Executive summary

With public budgets tight, and negative incentives a concern, government is keen to focus its help on the most needy, and letting others carry ***more of their own burden.***

This may be the start of a third way for welfare, in which individuals themselves are expected to take on more the responsibility for insurable risks presently covered by the state.

There is a wide experience to draw on, both from within the UK and abroad, of how private insurance can take up some of the strain and tailor a better service to today's more diverse population.

As with stakeholder pensions, any new approach is likely to focus around the target group of people in the £9,000-£20,000pa income range, who could provide for their own protection but at present perhaps do not do so.

The stakeholder model also suggests that insurance solutions should be based around large schemes with easy access routes, perhaps through employers.

This Stakeholder Protection Account (SPA) should include a number of different protections that fit neatly together.

Such packaging will help to reduce the gaps and overlaps that occur in the private insurance market today, and serves to cut marketing and other costs.

Priority areas are likely to be those which are amenable to the stakeholder approach of provision through groups, or where insurable state benefits are already under review, or where the private sector already has some expertise.

The key insurable benefits that could be included in a SPA package are probably disbility, sickness, unemployment, long-term care, and householder protection.

Reform should build on existing private-sector skills and plug the gaps where the state is most likely to retreat — it should not try to re-build National Insurance from scratch.

Many of the alleged deficiencies of private insurance can be overcome by designing SPAs around large schemes with longer-term contracts.

Product, not sales, regulation, should aim to keep the SPA simple and affordable.

The limited introduction of positive incentive structures will help keep claims costs down and encourage more personal saving and responsibility.

The package of insurables should be designed to work constructively together with state welfare and private savings vehicles.

Section 1

The growing debate

Welfare reform is a pressing issue

This government has pledged to get a grip on state benefit spending, which it regards as a matter of serious concern.[1] Among the most worrying aspects of it are:

- the conundrum that ***pure welfare spending is growing fast, despite generally rising levels of health and prosperity***. For example, a third of the total spending now goes on means-tested benefits — twice the 1979/80 proportion;
- the worry — expressed by the Prime Minister in his recent Toynbee Hall lecture[2] that fraud and mispayment may be undermining the public's support for state benefits;
- the ***waste of human talent*** which the figures represent, in particular the many people who are trapped in unemployment and poverty by the system's disincentives;
- the sheer ***strain on the public finances***. Total benefit expenditure is nearing the £100 billion mark, far more than is raised by Income Tax (£88 billion).

BOX HERE:
NUMBERS ON BENEFIT

Welfare spending is missing its target

The statistics on benefit spending are a depressing catalogue of our failure to get on top of poverty and exclusion. For example:

- expenditure on the main means-tested benefit, ***Income Support***, is rising 8% per year. Two-thirds (67%) of those under 60 on Income Support are on benefit for a year or more;
- the number of ***lone parents*** has grown rapidly, to 1.7 million. Around two-thirds of lone parents receive Income Support — 90% of those who have never been married;
- close on five million people receive ***Housing Benefit***. Spending on it has grown by an average of 11% per annum in real terms, to £11.5 billion today, but fraud accounts for just under £1 billion;
- since 1979/80 spending on ***benefits for sick and disabled people*** has grown from £7 billion to nearly £24 billion — from 15% or total benefit spending to 25%. ***Disability*** benefits have grown by 14% per year: ***Disability Living Allowance*** has increased by 19% per year since its introduction in 1992/3;
- ***benefits for unemployed people*** are currently well below their peak — but at around £8 billion they are still costing twice the 1979/80 figure.

All of this has made increasing numbers of people ask whether today's benefit system is really tackling today's problem, or is appropriate to today's society. It has forced politicians to look critically at how the postwar welfare state has developed, and to consider whether there is ***a third way for welfare***.

The welfare problem has changed

Demographic and social changes have certainly caused the social benefit system to work in ways that were by no means intended by its original designers.

Longevity. State pensions, for example, were introduced by Lloyd George at a time where average life expectancy for a working man was scarcely more than **45.** In other words, the pension was simply an ***insurance policy*** against the very unlikely chance of living much beyond working age

(and thus, for most people, with nothing to live on).

Today, however, things are quite different. With average life expectancies of **around 73** for men and **79** for women, the prospect of living much beyond working age is now a reasonable certainty. Pensions have ***changed into a form of saving*** rather than insurance. And yet the state still provides them through an unfunded pay-as-you-go system — which may make perfect sense for insurances, but which is proving to be a rather shaky foundation for a savings system.

Diversity. Further demographic changes have twisted the effect of other ideas on which the twentieth-century welfare state was built.

For example, Lord Beveridge could be fairly confident that any benefits paid to the elderly would be helping to alleviate poverty, since few elderly people had much in the way of savings or income. The same was true for unemployed people, sick and disabled people, and (broadly speaking) families with children. So it made sense to give benefits to everyone in such population categories: most would hit the poverty target, and administration became blissfully straightforward.

But while this ***categorization*** approach still remains, we are much less likely to hit the poverty target today, because the population in each group is far more diverse:

- ***some pensioners are very poor: but many are not***, with around 30% of them having incomes *above* the national average. Raising the state pension for everyone is no longer the best way to tackle poverty;[3]

- public concern about state benefits going towards the mortgage costs of ***unemployed people*** with million-pound houses led to a change in the rules — a vivid illustration that not all unemployed people today are on the breadline;

- nor is the income / wealth profile of ***people with disabilities*** much different from that of the general population. It seems odd that the several disabled people in the House of Lords should have an automatic right to state benefits;

- with women leaving it later and later before their first child is born, ***families with children*** have more savings and larger incomes than ever before. The bulk of Child Benefit goes to people well above the poverty line.

Confusion. The changing demography, and the piecemeal policy changes that have been made over the years, have left us with a social benefits system that ***mixes up the very different principles of welfare, saving, and insurance***.

Thus Tania Burchardt and John Hills estimate that three-quarters of what we call the "welfare state" is not actually welfare at all, but ***life-cycle smoothing***.[4] It is not a redistribution of resources from rich to poor, but a system which takes resources from people at one time in their lives and gives them back to precisely the same people at some other time.

Some commentators see this as a blessing. With the middle classes absorbed into the system, they are less likely to stignatize the needy or vote to reduce their benefits.

On the other hand, this inclusivity has allowed the middle classes to vote themselves more generous benefits and — perhaps unwittingly — portray it as "welfare". But in any event, it is a dismal view of human nature which requires a deceit in order to make us do the right thing. If electors could see how little of the "welfare" budget actually went on welfare, might they not be as likely to demand an *increase*?

What is certain is that, as long as the principles of insurance, saving and welfare are conflated in the benefit system, we will never be able to scrutinize the value for money that we derive from any benefit. Only by ***unbundling the three elements*** can we see how much we are spending on each of them, how well-directed is our welfare aid, and how

effective are our insurance and saving programmes.

A third way for welfare?

Such thoughts have led policymakers to reconsider the role of the state and of state benefits in the society of today.

Work as the best welfare. For example, the ***New Deal*** marks a clear commitment to the principle that being in work is more likely to promote the welfare of individuals and their families than being on benefits. Those who are of working age and who can work should therefore be encouraged and helped to find employment, rather than being consigned to benefits by default.

Some analysts are starting to argue that people of working age should be required to exhaust all prospects of work, before they can fall back on the benefits system; while others suggest (as Beveridge proposed) that state aid should be only temporary, or limited to some lifetime amount. Clearly, work incentives are taking a much more central position in today's welfare policy debate.

Generous benefits to the needy. If more of the welfare burden can be taken up by employment, then ***greater resources can be spared for those who cannot work***, such as the elderly or those with profound disabilities. Benefits for those who are genuinely unable to work could therefore become more generous; but again there is a growing view that such help should be focused on the needy, rather than being spread through the whole of the non-working population.

Ultimately this suggests that pensions and disability benefits would be higher, but means-tested. While there are incentive problems with means-testing benefits, these are probably less severe for the unable-to-work population.

Unbundling responsibility. This general line of thought, which is starting to emerge from within the present government's policies and policy discussions, suggests a ***new division of responsibility*** between the state and the individual.

The state has always assumed a welfare role, and clearly this element must continue. But social change has turned some of its original welfare concepts into pure insurance or savings plans. Why should the state carry on trying to be an insurance company, if most people of working age could quite reasonably provide for themselves through the commercial insurance sector?

Of course, it may not be possible to divide the welfare, insurance and saving responsibilities so neatly. The boundary between those in need and those who are able to provide for themselves may be fuzzy; or there may be social-solidarity or other reasons for some continuing state involvement in pensions or insurable benefits. But if we can develop a clear vision of a workable future, then at least we can make sure that any piecemeal reform that occurs in the future is broadly in line with that vision.

