A role for dispute resolution and appeals is required:
  - Not adversarial through the courts
  - Based on expert decision making.

6 Distribution and Use

This report is being provided for the sole use of the Insurance Council for the purposes stated in Section 1 of this report. It is not intended, nor necessarily suitable, for any other purpose. This report should only be relied on by the Insurance Council for the purpose for which it is intended.

We understand that the Insurance council may wish to provide a copy of the report to the Productivity Commission. Permission is hereby granted for such distribution on the condition that the entire report, rather than any excerpt, be distributed.

No other distribution of, use of or reference to this report (or any part thereof) is permitted without our prior written consent. Third parties, whether authorised or not to receive this report, should recognise that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data contained herein which would result in the creation of any duty or liability by Finity to the third party.

The report should be considered as a whole. Members of Finity staff are available to answer any queries, and the reader should seek that advice before drawing conclusions on any issue in doubt.

Part III Appendices

A "NATIONAL COMPETITION POLICY LEGISLATIVE REVIEWS – Understanding Scheme Failures, 1998"

NATIONAL COMPETITION POLICY
LEGISLATIVE REVIEWS

WORKSHOP ON STATUTORY MONOPOLY
CTP ARRANGEMENTS

Understanding Scheme Failures

Presented on 24 July 1998

by Geoff Atkins

Table of Contents

I. Introduction

A case study approach was adopted for this session. Five case studies of compulsory third party ("CTP") scheme failure (or at least crisis) were identified, with brief descriptions of:

- the scenario before the crisis
- what happened in the crisis
- the consequences
- lessons to be learned

The analysis of each case is intended to describe the dynamics of the situation, rather than provide a detailed history of what occurred.

Disclaimer: the views expressed are the personal views of the presenter, not necessarily those of the firm he represents or any of the clients he advises.

II. Case Study 1: New South Wales pre-1987

Scenario

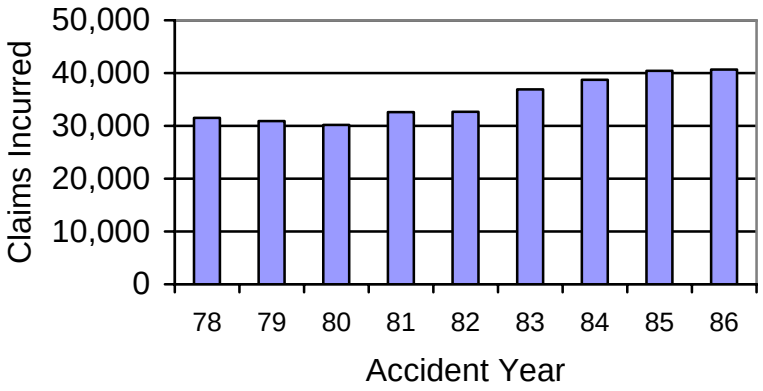
Prior to 1987, the CTP scheme in New South Wales was a government monopoly. The scheme provided benefits based on common law. There were few restrictions placed on common law benefits.

The scheme was managed by GIO, and a separate fund was established within GIO for dealing with scheme funds. CTP premiums were set by the government.

What Happened?

New South Wales experienced a rapid and serious blowout in claims, especially whiplash and minor claims. The cost of large claims also increased. This increase in claims cost was accompanied by a significant increase in frequency. For example, the number of claims grew from 30,000 in 1980 to over 40,000 in 1986. Fraud was believed to be rampant.

Table 1.1 - New South Wales
Number of Claims



In the face of increasing claims costs, GIO management was ineffective. GIO mistakenly tried the "settle quick" approach, paying whatever it took to settle the claims quickly. This fueled the increase in claims costs.

Premium increases were recommended by GIO but resisted by the government.

Consequences

Claim liabilities blew out dramatically. The scheme was unfunded by more than $2 billion. GIO management of the scheme lost credibility.

