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**INSURANCE
AND REGULATION**

**SERVICES
AND COMPETITION**

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When one considers that every year consumers pay out hundreds of billions of dollars (over 10 % of their income) for insurance and that from this money of the insured hundreds of billions are accumulated as capital investment, it is staggering how little informed are the insured and the public in general about procedures in the field of insurance. Recently, however, in the United States of America public debate about consumer problems in insurance has begun which is slowly focusing attention on the basic problems.

The principal themes of this debate are

- more or less state regulation of insurance. That is at the same time tied up with the question of more or less competition in the field of insurance
- discrimination of the insured through exaggerated classification (especially in automobile insurance)
- problems of the consumer in the availability and affordability and in the supervision of insurance protection.

The new European laws about insurance that must in the same way deal with these problems are emerging, in contrast to the procedures in the United States of America, in the absence of publicity. This isolation and the lack of information is justified by those responsible on the grounds of the complexity and with the inability of the consumer to understand the complicated procedures in the insurance field. Notwithstanding this insurance is not complicated. It first became complicated when about 100 years ago stock companies began to carry on their particular style of profit seeking business in the field of insurance.

In the following study the actual influences and developments shall be illustrated and represented, as – at present – all consumer problems in insurance boil down to the question concerned with the nature of insurance.

Many people either do not know or do not observe the fundamental difference in the way in which insurance is undertaken these days, namely on the one hand by the insured themselves (in non profit making mutual or public insurance institutions) and on the other hand profit seeking through stock companies, which represent „insurance” as their economic performance. It is a great mistake to assume that these different forms of insurance are one and the same and that identical theories, concepts and laws can be applied to it. It is also totally unjustified that “insurance” in general is met with such far-reaching mistrust.

The nature of insurance

The starting point for all research of insurance problems must be the question concerning the nature of insurance.

To insure oneself, one’s family, one’s property and one’s livelihood is a very natural need.

A human being has many capabilities with which to do things. These he wishes to preserve and develop to increase his efficiency.

A simple example: a man wishes to construct a shelf. Besides his own practical ability he requires wood and nails as basic materials, that will enable him to construct the shelf. This man can without difficulty calculate how many nails he requires for his project. However there remains one problem:

the uncertainty of the future ! –

There is a danger that he will hit some nails crookedly and that he will not have enough nails in order to complete the shelf and fulfill his capability.

Danger is the possibility that a capability can be disadvantageously altered or destroyed.

Risk is a capability that can be disadvantageously altered and destroyed.

The man in our example has several alternatives in avoiding the risk and danger to his shelf building. He can simply say: „It is quite unimportant to me whether the shelf is ready today. If I hit too many nails crookedly I can buy some new ones later and carry on with the work later on.” – He can even say: “If I do not make this shelf then I can use the wood for my fire.” – This man sees no danger attached to his project.

Danger and risk are determined by reference to the value attached to a particular capability.

If the man wants to complete the construction on a particular day then he attaches a particular value to this capability and he has a natural anxiety to insure this capability – he has an interest in and a need for insurance.

Insurance is a precautionary measure taken to preserve a capability.

In our example the man will buy sufficient nails so that he can be certain that he will have enough even when he hits many of them crookedly. He makes a “nail reserve” ! Thus he has taken away the danger of not finishing the construction and overcome the risk. He can, without a worry, hit the nails. If he hits it crook-

edly he can take another. He has insured himself.

Insurance is covering a sufficient need of substitutes or means in order to retain a capability.

The result will be different for the person who wants to complete the construction on a particular day but who fails to make a nail reserve. For such a person every blow of the hammer contains the danger that his goal will not be reached. This man can only insure himself by hammering with great care and caution. He can, however, for example drill the nail holes, in order that he will not be surprised by some hidden knot in the wood.

Insurance can thereby be achieved in that a danger will be limited or removed (defense against danger).

Hitting the last nail crookedly before completion could be a loss for all shelf-makers. However, exactly as danger and risk are assessed according to the value that one attaches to his capability so is the loss that actually occurs to be assessed. The man who was indifferent to the construction of the shelf and who now uses the wood for his fire, does not see himself as having suffered any damage.

Damage is the disadvantageous change or destruction of a capability to which a particular value is attached.