Wide experience to draw on

Experience of other countries. In this task we can he helped by the example of other countries, where we often find that much more responsibility for self-protection is devolved onto individuals.

Many countries leave up to individuals and families a number of things that are seen as necessarily a state responsibility in the UK — without society degenerating into some Dickensian nightmare. Others, facing exactly the same expenditure and incentive problems that we suffer, have actively transferred responsibility from state to individual, and have reported nothing but gain from the process.

In the Netherlands, for example, the state industrial insurance board no longer pays ***sickness benefit*** during an employee's first year of illness.[5] In 1994, responsibility for the first six weeks of sick pay was passed to employers. A year later, absenteeism had dropped by nearly 20% as employers put in more vigorous absence-management programmes. Encouraged by this, in 1996 the government made employers responsible for the first year of sick pay.

Private finance and responsibility is growing in the ***long-term care*** sector too. **In** Germany: people can opt out of the state long-term care insurance programme, or stay in and top up the state cover as they choose. France is developing similar topping-up systems

In many countries, a great deal of individual provision is not financed through private insurance but through ***private savings***. In Ireland, Germany and Spain, for example, gross private savings rates are roughly equal to public spending on social protection.[6]

However, apart from private medical insurance, in which there have been many decades of growth and experience, it is comparatively rare to find widespread private provision of social insurance — such as income-maintenance insurance against the risks of ***unemployment, incapacity, or long-term sickness***. The historic dominance of governments in these functions is one reason: but as we have seen, that dominance is now being undermined.

Experience in the UK. The UK, of course, already demonstrates a mixture of public and private provision. with the latter growing in importance. Over 70% of our ***pension*** benefits, for example, are financed through private plans (and even Sweden manages to finance 50% privately).[7]

Health services in the UK are dominated by public provision, but the pure private sector has almost doubled from 9% to 15% of the total, with especially rapid growth in over-the-counter medicines, spectacles, as well as in private medical insurance.[8] Over 900,000 operations are done in each year in the private sector's 223 acute hotpitals.[9] The private sector is also strong in ***pyschiatry*** and provides about 85% of the country's ***long-term care*** services.

In the UK, other insurance approaches exist that could perhaps provide the foundation for a more comprehensive solution to the problems facing state benefits today.

Thus the confusingly named ***Permanent Health Insurance*** will replace half or two-thirds of a person's income in the event of long-term incapacity. Such insurance is widely included as part of workplace benefits packages, and can be structured to provide the same security for the whole of a person's career.

Accident, Sickness and Unemployment (or ASU) policies tend to be shorter-term contracts, and are typically used to cover the specific period of a loan. Often, they specifically cover mortgage repayments, stepping into the gap opened up by the tightening of state benefits for this purpose since October 1995.

Life insurance is a common way of providing against the untimely death of a spouse or partner, which again can help people to repay outstanding loans and provide for bringing up children. And insurance to cover ***funeral expenses*** is growing increasingly popular.

Critical Illness Cover pays out a lump sum in the event of serious illness, such as a heart attack or stroke. Again it can be used to repay or re-structure debts, or could go to the purchase of equipment and other help that might be necessary. Interestingly, the benefit is still paid, even if the insured person makes a complete recovery and is able to return to work.

Some companies offer a package of such insurances. Pearl, for example, offers a 'Protection Account' which allows people to select some or all of:

- on death, a lump sum for dependents, a lump sum to repay a mortgage, and a lump sum for funeral expenses;
- for serious illness, a lump sum, and a regular income.

Implications for reform

Gven the right partnership between the state and the private sector, it should be possible to devise an improved social protection system that relied more on private saving and insurance, and this is our task in what follows.

Section 2

The stakeholder model for reform

Big bang and incremental options

How best to put in place a new relationship between the state and individuals is a wide-open question. One might categorize the options into three broad categories:

- ensuring that private insurance ***builds on state provision*** more rationally;
- encouraging private providers to ***fill the gaps in state provision***; and
- allowing people to ***opt out of state provision*** completely and move into a private alternative.

Closer supplement. The first approach, of building on state provision, suggests that we should encourage the private sector to grow a set of products that supplement rather than replace insurable state benefits, and reform state benefits to encourage private take-up.

At present, private insurances are structured in ways that ***do not match up neatly*** with state benefits, leaving people with gaps and overlaps, and generally confusing their choice. Partly, this may be due to insurance being aimed at generally wealthier people who are excluded from state benefits or who see them as too small to take into account. But if we are to provide a much wider population with access to self-protection through insurance, then the boundary between state and insurance benefits becomes much more relevant.

Likewise, state benefits are ***not structured to encourage*** those who can make private provision to do so. If anything, because of means-testing, it does the opposite. Recent reform proposals on state benefit entitlement for disability, for example, actively (though probably unintentionally) penalize those who take out private insurance, making it less likely that people will seek to protect themselves.

Filling the gaps. Despite the distaste for means-testing that is expressed even at ministerial level, the means-testing principle is likely to spread. In the absence of some truly radical approach to reform, tightening the eligibility for state benefits is a relatively direct and effective way of controlling costs.

This is likely to open up ***gaps in National Insurance coverage*** that could in principle be filled by private arrangements; and again, the government could move to ensure that these matched the gaps in state coverage closely, were good value, affordable, and readily accessible to a wider population, and promoted members' interests — perhaps with some variant of the ISA CAT-marking scheme.

Opting out. A third broad strategy may be to allow people to ***opt out*** of some or all of the insurable benefits presently provided by National Insurance, just as they are able to opt out of the upper-tier state retirement pension. The role of government would be to ensure that there was a good-value alternative to which NI members could migrate.

This approach has many merits, giving people the maximum flexibility in a protection package that is relatively easy to explain and encourage. However, such a transition would probably be regarded as too radical and risky for the present government.

The likely outcome. At present the most likely future would see ***incremental change*** in benefits — revising the eligibility, coverage and rates of benefits one by one, without suggesting any overall strategy — rather than any big-bang reform.

Accordingly, there may be scope for the supplementary or gap-filling approaches; and again, if one starts with a clear vision of the possibilities, then piecemeal reform can remain congruent with it.

The Stakeholder Pension could provide a model

Looking at the development of the ***Stakeholder Pension*** might give us a clearer idea about what sorts of policy change is practicable in the social benefits area, and therefore what approach might fruitfully be taken in the reform of insurable state benefits.

ShP structure. The Stakeholder Pension (ShP) is designed to be a ***very straightforward*** pension offering, requiring little in the way of financial advice apart from a simple decision-tree of some sort.

It is ***targeted***, very specifically, at those on earnings of between £9,000pa and about £20,000pa — a group which, it is felt, could provide for themselves but at present tend to under-provide. Those on lower earnings are regarded as having insufficient earnings to be able to make a viable contribution to their own retirement protection, and indeed state benefits will be increased for this group. Those on higher earnings, meanwhile, are seen as being already well served by private alternatives, both individual and group schemes.

The ShP solution is built around the concept of ***large schemes*** with perhaps 50,000 or more members each. Employers and other groups are seen as ***gateways*** through which large numbers of scheme members can be recruited. And schemes must be structured to ensure that the interests of members are attended to.

Political essentials. The government's designs for the ShP may give us a broader understanding of what approaches might be acceptable in terms of reforming other parts of the welfare state and national insurance system. Looking at the broad political lessons that emerge, the ShP proposals are characterized by:

- ***not being a big-bang approach*** ~ the change is the minimum necessary to meet the government's stated aims;
- ***no major reform or disruption of existing provision*** ~ such as personal or occupational pensions (at least, this is the intention);
- ***no new compulsion*** ~ the ShP sits alongside existing provision;
- ***state support is focused on the poor*** ~ the working poor, the non-working poor, and the non-working elderly;
- ***the non-poor are encouraged to provide for themselves*** ~ with easier, collective arrangments for those in the £9,000-£18,500 category;
- ***a focus on member protection*** ~ keeping costs down and service high by operating through competing but collective arrangements.

Keeping these strategies in mind might give us a good guide to what might work in reforming the insurable parts of the social security system.

Key features of a Stakeholder protection package

The ShP is just part of the process by which responsibility for self-protection is being shifted, gradually but continually, from the state to the private citizen. Designed as it is to achieve this while avoiding all the political obstacles that lie in the way, the ShP may well provide a model that could be adapted to bring the same process to bear on the insurable state benefits.