The scheme was completely reformed and replaced by TransCover in 1987. Transcover provided statutory entitlements rather than common law benefits, but the new scheme was still fault-based. TransCover was subsequently replaced by a competitive scheme in 1989.

To pay off the unfunded liability, motorists paid a $43 levy from 1989 to 1998. The levy was insufficient, however. The State budget picked up the rest of the cost.

Lessons

The common law structure proved to be unmanageable in New South Wales.

The lack of financial responsibility in pricing:

- led to the problem being ignored for too long
- ran up a huge unfunded liability
- caused the scheme to eventually be replaced

There are risks in having a single administrator responsible for a CTP scheme. GIO decisions on the approach to claim management contributed to the problem.

III. Case Study 2: Victoria pre-1986

Scenario

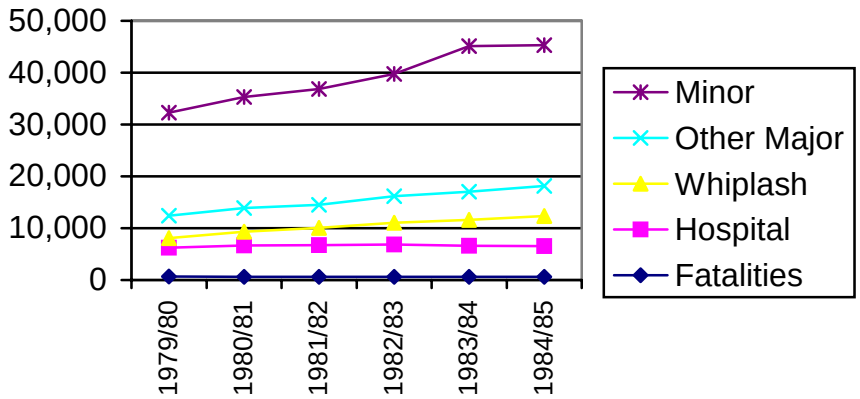
The State Insurance Office was responsible for payments litigated under common law. No fault benefits (up to $20,800 per claim) were provided by the Motor Accidents Board. CTP premiums were set by the Treasurer on advice from an independent Premiums Advisory Committee. Premiums were collected by the Road Traffic Authority at the time of vehicle registration.

The CTP scheme was an effective government monopoly, split between two agencies.

What Happened?

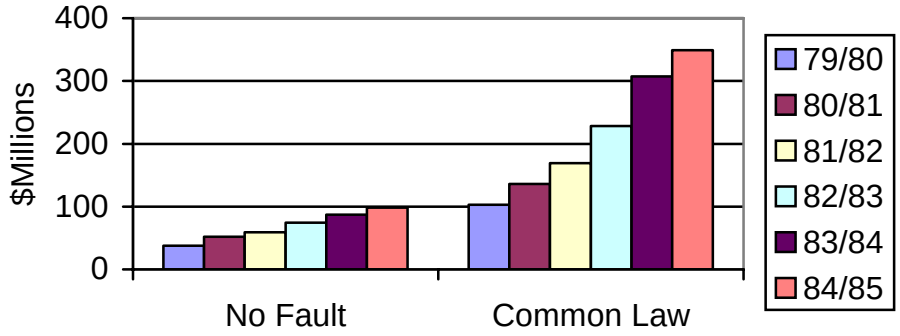
First, as can be seen in Table 2.1 below, too much money went to minor injuries.

Table 2.1 - Victoria
Claims by Injury Type



Second, the cost of claims trebled between 1980 and 1985, mainly from common law. Table 2.2 shows the increase in financial year payments over this period.

Table 2.2 - Victoria
Claim Payments



In 1986 the Premiums Advisory Committee recommended a rate increase from $181 to $500.

Why?

Several factors combined to cause the problems in Victoria. First, there was no threshold for common law claims. Smaller claims intended to be dealt with under the no fault amendments could also be pursued under common law. The government had no ability to manage adverse court decisions and the rising demand for common law.