Thus the essential elements which are meaningful in insurance are as follows:

- the uncertainty of the future
- the capabilities of a human being
- the danger
- the risk
- the interest in insurance

- insurance by providing reserves of substitutes
- insurance through defense against danger
- the damage

It has also become significant in the examples how risk, danger and damage through the evaluation of a capability are influenced and how they influence one another.

No value - no danger !

No danger - no risk !

No value - no damage !

It is important to recognize what is frequently overlooked: insurance, danger, risk and damage are connected with the capabilities in its widest sense. Only in the second stage “things and money” as capabilities in the narrow sense, are objects of insurance, with get their value only by giving capabilities to people. A thing which does not give a capability to people has no value. There is no interest in insurance.

The most important capabilities in connection with things is the ability to use, sell and value them. It is always said that insurance may not lead to an enrichment of the insured in the case of damage. In such cases an enrichment is always considered in terms of a purchase price and thus a contradiction arises where old buildings, used household articles, cars, office equipment and machines are replaced by reference to the value as new, according to the terms of the contract of insurance. This contradiction is resolved by realizing that insurance has nothing to do with the monetary value of a thing but with the capability that it provides to use it (value of use). The family, which through the benefit of insurance builds a new house, to replace their house totally destroyed by fire, is enriched when valued in terms of money, since they own a new house. However, they

use the new house in precisely the same way as the old.

In this example it can also be shown that this family, in “insuring their living in a house”, did not have it so easy as the man who constructed the shelf, who merely retained a couple of nails in reserve. A person or family cannot possibly have a second house in reserve merely to retain the capability to live in a house.

There are many examples of capabilities that a person alone can either hardly or not at all compensate for. For example, no one can keep spare limbs or a healthy body in reserve, in order to preserve his life, movement or working ability.

When there is a great damage and loss to movement and working capability then the individual must depend on the help of other people.

Since time immemorial people have grouped themselves with a view to communal protection against danger. When damage occurred the members of a group helped themselves mutually. Thus since ancient times living communities – from individual families to the state – have been a form of “insurance” (provision of existence).

Insurance was in its origins mutual practical help e. g. defense against danger, reconstruction of a hut or laying up stores jointly. For cases of loss promises were exchanged to compensate lost materials or capabilities in the form of natural substitutes or work – and gratuitously; for help is always gratuitous – a form of gift !

Insurance is the reciprocal promise of practical, gratuitous help for a common compensation of losses.

Through the necessity for practical help in the case of loss, insurance was naturally limited both in area and number of per-

sons concerned. The simple promise of future help is not particularly certain. Besides the person who suffers loss always results in relying to a great extent and for much time on his fellow human beings. And in the case of greater loss, many or all of the members being involved, this group was too small for insurance and could repair the loss, either with difficulty or not at all.

This shortfall in “insurance by mutual practical help in the case of loss” was overcome by the introduction of money. Through the money it became possible to provide the work and help in advance that, otherwise, was only promised and could only be effected after the loss. It became possible to store and provide work and help in the form of money. This may be illustrated by the following picture: someone works and packs his work into a box. The box is sealed and a number representing the standard value of the contents is written on the outside – a 1, 2, 5 or 10. The box, full of performed working capacity with a number on the outside is the money.

The man who has created for himself this box can retain it for his own purpose. Then he saves and insures himself at the same time, in that he lays out for himself already performed work. Thus he can replace a capability that he may later lose. He can also give this money to a group that together with the money of the members, can provide for particular emergencies. So a group saves – a group of insured is established ! – In the event of loss the individual need not provide his own personally promised help. He has already provided in advance, “stored in a box” and made it available as money. The person who suffers a loss will be given a “box with stored work capacity”, that will enable him to replace his lost capability.

This work capacity that is provided in money can at any time be

changed through the purchase of articles, whereby the purchased article represents the former work. By selling this article it can once again be changed into money and by ordering a service the money can be changed into work again.

Money became a means of exchange for articles and work.