If so, a successful strategy for insurable benefits would probably incorporate the following key features:

- it would centre on a ***relatively simple vehicle*** — perhaps a package of protections that fit naturally together, and fit with state benefits, without unnecessary confusion or overlaps (we might call this a ***Stakeholder Protection Account (SPA)***;
- it would be ***aimed at those in the £9,000-£20,000pa income band***, who may be able to take on more of the burden themselves if it were easier for them to do so;

- ***existing welfare protection*** would be skewed more towards those on £9,000pa or less;

- it would aim to reduce costs and pool risks by working through ***large group schemes***, with employers and other groups providing the natural ***gateways*** into them;

- specific measures would be incorporated so as to ensure that the ***interests of members*** were protected at all times;

- people would not be forced into the new arrangements, but simplicity and value would make them attractive, and there may be some ***rebate*** from National Insurance to help those who preferred to go into them.

Section 3

The scope for change

Identifying the opportunities

If in principle it is possible to design a Stakeholder Protection Account which would help those who can protect themselves to take more responsibility for doing so, the next question is what state benefits it might supplement, enhance, or replace.

Confused structure. At present, state benefits are a complicated mixture of programmes — some that are mean-tested and some that are not, some that depend on the individual's past contributions to National Insurance and some that do not. Of these, there will be:

- some that are ***potentially insurable in something near to their present form***;
- some that ***could be insured if the welfare element of the benefit could be unbundled*** and provided by the state in some other way; and
- some that are ***more purely welfare benefits*** that would be difficult to provide privately.

Benefits already under review as a starting point

Already there are reforms and policy discussions in progress on a number of benefits, which may indicate where politicians see the most need for change.

Benefits for ***disability and long-term sickness*** are now under scrutiny, for example, since the rising numbers of claimants has led to suspicions that these benefits are leaking out beyond their intended targets, and that poor checking mechanisms and strong perverse incentives may be producing significant levels of fraud and abuse.

The debate on ***long-term care*** provision has perhaps not been moved on much by the recent report of the Royal Commission that was established to review it, but it is clear that the present system cannot long endure, and ideas are being debated.

The state is withdrawing from ***widows' benefits***, except in cases where the welfare of dependent children is involved.

Unemployment as such has not been a central focus of scrutiny, but related issues — such as whether state benefits should cover the mortgage repayments of unemployed persons — have already led to policy changes which prompt people to make greater provision for themselves.

Private-sector expertise as a starting point

Another clue to where reform might be practicable is the range of benefits which aleady have some counterpart in the private sector, and where (as we have seen) there is already an established expertise.

For example, the ***state pension*** has its counterpart in personal and occupational pensions. ***Widows' benefit*** is just a form of life insurance, often provided as part of a pension package.

For state ***incapacity benefit*** or ***sickness benefit***, the private sector has incapacity insurance (called, rather confusingly, permanent health insurance) or products which pay out when the insured person suffers a critical illness.

For ***unemployment*** there are already private insurance mechanisms such as income protection or mortgage protection plans, mostly designed to continue paying particular household bills in the event that the policyholder becomes unemployed.

The state's ***medical insurance*** programme is mirrored in private medical insurance, while ***long-term care*** has its parallel in a small but growing market for long-term care insurance.

Legal aid is available privately in the form of legal expenses insurance, while even ***criminal and other injuries compensation***, which might be regarded as a pure welfare benefit, could perhaps be managed through a form of personal accident insurance.

Stakeholder-style deliverability as a starting point

Benefits that are already under scrutiny, and those with counterparts in the private sector, therefore suggest themselves as prime candidates for a new partnership.

So too will insurances that pass a third test: that they are capable of being delivered in some easily-accessible large group arrangement, or which are otherwise amenable to the approaches taken in the Stakeholder Pension model.

Thus we might look at benefits that could be insured by or through ***employers***. Many firms have a company pension plan, and some have more extensive employee-benefits packages; so employers are a natural foundation on which to build large group arrangments.

Employer responsibility, such as statutory sick pay in the UK and the Dutch sickness and disability schemes, may well make firms less willing to expand employment. But they do lead to a much closer scrutiny of absenteeism and the design of much more positive incentive structures, which in turn has a positive economic effect.

The state's ***income replacement*** benefits in the case of redundancy or unemployment may also be rationally restructured through employer-based insurance schemes, perhaps with rehabilitation or retraining support featuring among its minimum standards.

For ***incapacity***, the route forward would seem to be partnership, with public and private sectors agreeing on assessment and service criteria. An employer-centred insurance approach would induce employers to avoid staff sickness by better prevention and health education, and by managing absence more effectively.

More difficult items

Welfare. It seems sensible to leave the more purely welfare benefits, such as income support, housing benefit, council tax benefit, and child benefit, off our agenda, since they are not properly insurable.

Health. It is also questionable whether the financial basis of the NHS should be considered as replaceable by private medical insurance. While insurers have much experience on handling this, the subject itself is controversial and unlikely to be attractive to today's politicians.

Nevertheless, there may be ways forward, such as proposals to supplement the state financing of healthcare with private saving through medical savings accounts. For the sake of completeness it is perhaps worth keeping such options in mind.

Section 4

Issues in reform

Problems facing private insurance approaches

There are some natural commercial limitations to the scope of private insurance systems which make people question how far they might be employed as a supplement or alternative to state insurance programmes.

Uninsurable risks. The first obvious limitation is that some people who are presently covered without question by the state could be uninsurable in the private sector.

Private medical insurers, for example, do not generally insure people for pre-existing conditions: which they say is a bit like trying to insure your house once it is already on fire. Similarly, people smoke, or who pursue risky lifestyles (eg engaging in dangerous sports or travelling to dangerous places) or are HIV positive, may find themselves excluded from various kinds of insurance, or at the very least, having to pay a significantly higher premium to obtain it.

Thus if it is to become a systematic supplement or alternative to state benefits, we would need to ***find a way of making private insurance coverage more inclusive***.

Risks and income. A related problem is that risk, and therefore the cost of insurance, is negatively correlated with income. Those on lower incomes are less likely to enjoy good health, are more likely to be injured at work, and face a higher risk of losing their job — all of which makes them more expensive.

The National Insurance system, by contrast, is redistributive, and better-off people actually pay higher contributions than do those on lower incomes — in other words, those with the highest risk are actually provided with their insurance more cheaply.

So again, if it is to carry more of the burden that is now put down to the state, we need to ***find ways of making private insurance more affordable to those with high risks but low incomes***.

Perverse incentives. Insurers are well aware that people's behaviour can change to take advantage of the fact that they are covered. Those with medical insurance, for example, may take bigger risks with their health, or may demand more medical care than they really need, since they know that someone else — the insurer — will pay for it. This phenomenon is called ***moral hazard***.

Ultimately, however, it is other policyholders who pay, in the form of higher insurance premiums. Insurers therefore have to guard against moral hazard if premiums are to be kept to reasonable levels.

They employ a number of tools for this purpose. For example:

- they may ***restrict the benefit to paying regular outgoings***, so that policyholders cannot make themselves better off by making a claim;
- there may be a ***waiting period*** before benefits start to be paid, so that policyholders have to dip into their own reserves before drawing benefits;
- they may ***require policyholders to pay part of each claim***; or
- ***benefit payments might be limited in duration*** to a certain number of months or years.

Such features make private insurance benefits rather different in character from state benefits. The state is less willing to employ waiting periods or cut-offs that leave anyone unprovided, since not everyone may have savings with which to plug the gaps.

Such differences were highlighted by Tania Burchardt and John Hills[10] to suggest that the private sector, with its inevitable gaps, could never replace state insurables; and clearly ***some solution to the issue of***

incentives versus universality is required before more of the state insurance burden could be shifted to the private sector.

Anti-selection. Another difficulty arises because private insurance is usually a voluntary purchase. That means people can choose to take out only the insurances which they think they might well make a claim on — since they know more about their own health and circumstances than the insurers — and leave the rest.

Where take-up is voluntary, therefore, insurers find themselves presented with systematically riskier-than-average customers, which in turn makes private insurance more expensive than it might be if everyone were compelled to insure (as they are in the state system). Any voluntary transition from state to private coverage is therefore that much more difficult to effect.

There certainly are solutions to this. For example, ***the cost burden of anti-selection could be avoided if everyone were compelled to transfer from state to private coverage***; but then, could such a policy be made acceptable?

Individual contracts. Some insurance contracts are expensive because they are ***bought and sold on an individual basis, and often tailored precisely to individual needs***, all of which makes them costly to market and administer. The state system, by contrast, offers a highly standardized benefit package for which membership is compulsory, so much of this administrative cost can be avoided.

Insurers can certainly reduce their costs significantly by offering ***group insurance schemes through employers or large affinity groups***. It would seem that some such solution might be helpful as a way of enabling private insurance to share more of the state's burden.