Second, fraud was perceived to be rampant.

Third, there was poor co-ordination between the agencies.

Fourth, the recommendations of the Premiums Advisory Committee were ignored.

Consequences – Reforms

To address the lack of co-ordination between agencies, the government established a single organisation (TAC) with overall management responsibility for a new scheme on 1 December 1986.

The government abolished common law rights below a certain threshold. The benefit structure of the scheme was revised to lower the benefits provided to those with less serious injuries. These changes were intended to reduce fraud.

Premiums under the new scheme were set on a “ten year fully funded” approach. Under this approach, premiums were set high enough to pay all claims in the coming ten years, and to build up a fund sufficient to cover all outstanding liabilities at the end of the ten-year period.

Victoria set out to become a leader in accident prevention. The TAC succeeded in this regard.

Consequences – Who Paid?

The CTP scheme faced an estimated unfunded liability of $1.6 billion at 30 June 1986. This liability was primarily paid off by a 16% premium increase. The government also provided once-off support of $30 million. In the end, the liabilities as of 30 June 1986 were run off close to $1 billion.

Lessons

Prior to reform, insurers spent $0 on road safety or accident prevention; post-reform spending paid off. Victoria became a leader in accident prevention.

As in New South Wales at the same time, the government's reluctance to increase premiums exacerbated the financial crisis.

The common law benefit regime didn’t work in Victoria.

Table 5. Case Study 3: South Australia 1984-87

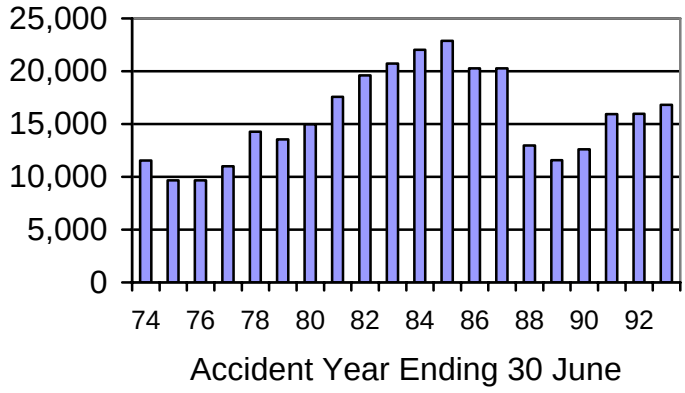
Scenario

The CTP scheme in South Australia in 1984 was a common law system underwritten by the State Government Insurance Commission. The scheme had a deficit of $30.4 million at 30 June 1985.

What Happened?

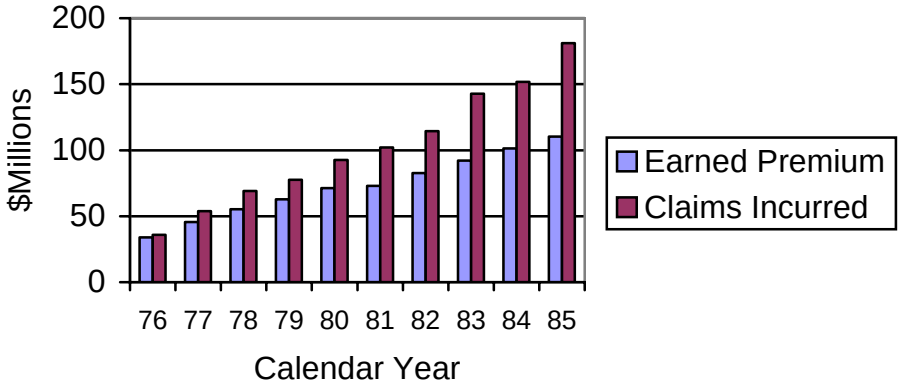
The average cost of a claim rose sharply in the ten years from 1976 to 1986. The increase can be seen in Table 3.1 below, which also shows the more recent history.