Money has the great advantage that it can be stored for any length of time and in the smallest space and in any amount. It can easily be divided and the persons who suffer a loss become, by a once and for all payment, independent of the group. They can, with this help, in the form of money, replace any materials and capabilities and purchase natural compensation and work. Thereby a completely new capability was created: the capability to replace work and practical help by money and financial help. Money became the means of compensation in insurance. It made, by reason of its neutral save-ability and its transform-ability a new form of precaution possible. Previously it was uneconomical or impossible to keep every thing in reserve, but now money made insurance for all different cases possible.

The oldest example of "insurance" was the alliance of donkey handlers in the distant past. If their donkeys, with which they earned their living, fell victim to beasts of prey or robbers, then they did not require practical help, but new donkeys. To hold and feed a large number of donkeys in reserve, without their doing any work was uneconomical and for an individual quite impossible. In the case of loss they had to be bought. Thus the donkey handlers resolved to provide mutually for compensation for donkeys that were lost. In the same way in ancient Rome ship-owners united in order to compensate one another for damage, when their ships or cargo were lost.

The promise of mutual practical help in the case of loss as the means of insurance was replaced by mutual financial help and the provision of money. Thus insurance became more certain, because by the provision in advance of mutual help before the loss, the financial risk could already be overcome.

Insurance is the common provision of money with a view to mutual loss pooling.

Because of the particular characteristics of money it was possible to set up larger groups of insured, which for the economic effectiveness and certainty of insurance are of decisive meaning.

Economic management is the reasonable decision of the individual over the application of his assets – in this case over the investment of his money, in order to achieve insurance in the most economical way.

The man, who wishes to answer the question whether to insure himself and whether he should save money alone or in a group will ask himself first:

Can I possibly suffer a loss ? –
How great could the loss be ? –
When could I suffer the loss ? –

On account of the total uncertainty of the future no one can possibly answer these questions alone and, because of these uncertainties, only with difficulties can he provide alone for a possible loss and its uncertain consequences. What is the point of a man beginning by saving 100 dollars today for a reserve house when his house is completely burnt down tomorrow ? –
What has a person forgone if he saves money for a reserve house to the date of his death if his house never burned down ?

–

The individual cannot solve the problem of the uncertainty of the future in the case of large risks by saving money. Only a group for which the law of averages applies can do so.

What is totally unknown to the individual – when he suffers a loss of whatever dimension – can be predicted for a group with reasonable precision in accordance with the law of averages the more precisely the larger the group is. Everybody knows this law, according to which in the game of dice or roulette in the course of time all numbers come up an equal number of times. So is it possible, by reference to statistics accurately to predict, how much time and with what consequent losses in a country within one year will occur. Thus it was often the only possible solution and in every case the most economical, that for larger losses not the individual, but a group, saved with the aim and the will to compensate, as a group and gratuitously, all losses through mutual financial help.

Thus are the problems of insurance explained and the way in which they were solved are illustrated.

The uncertainty of the future is to a great extent overcome by the setting up of a group of insured. For this large number the financial risks can be assessed in their totality and can be overcome through the common provision of a corresponding reserve of money for loss pooling.

The traditional insurance institutions

As the sphere of actions of the human being and his possessions, through increased civilization and technical development, became ever greater, so became the capabilities and thus the need for and interest in insurance ever greater. Professional

corporations and house owners in the Middle Ages were united in “mutual insurance associations” and “public insurance institutions”, since more than any other association the groups of insured required an administration office which undertook the organization of the association and, in particular, the collection and distribution of the funds provided.

These administration offices of the insurance institutions of the Middle Ages assessed by reference to statistics and the law of averages the amount of money required to cover the losses and the expenses for a particular period of insurance. This money requirement was apportioned to the members and insured and paid by them in advance in the form of contributions. Naturally this money requirement could only be assessed. Fortuitous and unforeseen variations in losses created both plus and minus irregularities. If, after the application of money for costs and damage compensation something was left over this was either repaid to the insured or set off against future contributions. If the contributions paid in advance were insufficient, then the insured had to make corresponding additional payments. The insurance institutions and the administration offices claimed no profit, not even for the efficiency of their services which they gave to the insured. Above all costs were for the personnel and, only to a small extent, for technical equipment. All the costs were paid in advance by the members. There was no risk for the enterprise. The mutual insurance associations and their property belonged to the members, who at meetings of the associations and through representatives dictated the business policy.