Uncontrollable risks

The private sector finds it difficult to offer products when the risks concerned are unknown, or cannot be controlled through positive incentives, or are interlinked with other risks.

An international economic downturn, for example, might lead to widespread unemployment in the UK, which could be hard for unemployment insurers to absorb, particularly if interest rates and investment income were falling at the same time.

Or again, the future costs of providing medical and long-term care services are difficult to predict far into the future. All sorts of new and expensive techniques may become available, and the standards of care demanded by policyolders may rise.

While such risks remain insurable, the uncertainties may make them very expensive to provide for. The lesson, surely, is that insuance should focus on those risks that are containable and that we should use other methods (such as private saving or state provision) for the others.

For instance, the hotel costs of long-term care are much more predictable than the future nursing costs. Thus the hotel costs might be easily and properly insured, while the nursing costs might be provided by the state (the Royal Commission solution) or paid by some mixture of saving, insurance, and state finance.

There are problems in state benefit programmes too

Private insurance may have its apparent limitations, but there are serious problem in the state sector too. The choice is not between a perfect system and an imperfect one, but between two systems with different shortcomings.

Moral hazard. Thus the most serious moral hazard problems are to be found in

the state sector, precisely because it is hard for the state sector to allow gaps in its coverage.

If the state imposed a time-limit on income support, for example, it may leave some people without any means of subsistence other than charity. Or if the principle of prescription charges — itself introduced to stem the over-consumption of medicines — were extended to GP and hospital services, then some people might not be able to afford the treatment they need. But in consequence, the moral hazard problems remain — some people being unwilling to leave benefits and seek out work, others troubling family doctors unneccessarily for trivial complaints.

Meanwhile, the fact that private-sector policyholders can rely on the state to help fill some of the gaps in their coverage means that insurers face less pressure to make their own policies more comprehensive. In other words, some of the gaps in private insurance exist only because the structure of state benefits allows them to.

Policy risk. The failure to tackle moral hazard and the pressure which it puts on cost in turn produces ***policy risk*** for the state-insured population. Faced with budget shortfalls, governments unilaterally change the terms of the benefit system in order so as to staunch the haemorrhage of public money. It may mean that:

- ***national insurance contributions are raised*** (the rate rises, or the obligation to pay is spread to more people): or that
- ***people do not get the benefits they were promised***, or do not know whether they are entitled to benefit (or have to test it in the courts).

Though the private sector's ***explicit and enforceable contracts*** have their own problems in dealing with long-term trends (eg there may be dramatic changes to medical technology or unexpected epidemics may strike), enforceable contracts do seem preferable to the uncertainties which the state system has imposed on the most vulnerable groups.

Claims management. The sector is not only less able to manage risk by designing out moral hazard; it seems to be a good deal less effective in managing claims.

Unfortunately, the customary answer to rising claims costs in the state sector is to reduce the coverage for everyone — rather than to identify more precisely the degree of need and match the generosity of the benefit more closely to it.

Lack of funding. The state pays its claims out of current receipts, which means that its ***benefits cannot grow faster than taxation rises***. The private sector can afford to be more generous with its benefits because its claims are ***backed with an investment fund***. Thus the resource from which private insurance claims are paid can grow at compound rates of interest.

Confused objectives. The private sector has the further advantage that it can concentrate purely on insurance principles, and make those work with maximum efficiency and precision. The state system, however, is burdened with conflicting aims such as the redistributive principle, not to mention the politicization that surrounds the whole system. Often it is unclear how much of any state benefit is insurance and how much is redistribution, making policy confused and less effective as a result.

Less attuned to individual needs. The state product is also less tailored to the needs of the individual. By and large it offers small flat-rate benefits, whereas the private secctor's benefits can be matched to meet the actual household outgoings, or the exceptional one-off expenses, which claimants face.

Thus long-term care insurers commonly build into their contracts some early counselling to help people deal with the many problems that result when they or their relatives begin to need more care.

Critical illness cover, too, is beginning to focus not just on providing a lump sum or a regular income, but a range of helpful support such as:

- lump sums to cover medical and recuperative expenses, equipment, home adaptation etc;
- lump sums to restructure debts
- compensation for suffering and shortened expecations
- an income for living expenses
- an income for nursing costs and other additional expenses.

State and private sector convergence

Both public and private systems have their limitations, therefore; and despite the much-criticized limitations of the private sector, it does have some features which might well be regarded as an improvement over today's state benefit structures.

Indeed, ministers are increasingly willing to consider the reform of insurable state benefits a more genuinely insurance-based principles — perhaps mindful of the disincentive effects of current structures and the rising costs of the system. Certainly there are enormous political obstacles against any move in this direction, but it is clear that some state / private convergence is possible.

A private system would ***enable people to tailor their insurance package*** to suit their particular perceptions of need (say, choosing a high excess on medical expenses that can be met from family savings, but having the security of greater cover for catastrophic illness). There will be an ***increasing demand for such tailoring as lifestyles continue to diversify***, so the policy of allowing people to opt out of the state system and into alternatives could be popular.

All this suggests that ***a private-sector approach to basic insurables can deliver value***, either as a supplement or an alternative to some state benefits, although it might require changes in how state benefits are structured. By reforming some of its eligibility and claims criteria, for example, the state might be able to save money and yet provide an acceptable (or better) insurance alternative at lower cost.

Section 5

Towards a specification

The Stakeholder Pension approach, if applied to insurable benefits as a Stakeholder Protection Account (SAP). does seem to offer some answers to the various problems that beset private and public provision as they are presently structured.

Focusing on the right target group

By ***concentrating on those in the £9,000-£20,000 income band***, for example, this approach would benefit the right target group — those who could afford a well-structured insurance package, but who rely heavily on the state alternative at present.

If it exposed this large group to some of the more positive incentive structures employed by private-sector insurance managers, a SPA approach would have a widespread impact on work incentives and on the public finances. And indeed there would be less problem about using waiting periods, co-payments, or other incentive structures for this target group than there would be for those on lower incomes (who are less likely to have savings or other forms of support to draw on if private insurance did not cover them comprehensively).

Those under £9,000pa are probably still best provided for by the state system, as is the intention with Stakeholder Pension. Insurance would certainly be expensive for this group, and in any case, the greater bulk of the state support that goes to them is probably best classified as redistributionist welfare payments rather than pure insurance benefits.

Those over £20,000, on the other hand, have the resource to insure or save for themselves. Arguably no further action is needed on their behalf. Nevertheless, the choice for many such people at the moment is a range of different insurances which do not dovetail neatly with what is available from the state, and which either overlap with each other or leave gaps between each other. If the SPA idea became the foundation for new insurance packages that could easily be built on without too much consideration being needed, it might be a useful contribution to the needs of this better-off group too.

Gains from group access

Cost reduction. Structuring the Stakeholder Protection Account, like the Stakeholder Pension model, around large group schemes allows the cost of the package to be kept down. Groups of 10,000 or more can help to reduce significantly the administrative cost associated with individual insurance contract management. Size also reduces the insurers' problem of anti-selection, since very large groups will probably include a number of both good and bad risks.

Stakeholder Protection Accounts could be offered to the public by employers and affinity groups, local authorities, or efficient distributors such as utilities and credit-card companies. The stronger the mutual interest among members, the more the employers or group leaders have an incentive to keep costs down by contributing towards the sensible management of risk within their own membership.

Easy access. There could even be an obligation on employers to facilitate payroll access to a Stakeholder Protection Account, as there is with the Stakeholder Pension, unless they already provide a superior employee-benefits package of their own that covers the main insurance elements. But we must be careful about prompting employers to drop down in quality to a simple Stakeholder package (a criticism made of the Stakeholder Pension proposals), and instead give them

every incentive to offer an employee package of the highest possible quality.

Easy take-up. Making the insurance package simple to understand, with clear rules about contributions and benefits, will also encourage take-up and so dilute the impact of anti-selection. Including a range of different forms of protection in the same package will also make it harder for people to self-select against the providers: they have to take the whole array of covers, not just the one they think they might well claim on.

Benefits from packaged protection

Looking at the issues in providing an alternative to the state insurables, the ***packaging*** of income-maintenance insurances such as disability and unemployment covers would appear to be a promising direction. This has four advantages:

- it ***reduces marketing cost***, because several different covers can be sold and administered as one;
- it ***allows the covers to be made complementary***, so that customers are not paying for duplication;
- it allows insurers to ***widen the risk portfolio***, whereby people with different unemployment, long-term care, or disability risks can be quoted one reasonable premium for the whole package, rather than a cheap premium for one risk and an unaffordable one for another; and
- within such a package, ***funded products can generate the capital needed*** for the intertemporal financing of insurance-intensive products.