Table 3.1 - South Australia
Average Cost per Claim ($95/96)



As shown in Table 3.2, this increase in the cost per claim led to a dramatic increase in claims incurred by year.

Table 3.2 - South Australia
Premium and Claim Statistics



Factors Contributing to Fund Deterioration

The State Government Insurance Commission "had no control over the premiums, the cost of claims, or the obligation to continue as the sole insurer". The increase in average claim size was caused by changes in common law, adverse court decisions, and increasing use of solicitors.

Premiums were inadequate because of government intrusion.

Consequences

Amendments to benefit entitlements were instituted with a maximum award of $60,000 for pain and suffering, based on a points scale from 0 to 60. It placed other restrictions on circumstances in which a claim could be lodged and on the benefits payable. A premium increase was finally approved.

The fund gradually recovered, and stability of claim costs and funding returned under SGIC management.

Lessons

Unlimited common law is prone to cost blow-outs. As in previous case studies, government premium setting kept premiums too low. It is difficult to get government attention to financial soundness.

In the case of South Australia, the scheme reform took place without structural change.

Table 5. Case Study 4: Western Australia 1991-93

Scenario

Benefits under the CTP scheme were provided according to common law. The scheme was run by a government monopoly, the State Government Insurance Commission ("SGIC").

What Happened?

Between 1990 and 1993, SGIC got caught up in “WA Inc”. During that time, SGIC wrote down assets of $550 million, mostly belonging to the CTP Fund, including:

	$m
Bond Corp & Bell Group	260
Rothwells	30
Spedley	16
Property writedowns	190

By 30 June 1993 the deficit in the CTP fund was $330 million. The SGIC gained an increase in premiums of 30% in October 1991. A recommended increase of 12% in October 1992 was not approved by the Minister of Finance.

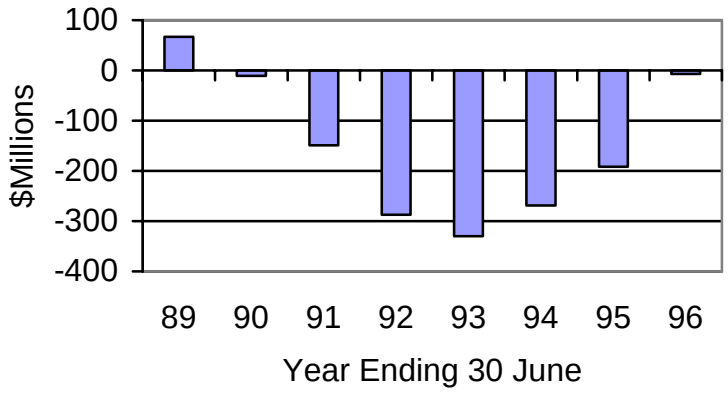
Consequences

SGIC introduced a $10,000 threshold/deductible for general damages. General damages were limited to $200,000 per claim.

A premium levy of $50 per policy from 1993-96 provided $158 million in funds. The government paid $75 million into the fund in 1996. The remaining $97 million deficit was cleared by improved investment returns. Table 4.1 below shows the annual deficit reductions.

SGIO Insurance Limited was privatised and floated publicly, although the CTP scheme remained in government ownership.

Table 4.1 - Western Australia
Reduction of Deficit



Lessons

Investment risk is material, and government funds are not immune from it.

Table 5. Case Study 5: New South Wales 1993-95

Scenario

The CTP scheme in New South Wales was privatised on 1 July 1989. Market share at that time was allocated. Price competition was introduced on 1 July 1991; insurers then had to compete for market share.

Prices fell from $350 to $200 from 1991 to 1993, due to competition and good claim experience.