The mutual insurance associations and the administration offices provided work for the group of insured, a service for the economic solution of the problem of “insurance”, in the same way that banks provide a service for the economic solution of the problem of saving or transfer of money.

The performance of the mutual insurance associations and public insurance institutions was the cover of a requirement for work with a view to the economic production of insurance through a group of insured.

But just as the banks do not save but the savers themselves and just as the banks do not pay the bills of their clients but the clients themselves, so the insurance institutions do not insure the members but the insured insure themselves through the mutual financial help and the provision of their money.

Insurance can only be provided by the money of the insured. Thus insurance is the economic performance of the group of insured but not that of an administration office or a company which can only perform a service for the economic achievement of insurance through the group of insured.

Undivided contributions

It is important to realize that the insurance contribution was made up of two parts which were entrusted to the administration offices and until used remained the property of the insured:

- one share for the costs of administration (contribution for expenses)
- the actual “insurance contribution” for loss pooling within the group (contribution for loss pooling)

The insurance contributions were, for a variety of reasons, not divided and the two very different parts were specified neither before nor after the insurance period. The insurance institutions were run by public institutions or with the cooperation or control

of the members and operated as cooperatives with no view to profit. Great trust was placed in them in that they handled the money entrusted to them in a responsible manner. On account of the uncertainty of the future that could never be avoided the payment for damages could not be specified exactly in advance. The resultant subsequent settlement of the contributions was controlled by the public institutions or by members and all the surpluses of contributions were correctly repaid, set off against future payments of contributions or passed into security reserves.

The change in the field of insurance caused by the “insurance by stock companies”

The insurance world was, until the 19th century, in order and insurance had until that time developed peacefully. Nobody can maintain after the representations so far shown, that insurance as mutual help of insured or the performances of the insurance administration offices are complicated or could cause reproach.

Then, however, there was a complete revolution which led insurance towards complication and mistrust and to the necessity for State control

In the 19th century the stock companies encroached into the insurance field. The so-called “profit making insurance” came into being.

For the consumer it appeared that there was no great difference between the method of operation of the stock companies and their predecessors and “competitors”.

The stock companies applied the same terms and conditions of insurance as their predecessors and competitors.

They collected an undivided contribution and did not quote in advance the costs of operation and the actual insurance contribution just like the predecessors and competitors. As their predecessors and competitors the stock companies gave no subsequent account explaining the expenditure of the money paid to them, which they no longer called a contribution but a “premium”.

But the stock companies did not have the intention to return premium surpluses to the insured, but, instead, retained them as profits. Therefore they relinquished the right to require additional payment from the insured in the event that the premiums collected were insufficient to cover the loss. When such a case happened then the stock companies had to cover the loss by making payment from its own capital. The stock companies offered a “fixed premium insurance” which could not be altered either by refund or additional payment.

The novelty in this method of operation of the stock companies was that all surpluses were claimed and applied as profits. From the surpluses that resulted at the end of the company’s financial year the stock companies paid dividends to the shareholders and besides accumulated money in the form of reserve funds, and thereby the quoted value of the shares increased. In order that the quoted value of the shares did not increase too much, the reserve funds were, from time to time, applied to increase the original stock – a transaction, that the stock companies referred to as “self financing of privately owned capital from one’s own assets” and which resulted in regular free issues of shares to the shareholders (in addition to payment of high dividends).

No profit justification for stock companies in the field of insurance

The stock companies naturally need a “profit justification” for payment of dividends and “self financing of stock”. Profits must arise from an economic performance. However, as yet there is no legal or economic reason, why all premium surpluses should be applied as profits by stock companies. The mere fact that this has happened for 100 years is not a sufficient reason

Above all the following questions about the operation method and profit justification of stock companies in the insurance field remain unanswered:

- What is the performance on which they rely to justify their profits ? –
- What is the price for this performance ? –
- To whom does the premium belong after its payment ?

These questions do not arise for the traditional insurance institutions. They operate on a non profit making basis and therefore, do not need to quote a price for their services. They have the right to withdraw their costs from the contributions paid by the insured which, anyway, remain the property of the insured.