These points may suggest what a Stakeholder Protection package should look like. It may be, for example, that it packages today's income-protection insurances within long-term contracts such as already exist for private disability and long-term care insurance, and that some greater flexibility in the use of pension savings to fund certain insurances (such as long-term care insurance) might prove beneficial.

On the other hand, there are difficulties about bundling pension and insurance products together. The benefits of a single-product offering can be specified with precision: the rather more diffuse benefits of a package may leave policyholders with false expectations about their entitlements. Pensions and insurance work on different principles. It is also easy to price a single-product offering, since past claims experience is easily identified and recorded, but it is harder to set a price on a mixture of different covers.

Should there be compulsion?

The ideals for insurers are *identifiable risk, wide membership, some self-reliance, the possibility of pooling,* and *simple products.* In the Stakeholder Pension debate, many providers have urged *compulsory membership* as another key condition. but the present government has chosen not to accept this advice, at least for the moment.

Compulsory membership of a private insurance package would indeed reduce costs for a Stakeholder Protection scheme as well; indeed more so, since the savings on administration would in this case be supplemented by savings from eliminating anti-selection.

Nevertheless there remain political and practical barriers to the principle of compulsion and we need to define an insurance solution that does not necessarily rely on it.

Dealing with uninsurability

Careful product design should enable a Stakeholder Protection Account to take up some of the population that insurers today avoid as either uninsurable or very high-risk.

Large groups. Firstly, designing Stakeholder Protection around large groups enables bad risks to be pooled with better risks. Groups with come

common interest might even put pressure on their members to adopt a less risky lifestyle and so reduce the cost for the whole membeship.

Target group. Second, focusing the Stakeholder Protection approach on those in the £9,000-£20,000pa income bracket removes a large proportion of the hardest-to-insure population from the scheme, since many health and employment risks are negatively correlated with income.

Regulating access. A third approach is to regulate the conduct of insurance business so that the hard-to-insure population still have access at reasonable cost. Thus Ireland's voluntary health insurance programme is based around community rating — equal premiums for everyone of the same age, whether they are good risks or bad risks.

However, such strategies have their drawbacks. They leave no room for financial incentives for people to adopt less risky lifestyles. They deny entry to niche providers who might be able to handle specific risk groups more efficiently but cannot accept all-comers. They conflict with EU rules on competition.

Voluntary agreements are vulnerable to niche insurers coming in and cherry-picking — offering better terms to lower-risk groups. And insurers can subvert the aims of voluntary or mandatory regulations alike, by deliberately avoiding bad risks (by skewing their advertising towards healthier groups, for example). In a mandatory scheme, this could be countered by penalizing insurers who make above-average through cherry-picking — but by this point we have really begun to smother the very gains that we were seeking from bringing in the private sector in the first place.

Alternatively, as in the US car insurance market, ***the government could insist that insurers take on a share of the uninsurables***, cross-subsidizing them from other customers. However, the extent to which one should cross-subsidize some uninsurables (such as unsafe drivers) could be debated, particularly if it simply prompts them to take even greater but avoidable risks at everyone else's expense.

Vouchers. A fourth general strategy, ***voucher systems*** could give everyone access to a minimum standard of insurance cover, at the expense of other taxpayers, so ensuring that riskier customers still had access at reasonable cost. If the voucher did not cover the whole cost, there would still be some financial burden, but equally there would be an incentive on high-risk individuals to reduce their risk profile.

Insurance fund. A fifth strategy recognizes that much insurance risk correlates highly with age. As people become older, there is agreater chance of them falling sick, being disabled. or becoming unemployed. Again, this can be solved by a judicious mixture of saving and insurance through mechanisms such as a lifetime insurance fund. Thus policyholders would pay level premiums throughout their lifetimes: paying slightly more than the level of risk demanded in their ealy years, and less than the risk demanded later on. This alone could remove most of the problem of uninsurability.

Help through the tax system. Lastly, the ***tax or National Insurance system*** can be skewed in order to help those on low incomes find an affordable alternative.

Section 6

Keeping down the cost

Sources of cost

There are many things which affect the cost of insurance. We need to be aware of these in trying to design an affordable Stakeholder Protection Account.

There is of course the ***degree of risk***: the likelihood that people will enter and leave the insured condition (unemployment, sickness, etc). There are the ***terms of the insurance***: when benefits start, at what level they are paid, and when they end.

Interest rates too make a difference. Higher rates allow insurers to earn more on the premium income they invest, so enabling them to offer cheaper terms for the same benefit level. And the ability of insurers to diversity and spread their risks abroad makes a difference too.

There are some basic risks that we all share and which can be costed with accuracy, but for other items — health benefits, for example — there is almost no limit to what people might demand. So some insurance can be fairly standard,while others might contain ***open-ended top-ups*** that will cost the policyholder more because they deliver a higher than basic benefit.

Age is another issue. Age-related premiums solve many of the insurer's problems. Risk is roughly correlated to age, and age is fairly easy to establish without complicated tests. ***Gender*** too is a major factor: men are more likely to die earlier, for example, so life insurance and pension annuities are cheaper for them.

Incentives versus universality

One key to making a Stakeholder Protection Account affordable is to keep incentives as positive as possible. If our policies can encourage people to live a healthy lifestyle, to avoid unnecessary exposure to the risk of accidents, to maintain their value to employers, to seek work quickly if they become unemployed, and to build up their own savings against possible misfortunes, then they are less likely to make a claim on their insurances, and the cost of those insurances can come down. There are gains all round if people can see a direct benefit to themselves in acting more prudently.

On the other hand, if we are seeking an alternative or a systematic supplement to the state system, there are limits to how far we can discriminate. It would be a large departure from the principles of the state system, for example, to deny cover to or to charge much higher rates to people who had a high risk profile but who could not possibly reduce their exposure to risk.

Traditional cost-reduction tools

Insurers, however, seek to exclude customers who are almost certain to cost them money, and employ a range of tools to reduce moral hazard, to avoid unidentifiable risks, and to reduce the chances of them having to pay large claims over long and uncertain periods. Among the items in the insurers' toolkit are the following.

Avoiding bad risks:

- ***pre-scrutiny*** of risks (eg health screening before acceptance);
- ***exclusions*** (eg aids-related illnesses are not covered);
- ***short-term contracts*** allowing non-renewal if claims are bad.

Rewarding low risks, charging high risks:

- ***no-claims discounts*** (as in motor insurance);
- ***loadings*** (where higher risk customers pay higher premiums);
- ***premium discounts*** for those agreeing to reduce their risk profile;

Avoiding moral hazard:
- a ***waiting period*** (eg, the first 13 weeks of loss is uninsured);
- ***co-insurance*** (eg the insurer pays half of any loss);
- an ***excess*** (eg the insured pays the first £500 of any loss);

Claims management:
- ***claims scrutiny*** (eg using professional loss adjusters);
- ***in-kind benefits*** (eg providing hospital care, not cash);
- ***preferred providers*** (eg the insurer chooses the car repair shop);

Avoiding unquantifiable risks:
- ***limited benefits*** (eg paying the bills, not full income replacement);
- a ***cut-off period*** (eg, benefits are payable to 2 years and then stop).

How acceptable are these in a universal system?

The question for reformers is which of these approaches would be tolerable (or even beneficial) in a package aimed at the £9,000-£20,000pa income group, as a supplement or alternative to the state system?

Exclusions. As we have seen, it would not be consistent with the principles of national insurance to exclude people from membership just because some unavoidable misfortune — say, a mental or physical disability — made them net beneficiaries. There is certainly some toughening of attitudes on people taking avoidable risks — doctors refusing to treat heavy smokers, for example — but the broad aim is to be inclusive.

Premium discounts/loadings. Similarly it would be unreasonable for national insurance to charge people higher contribution rates on account of some unavoidable fact of life that makes them higher-risk — a serious medical condition, for example. So the principles of premium loadings and no-claims discounts seem hard to introduce too.

Where the risk is avoidable, it would still be novel to suggest higher or lower contribution rates, but these days it hardly seems wildly radical. Why indeed should smokers, who run higher higher health risks, pay the same national insurance rates as non-smokers? Or bungee-jumpers the same as birdwatchers? The desire to have an inclusive policy is one thing; but must we actually subsidize risk-taking? Should we not at least make people aware of the risks they are running?

Waiting periods. The measures that insurers employ to reduce moral hazard are unproblematic in a voluntary insurance system where the state will plug the gaps, but it is harder to extend them universally.

A waiting period before unemployment insurance is paid, for example, encourages people to be more careful to avoid dismissal; it encourages them to save against that risk; and it prevents people who are simply moving from one job to another taking a short holiday at the expense of others. On the other hand, people who lose their job through no fault of their own and who have no savings may find themselves in very difficult circumstances with a waiting period, unless the state fills in with coverage from the first day.