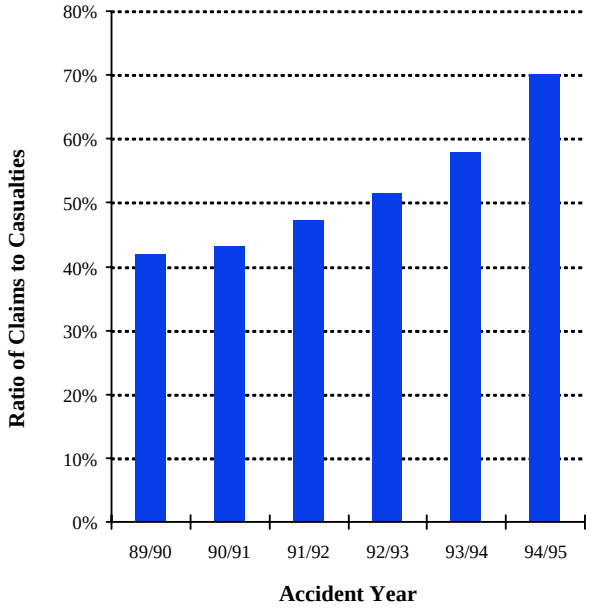
What Happened?

The number of minor injury claims increased dramatically from 1993 to 1995. Insurers made significant losses, after earlier years of very good profits.

Prices rose dramatically as well. Although prices only increased to 1991 levels, and they were not set by the government, they were politically controversial.

Table 5.1 below shows the ratio of claims to casualties. This graph demonstrates that the higher claim numbers were caused by a higher propensity to claim, not by more injuries.

Table 5.1 – New South Wales
Utilisation Rate

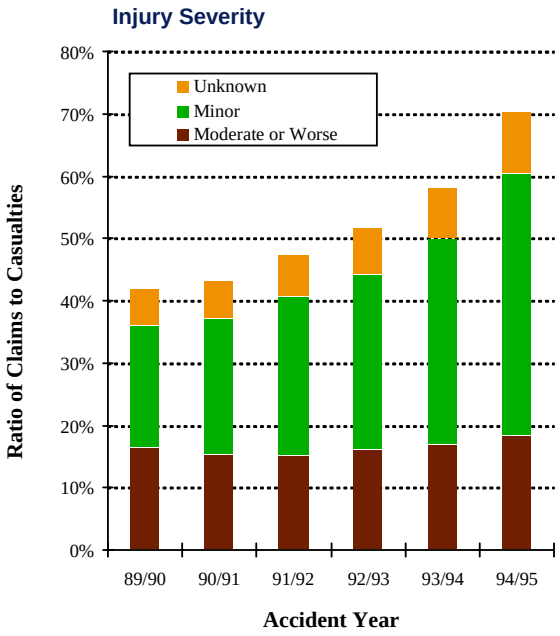


- In 1989/90 there were 42 CTP claims for every 100 injuries on the roads. By 1994/95 that figure had increased to about 70 claims per 100 injuries.
- The higher claim numbers are attributable to an increasing propensity of those injured in motor accidents to claim, not to more injuries occurring. In fact the number of injuries has fallen.

Source: Claim numbers - Tillinghast Report
Casualty data - RTA Statistics

Table 5.2 shows that the growth in claim frequency was all in minor injuries.

Table 5.2 – New South Wales
Utilisation Rate by Injury Type



- Claims are coded according to the severity of injury - minor, moderate etc., through to fatal.
- The increase in claims is attributable entirely to those who have suffered *minor injuries* in traffic accidents.
- More severely injured people (moderate or worse) are no more likely to claim than they were 6 years ago.