It would seem that the state system is moving more towards the private system in protecting itself against this moral hazard. The prevailing strategy now is to help people find a job, rather than to pay benefits immediately and indefinitely if they do not. The private sector too prefers early intervention, working with the policyholder to find a way of overcoming the claim event, rather than blindly paying out benefits for a long period: but it does depend on the cost of doing this in each case.

The conclusion seems to be that, if it is backed up by a real effort to help the policyholder back into work (or to get better, or to overcome a disability, or to do some form of work despite a disability) then some form of waiting period is not an unreasonable condition of a Stakeholder Protection Plan.

Co-payments. Co-payments, however — such as when the insured person is

required to pay a proportion of any claim — are much more controversial. With conditions that may be very costly and last a long time in particular, people may simply not have enough savings to go very far. In the case of long-term care, where the authorities can forcibly sell an elderly person's home in order to pay for care, it is deeply resented.

An excess. Excess arrangements — where the policyholder pays the first slice of any claim — could be somewhat different. Prescription charges are a form of excess in the NHS: the patient pays the first £5.80 of the cost of medicines, the taxpayer pays the rest. So the principle is not new, even in the state sector.

An excess is particularly useful in sparing insurers from the very high cost of managing large numbers of very small claims, and their effect on reducing premiums can therefore be disproportionately large — which is why they are so common in car and motor insurance.

Excess concepts have been mooted for ***long-term care***: that people should be expected to save or insure for two or three years' worth of care, and if they need more then the state — as the insurer or last resort — will pay for it. Such a system works in New York State and other places, and variants of it have been canvassed in the UK by experts such as martin Werth of Munich Re.[11]

Some would go further, and introduce more general excess systems into ***NHS care***. If the NHS concentrated only on the big or long-term conditions, for example, the savings would be enormous, because most of the cost of the Service goes on managing and delivering quite small packets of medical service. Some of those savings could be remitted back to the public in the form of a medical savings account which people could spend on medical care at their own discretion (or save it for later use), with special arrangements to guarantee continued access to treatment for those with chronic conditions or those on income support who exhaust their account.[12]

Claims management. Inefficient claims scrutiny is something which politicians recognise as a defect in the state system; and it is felt that there could be tighter checks on whether people really qualify for the benefits they claim.

Insurers have to balance the cost of these checks against the likely cost of claims; and sometimes a detailed investigation is not justified. Spot checks, however, might have a general deterrent effect.

Another method is to provide ***in-kind services***, rather than cash, where this is practicable: since then the cost of providing the service can be managed by the insurer. Rather than letting motorists get their car repaired at any garage in the country and then picking up the bill, whatever size it might be, for example, motor insurers today will often collect the car and have it repaired at one of their own agency workshops.

Or, they might nominate a list of preferred providers with whom they have negotiated a value-for-money repair service, and to whom the motorist can go directly. Health insurers, similarly, will nominate particular hospitals for their insured patients to use.

Limiting total claims cost. Limiting benefit payments to specific items — covering household bills or mortgage payments only, for example — is a method by which insurers can manage their total exposure to claims risk. And again it encourages people to save, since with no income they would still be in difficulties, even with all their household bills paid off,

It is hard to say how relevant this strategy might be in a Stakeholder Protection Plan. There could certainly be powerful advantages in an approach more like that of the private sector when some long-term or critical illness strikes: where the first priority is to get mortgage and other debts paid off and provide enough money for neccessary equipment, moving house, or home redesign, The state is rather poor at delivering this kind of up-front help. though it is certainly willing to pay a regular income in perpetuity (and sometimes, without much further scrutiny

of whether the claimant's condition has changed).

Time limits. Limiting the period of benefit, say between one and five years only, is another way that insurers can predict with more certainty the total cost of any claim, and so keep premiums down: but again it is quite contrary to the principles of the national insurance system, which could hardly leave sick or disabled people high and dry after just a few years.

There is still a case for having a time limit on the insurance benefits paid by an Stakeholder Protection Plan. If policyholders are still unable to work and drawing benefits two or three years after the insured event, there is a strong chance that they will always be so. At this point is it has really become a welfare event rather than an insurance event, and it is reasonable that the state should pick up the residual risk, which might involve means-testing or other welfare scrutiny. Given the very high cost of open-ended benefits, it seems fair that after an initial insured period, those wealthy enough to rely on their own resources should be asked to do so.

Section 7

Progress through partnership

It would seem that ***the private market could undertake a large part of the insurance which the state system presently provide***, though some benefits would have to be delivered in a radically different form that might give rise to ***political problems*** and which would certainly require some ***re-engineering of the boundaries between the state and the private sector***.

The need for partnership

The Stakeholder Pension is built on the idea of a partnership between the state and private sectors, where the state provides (and indeed, aims to provide more generously) for those who have no realistic alternative, while those who can opt out are encouraged to do so and enjoy the benefits of competitive provision and the superior returns from funding in the private sector.

Stakeholder Protection could fruitfully harness some of the same principles of partnership. We need to recognize that the incentive structures used by the private sector means that it is better at getting people back to work — and paying taxes. Private insurers will also want to intervene quickly — with early retraining or rehabilitation or medical treatment, for example — in order to reduce their exposure to long-term costs, while there is less pressure on state providers to think in this sort of way.

Complexity and awareness. The state for its part can help by keeping down the regulatory and tax management costs of a Stakeholder Protection Account, regulating it through benchmarking rather than complex sales regulation, and easing the tax rules to allow packaged products (which might involve some more flexible use of individuals' pension savings).

Even if the government stops short of making the Stakeholder Protection Account compulsory, it can still move to keep it simple and to promote public awarness of it and education about it.

Sharing risk. Private insurance focuses on risks that are both identifiable and manageable: only at great cost can it provide for risks that are unpredictable and open-ended. Thus private insurance might be the natural vehicle to cover the relatively quantifiable risk of two or three years' long-term care costs, while the state might be better placed to absorb the rather uncertain expense when people need care that might stretch many years beyond that.

Another issue that must be resolved is who carries the cost of epidemics, self-inflicted injuries, or the anti-selection risk that it becoming increasingly burdensome due to the availability of genetic testing.

Dovetailing state and private protection. Another beneficial partnership might involve shaping insurance and savings packages so that they fit naturally together and help keep down insurance costs. Insurers like their terms to include some measure of self-reliance, because that is an incentive to avoid making claims unnecessarily, and indeed to pursue a more prudent way of life that makes a claim less likely. If people have savings to rely on, therefore, the cost of their insurance can be cut. The state can promote such beneficial effects by ensuring that savings vehicles such as the ISA are structured so as to make it possible.

Assessment criteria. There needs to be, in addition, a public-private agreement about assessment criteria — what tests there are for what conditions, and what conditions trigger access to state and insurance benefits — and a sharing of information on past claims experience.

Minimum service quality. The minimum level of cover will plainly have to be set by the government, but this should be after

serious discussion with insurers, and in the light of their views on what is and is not commercially deliverable, and in the light of a debate about what is properly a welfare function and what is best provided by insurance.

If it is decided to put more reliance on private-sector alternatives, the proper role of the state should be to set standards, using courts or ombudsman systems to maintain service quality and supervise customer claims experience; but not to continue operating in some form of competition with private providers at the same time.

Positive incentives for self-help. Another helpful partnership strategy would be measures to ring-fence social benefits for those who insure, so that the insurance benefits they have struggled to pay for are not simply knocked off their state benefit entitlements. Current policy, unfortunately, seems to have gone in the opposite direction when it comes to disability insurance — but if we have a clear vision of where a succesfful partnership can lead us, such mistakes will become easier to avoid.

Rebate incentives. Governments must also be willing to redesign state-sector insurables so as to make migration into private alternatives affordable and natural.

Thus a more robust attitutde to moral hazard, in which some short-term or moderate costs were left to personal saving and responsibility, might reduce the apparent gap between state and private systems. Or again, if the state agreed to underwrite long-tail risks as a welfare function, it would help insurers to concentrate on the risks they are best able to provide for.

It would also be possible to speed up the migration to insured alternatives by making National Insurance rebates available, as they are today for people who opt into private pension plans.

Administrative co-operation. It is quite likely that providers would create their own clearing-house for the collection and distribution of premium revenues and the delivery of benefit payments, rather than trust to the National Insurance Recording System (NIRS). It would be natural to use for insurances the same clearing-house system that emerges for Stakeholder Pensions. For its part, the government would need to enable providers to tap conveniently into NIRS, particularly if rebates were on offer to people opting into the Stakeholder Protection Account system, or if SPA providers were obliged to give policyholders some consolidated statement of their insurance position, state and private.

Section 8

Specific insurables

It may be useful to speculate in a little more depth about the insurables that might be made a part of a Stakeholder Protection Account. The main insurable state benefits can be grouped into:

- ***retirement*** provision;
- ***disability***, ***sickness***, and ***long-term care***;
- ***unemployment*** insurance; and
- ***medical*** insurance.

These benefits are payable either as:

- ***replacement of income*** or the maintenance of some threshold of income over time (eg pensions and invalidity benefit); or

- financial support to cover ***major additional expenditures*** (eg disability living allowance, industrial injuries compensation); or

- the provision of ***in-kind benefits*** (eg NHS medical care).

Long-term care

Current debates. The Royal Commission's proposal to provide the nursing element of long-term care as a state benefit has not been greeted with wild enthusiasm by the politicians who would have to find the money. Indeed, at a time when we are looking to see how individuals might take up more of the burden we presently leave to the state, the proposal looks decidedly anachronistic.

On the other hand, it would help to make the chargeable elements of long-term care more insurable, since hotel and general costs can be predicted with more certainty than future nursing costs.

Future strategies. Long-term care is perhaps provided most efficiently through a mixture of saving and insurance. The insurance costs are hard to predict, since new medical technologies might allow people to live longer, albeit dependent for longer on the costly medical support. This insurance cost comes down if people are prepared to put their own savings towards care, or if they take out insurance at a younger age, allowing the premium to be invested and to grow. Including long-term care insurance as part of a SPA scheme would enable people to make this early commitment to their future costs.

The most obvious way of enabling people to apply their savings to long-term care, however, would be ***greater flexibility in pensions*** (such as allowing people to take a cash-free sum at retirement in order to purchase a single-premium long-term care insurance policy).

The second most likely outcome would be some ***risk-sharing*** scheme like the New York system, where individuals save for or insure the first two or three years of long-term care costs, and having made that commitment, the state then agrees to pay the costs of any longer spell in care.

Related benefits. While ***Attendance Allowance*** is commonly grouped with the various benefits for disablement and incapacity, its beneficiaries are mainly older people who are cared for at home. It could therefore be managed either as part of the long-term care element of the SPA package, or as part of the severe disability element.

Unemployment

Difficulties for insurers. Unemployment is a difficult risk to insure privately because ***anti-selection*** is rife (people who have reason to think they might soon lose their job are the first to apply for the cover), as is ***moral hazard*** (people with the insurance may care less about being fired). In addition, the ***risks are concentrated*** and ***uncontrollable***: the causes of unemployment (which may include government policy) are impossible to manage and may be very wide in their effecs (a general recession may produce

very large numbers of claims, for example).

International reinsurance may offset some of the risk concentration, since it is less likely that all countries would be in recession at the same time.

The fact that there is relatively little experience of this risk in the private sector, means that insurers have ***limited information*** on which to price the cover. The state has been covering this risk for many decades, but it is not clear that its data on unemployment risks is of sufficient quality to be much help in the exercise.

Waiting periods and limitations on cover, perhaps relating benefits to household outgoings only (such as mortgages, loans, and pension contributions) rather than paying an income-replacement cash sum, may be the only way to insure this risk, even as part of a SPA arrangement.

State-private partnership. The way forward would therefore seem to be a partnership, in which the state filled in the waiting-period gaps for the very poorest, but introduced incentive arrangements for others so that the state benefit came more to resemble the SPA alternative. It also seems reasonable to place a time-limit on SPA and state cover (as the Job-Seekers Allowance does) and treat anyone who remains unemployed beyond that time as a welfare beneficiary.

Disability/sickness

Selection and hazard. The issue of ***anti-selection*** has become a major concern with disability and sickness insurances. ***Medical screening*** might help overcome this, though it is expensive to employ and spreading the risk through group access might be a more cost-effective mechanism for SPA providers.

Moral hazard is a particular worry in the state sector — the spate of claims for disablement benefits during the last two recessions owes more to the weak controls against moral hazard than any true linkage between economic downturn and disability. It is however containable to the extent that medical tests can accurately establish a person's ability to work.and are cost-effective to apply.

As with unemployment, a long waiting period is most cost-effective, since there are many people whose incapacities prove only temporary and who can get back to work within three or six months. And it would tempt moral hazard to offer complete income-replacement benefits, since people exaggerate their earnings to maximize the benefit: some linkage to actual outgoings would be safer.

As with unemployment again, very long periods of disablement are probably better treated as a welfare problem rather than an insurance issue. This might mean a means-testing approach to long-term incapacity, as now happens with Jobseekers Allowance; but that need not be too controversial if the financial savings were directed more generously to those who really had no other means of support.

Agreed eligibility criteria. The definition of disability is all-important. There would need to be some agreement between public and private sectors on how claims are assessed, and a sharing of claims experience.

Pricing is difficult because the causes and nature of disability, and their impact on a person's future earning power, are hard to predict.

It is commonly agreed these days that claims-management strategies should concentrate on what the disabled person *can* do, and if possible to help that person into suitable work, rather than sideline them permanently as incapable of work.

Encouraging health and safety. The state could certainly help to promote health promotion, rehabilitation, and re-training. Ideally, lower premiums should be available to those pursuing healthier or safer lifestyles. Employers could be encouraged to install absence-management programmes, and to foster greater health and safety consciousness among employees.

Statutory Sick Pay may indeed encourage employers to do just this. And arguably the insurance for ***industrial disability***, ***death***, or ***injury*** should be borne by employers too, for the same purpose of encouraging employers to operate more safely.

Other benefits

Family benefits. Maternity benefit is at first sight hard for the private sector to insure because pregnancy is almost always a voluntary condition. Nevertheless, some companies do offer maternity benefits. Generally speakiing, however, savings-based solutions are likely to work best, as are solutions that are based on actual costs — so that people cannot profit from insurers as a result of making this voluntary choice. Benefits to needy families with children would in any case remain a welfare function of the state.

The future of ***child benefit*** is already under debate, since most of the expenditure goes to people who do not really need state support; and likewise ***one-parent benefit*** has come under scrutiny as the number of single parents rises. It seems difficult to transfer either of these into a SPA insurance package, particularly so when the policy debate makes their future design uncertain.

Health and social care

The UK and other countries now have considerable experience in managing ***private medical insurance***. However, to replace the NHS with private medical insurance on a wide scale would be politically contentious, so it may seem unlikely that health insurance has any place in a Stakeholder Protection Account.

Nevertheless, there is certainly some case, on the grounds of moral hazard alone, for moving in this general direction, provided always that everyone who needs medical care is still guaranteed access to it.

A mixture of saving and insurance might be the way forward here. Extending the principle of prescription charges into other medical services would still guarantee free healthcare to the elderly and those on the lowest incomes, while introducing for those who could afford it some more positive incentive to use medical services more carefully.

As mentioned above, a mechanism of medical savings accounts could see the NHS (and private insurers) concentrating on providing the larger medical services only, remitting the cost saving back to individuals to use on health services at their own discretion, or to save for later use (perhaps to boost their retirement income). There is already considerable experience of the use of this principle in the private health sector in the US, resulting in lower costs for providers and a greater feeling of access and control among patients. This evidence, and details of how this same principle might be applied in the UK context, have been outlined in the Adam Smith Institute report *Medical Savings Accounts*.[13]

Section 9

Transition mechanisms

Route forward still undecided

Gaps are certainly opening up in the welfare state, which might make space for a form of Stakeholder Protection Account that filled the gaps and supplemented the existing system, but the future relationship between state and private sector is still unclear.

There are a number of possible outcomes. Politicians might:

- continue to provide a flat-rate service available to everyone, leaving those who want to supplement it privately (as with the NHS and private medical insurance today);
- seek to cut costs by bearing down on benefit eligibility, trusting that those made ineligible will save or insure (as with the reform of widow's benefit);
- actively encourage people to take up new private supplements or alternatives to state benefits (as with the Stakeholder Pension and rebates from the State Second Pension);
- aim to provide more generous benefits, but only on a means-tested for those who are demonstrably unable to work (as in the New Deal or the Minimum Income Guarantee for pensioners);
- make a minimum level of private insurance compulsory (as with Statutory Sick Pay or motor insurance).

The answer to that will determine the structure of the private-sector offering. We then have to decide how to structure the Stakeholder Protection Account package, how to adjust state benefits so that they dovetail more precisely with the SPA approach, and whether as a stepping stone some state insurable benefits could be transferred to private insurance or reinsurance arrangements, as has already been done with statutory sick pay in the UK and sickness insurance in the Netherlands.