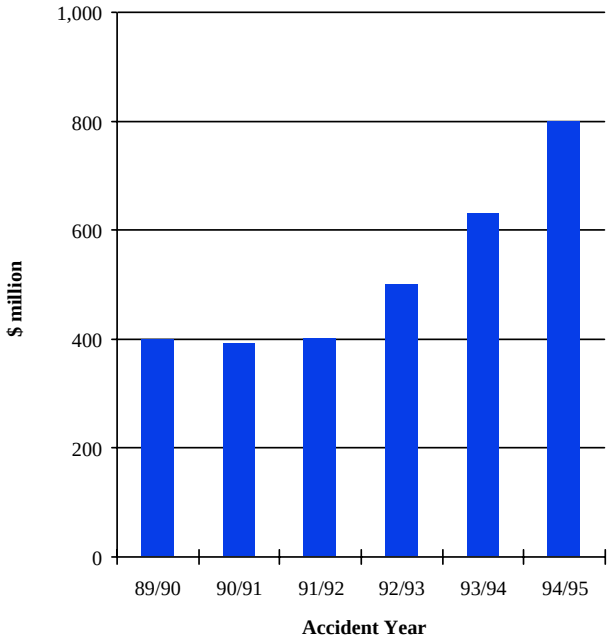
Source: Claim numbers - Tillinghast Report

Casualty data - RTA Statistics

Split by injury severity - based on Trowbridge Consulting's analysis of industry claims data provided by Price Waterhouse

Table 5.3 shows the increase in annual claims costs. Claim costs escalated rapidly from 1992/93 to 1994/95.

Table 5.3 – New South Wales
Claim Costs



- Estimated claim costs have increased considerably in recent years.
- First three years were stable before escalation started.
- 1994/95 costs are around double those for 1989/90.

Chart shows the estimated total cost of claims for the accidents occurring each year (both payments so far and estimate of payments yet to be made). Amounts are discounted to net present value in the accident year.

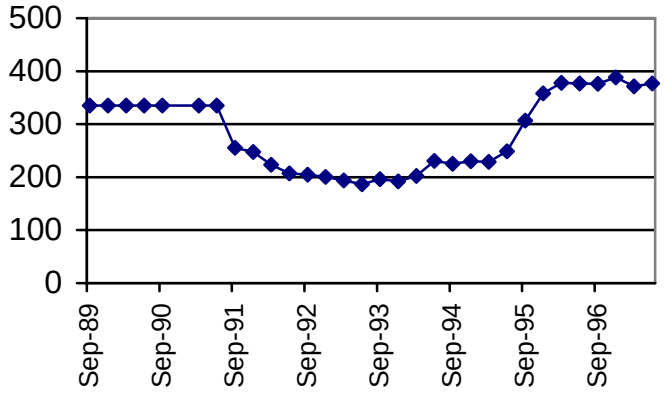
Source: Tillinghast Report for MAA "Estimation of Industry Average Pure Premium for Renewals in 1996"

Consequences

Pressure for scheme reform came from both insurers and politicians. Insurers were concerned about increasing losses, and the politicians were concerned about the rising premium level.

Further amendments to the general damages entitlements were made in 1995. The reforms stabilised premium rates. Table 5.4 shows the average premium rate from 1989 to 1997.

Table 5.4 - New South Wales
Average Premium Rate 1989-97



Lessons

The same scheme design problems can occur in a competitive scheme. The common law benefits that were a problem in New South Wales in 1987 (see Case Study 1) are still leading to instability in the losses in the state.

The insurers' ability to control prices gave them considerable power in forcing reform. In the current New South Wales scheme:

- government controls benefits through legislation
- insurers control price
- government still cares about price because insurance is compulsory

VII. Summary of Case Studies on Scheme Failure

The common law structure is difficult to manage. Strong legislative design is crucial to minimise loopholes and the ability to change legislation is needed to close them.

Problems with schemes being underfunded have arisen mainly from claim costs, although investment risk can also be a factor.

In the case studies, we consistently see a lack of responsible pricing if the scheme is Government controlled.

The community will not accept excessive premiums, whether the scheme is run by a monopoly or under competition. The reaction of the community to increasing premiums can help to force reforms.

Reductions in benefit entitlements are the ultimate (and only successful) measure to control *premiums.*

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