Benefit package design

In terms of commercial practicability, one could envisage a simple and low-cost Stakeholder Protection Account, with a package of covers provided on a group basis and aimed at the same target group as the Stakeholder Pension.

A typical benefit within the package would have a waiting period of perhaps 3 months, after which benefits would be payable that replaced previous income (based on, say, an average of the person's income over the last two years), or which continued to pay household expenses including mortgage payments, plus any further expenses that arose by virtue of the insured event happening.

One might expect the package to include early cash benefits for the restructuring of household debts and other costs such as the purchse of necessary equipment, training, or counselling.

In the longer term, benefits might taper down to some basic flat-rate benefit unrelated to previous income, which would help keep insurance costs down; or the state could continue to support the individual, on a means-tested basis, as part of its welfare function.

Long renewable contract periods would encourage loyalty on the customer side and service on the provider side, and a long contract reduces marketing and underwriting costs, so making the package affordable to more people.

Another aim would be to keep the SPA system accessible to the widest number of people in the target group, but to allow people to build on it and add further cover simply and without the overlaps that are typical in the private market today. Better-off people with savings, for example, may elect to have longer waiting periods in return for higher rates of benefit; or they might wish to pay more to

add some new benefit that is not included in the SPA package, or higher rates of benefits for the events that are included.

Moving through the boundaries

The migration strategy from more state to more private provision thus depends on the different strategies adopted for different state benefits.

Broadly, however, the migration to a Stakeholder Protection Account system could be encouraged by voucher systems (which guarantee everyone access to a basic private service package, but allow people to top up as they choose); or more simply by tax reliefs and NI rebate incentives for leaving state insurables and opting for SPA cover. It would help reduce costs and bring greater certainty into the system if people taking a rebate could not opt back into the state system once they had elected to take out a SPA package.

In any event, it is clear that the state has an obligation to ensure that everyone has access to a basic protection package of some sort (state or private) and that individuals can easily build on that to increase their level of protection of extend it into other aspects of life.

Add ons

(see******** WPA 241 package).

238. Contingency fund****
239. ideally 3 months income replacement
240. or basic benefits
241. premiums, say 1% of income
242. set rte to keep average person OK (eg £3k-£5k)
243. grows through life unless drawn down
244. saving (reduces claims), not a premium
245. ring-fence pension
246. heritable (so peple will conserve)

BOX****
225. Costs
226. concept of risk rates £ per £1000 cover
227. excluding expenses and admin
228. tables
229. (blue collar 2x cost)

230. year old on average income (20k)
231. PHI £200
232. LTC £100
233. PMI £300 (ex A&E)
234. Pension (incl waiver of premium, life cover)
235. about £3000 for 2/3 pension (total 20% of salary)
236. about £500 for basic pension (total 10%+ of salary)

237. (what about coverage of family members?)

BOX 1
Numbers on main benefits (millions)

	1949/50	1979/80	1996/7
State pension	4	8.9	10.6
Child benefit	4.8	13.7	13
Income support	1.1	3.2	5.8
Jobseeker's benefit	0.1	0.5	0.3
Incapacity benefit	1	1	1.9
Family credit	0	0.1	0.7
Attendance/DLA	0	0.3	2.6
Housing benefit	0	3.2	4.4
Council tax benefit	0	5.3	5.8

****** UPDATE******

****** BOX**
****** update conditions and rates**

Means-tested income replacement benefits

These are intended as welfare support measures and there may be a limit to how far they are potentially insurable privately.

Income Support — a means-tested benefit. Premiums are payable for disability, severe disability, disabled children, and carers. Eligibility for Income Support can act as a gateway to other benefits such as Housing Benerit and Council Tax Benefits.

Housing Benefit — a means-tested benefit to assist with rent and mortgage interest payments for people on low incomes. It is administered by local authorities but largely financed by central government. Claimants on Income Support generally receive their full eligible rent as benefit; others receive means-tested help. Premiums are payable for disability, severe disability, disabled children and carers.

Council Tax Benefit — a means-tested benefit to help with council tax charges, and administered by local authorities. Premiums are payable for disability, severe disability, disabled children and carers.

Jobseeker's Allowance — a means-tested benefit of temporary duration for those actively seeking work. Premiums are payable for disability, severe disability, disabled children and carers.

Benefits for sick and disabled people, and carers

Statutory Sick Pay — not strictly a state benefit, but a legal obligation on employers to pay workers earning about £64 pw the amount of £57.70pw for the first 28 weeks of illness. After that the employer's obligations end, but Incapacity Benefit becomes available from the DSS.

For those who do not qualify for SSP, such as the self-employed, Incapacity Benefit of £48.80 per week is available up to week 29, then at £57.70pw up to 52 weeks, then at the long-term rate of £64.70pw thereafter.

Incapacity Benefit — for people who are assessed as incapable of work and who have made the required NI contributions. Paid at three rates, mainly dependent on length of time on benefit. From week 29 of illness to week 52, it is paid at the £57.70pw rate, and thereafter at the long-term rate of £64.70pw. There are additions for dependents and depending on age at the onset of incapacity.

Severe Disablement Allowance — for people who are severely disabled and assessed as incapable of work but who have not made NI contributions to get Incapacity Benefit. Additions are available for age and dependents.

Disability Living Allowance — for people who become severely disabled before the age of 65 who need help with personal care and/or mobility. Not means-tested, nor dependent on NI contributions. Paid at three rates for the care component, and two for the mobility component: someone unable to dress or prepare meals, for example, might qualify for between £13.60pw and £51.30pw. Can be paid alongside other benefits, if relevent criteria are met.

Disability Working Allowance — paid to people in full-time work and with a disability or illness that disadvantages them for employment. Not dependent on NI contributions, but means-tested.

Invalid Care Allowance — for people looking after a severely disabled person for more than 35 Hours per week, and earning not more than £50 per week, after allowable expenses. Not means-tested nor dependent on NI contributions. Additions for dependents.

Industrial Injuries Disablement Benefit

This benefit is paid as a result of no-fault accidents at work or the onset of work-related diseases. It is paid out after the first 15 weeks of disablement. The rate is £20.94pw for someone considered to be '20% disabled', rising to £104.70 for someone completely disabled.

Box ****

Private insurance products

Permanent Health Insurance — a form of income protection policy which pays a regular, monthly income to people who cannot work because of illness, accident, or injury. Benefits usually begin only after a waiting period,

commonly 13, 26 or 52 weeks. Usually the amount paid out is around half to two-thirds of the person's former gross yearly earnings.

The cost of this kind of policy is heavily dependent on the type of work which the policyholder does, since different jobs involve different levels of risk. Thus the typical premium for a 35-year-old building worker seeking index-linked benefits of £10,000pa after the first six months might be around £44 per month whereas a keyboard operator might pay only around £17 per month.[14]

Accident, Sickness, and Unemployment — ASU policies are usually more limited in duration, often being used to back up a mortgage or long-term loan. Their benefits may be more limited too, paying out a one-off sum or unemployment benefits for, say, a year only. It is also possible to buy the components separately.

As an illustration, a CGU accident and sickness policy paying a 35-year-old manual worker £10,000pa would cost around £38 per month. The waiting period would be only 30 days, but it would only pay one year of benefits.[15]

Critical Illness Cover — pays out a lump sum when the insured person is struck by specified severe medical conditions. The broad aim is to help someone struck down with a serious illness to cover or reorganize household debts such as a mortgage, and to finance medical support and any increased living expenses. But it does not depend on the person's ability to continue working: for example, the insured person could suffer a heart attack, claim on the policy, and then make a complete recovery and resume work.

Life assurance — may be taken out to cover the premature death of a partner, and thus to make up family income if the breadwinner dies. A 'term' policy will pay a particular amount if death occurs within a specified time — say ten or twenty years. Thereafter there would be no pay-out. A 'whole life' policy costs more, but pays out whenever the person's death occurs.

** Female rates

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1 As an indicator of this, see (***focus papers onwelfare reform)

2 **Toynbee hall lecture date ref

3 A point made by the Prime Minister *** reference

4 John Hills: ***The Future of Welfare*** (Joseph Rowntree Foundation, 1993)

5 See ***Info*** i 117E (Ministerie van Sociale Zaken en Werkgelegenheid), September 1996-5371.

6 (XX ref BH&P p44)

7 (XX Ref OECD 1998)

8 (XX reference Tania Burchardt, John Hills and Carol Propper p10)

9 Source: Independent Healthcare Association.

10

11 See, for example, Martin Werth, "Achieving a Viable Funding Solution" (BUPA Health Debate, 1998.

12 msa piece

13 med sav accs report ref

14 The Times Money Guide, 6 February 1999, p5

15 The Times Money Guide, 6 February 1999, p5