For a layman it is practically impossible to say what the difference between a traditional insurance institution and a stock company is. Both perform the same tasks such as advising in the conclusion of the contract, collection of premiums, management of the contracts and the money, claim settlement etc. All these tasks are paid for from the cost portion contained in the premium paid in advance by the insured. Since the stock companies in the insurance field do not have to invest in

“production plant” the operating risk of their functions is extremely small. These particular circumstances in the management of insurance portfolios is the reason why the traditional insurance institutions have operated in a non profit making way up to now.

No structure for performing services

The fact that the traditional insurance institutions operated without profits is no reason why the stock companies should not perform the same tasks profitably and make their profits through the efficiency of their method of performance and management of capital. However it would have required very important alterations in order to change the performance of the traditional insurance institutions into a profit making service.

Service is the cover of a requirement for work through the performance of work on strange objects and persons with a view to bringing about an economic result.

With reference to stock companies in the insurance field this formula must read as follows:

The service of stock companies is the cover of a requirement for work by the collection, administration and distribution of the insureds' contributions for loss pooling with a view to economic achievement of insurance by the insured.

For this service the stock companies should have demanded a price and could have retained the price surpluses over their costs as profit. They should then, however, in contrast to the non profit making insurance institutions, divide the premium into a price for their services and the contributions for loss pooling

of the insured. The prices for services would have become the property of the companies and the contributions for loss pooling would have remained the property of the insured. The contributions for loss pooling would – as in the case of the traditional insurance institutions – have been assessed in advance and could have been regulated according to the outcome of losses by refunds or additional payments. It could however have been fixed in advance after the setting up of corresponding safety reserves which would have remained the property of the insured.

the stock companies could, for example, have made the following offer: “For the pooling of losses within the group of insured you have to pay a sum of 100 dollars as a contribution for loss pooling. A surplus will be refunded and a deficit will be required from you in the form of an additional payment. The price for our services is 50 dollars. We shall pay a certain interest from reserves, which we shall invest from the surpluses of the insureds’ contributions for loss pooling. For any particular services particular fees will be accounted.”

This offer and method of operating would have corresponded to the procedures in the field of banking. The division of the premium and the quotation of a price for the services would also be compatible with the method in which the insurance institutions are dealt with in the National Accounts and determination of the Gross National Product – namely as service firms. Not the premium income, but only their operating costs are seen – like prices – as the “creation of value” in the sense of the Gross National Product. As a result the stock companies had to quote a price for their services, since the regulations concerning the quotations of prices, which is a condition for any competitive trade, also apply to them. However, they do not specify prices for their services ! – As long as the premium is not divided into

a price and a contribution the so-called “external factor” for a service of the stock companies does not exist. Without this factor a service cannot possibly be given (the suit at the cleaners, the parcel at the post, the money in the giro transfer, the student in a lesson etc.) This external factor, which remains the whole time the property of the customers is, in insurance, the money of the insured, the contribution for loss pooling which the administration offices collect, manage and distribute. It goes without saying that companies that wish to perform a profit making service in the field of insurance, must designate the insureds’ money and deal with it separately in the statement of accounts and should not take any profits from it.

If the stock companies had, 100 years ago, undertaken their functions in accordance with all these legal and economic fundamental rules and if they did so today, then “insurance” would not have become complicated and the above-mentioned questions concerning the performance of stock companies, the price and the property in the premium would never have arisen:

- the stock companies could found their profit justification on a service,
- the prices for this service would be specified definitely,
- an undivided premium would not have existed. This would be broken down into a price for the service and the contribution for loss pooling. Only the service price would pass over into the property of the stock companies. The contributions for loss pooling would remain, until payment to the persons suffering a loss, the property of the insured.

The stock companies have for 100 years drawn their profits and built up their “property” and capital stock, not from the price for their services but from the surpluses of the contributions for loss pooling. Therefore a service theory cannot be reconciled with their methods of operating. When the performance of the administration offices in the field of insurance is often described as a service, this is only true for the non profit making insurance institutions but not for the stock companies.

The stock companies do not perform a service because they do not deal with the contributions for loss pooling as strange money (the external factor of a service) and do not quote a price for their service.

“Production theory” of insurance

The stock companies describe the total premium as a price for their performance. If this price is not a price for a service then it can only be the price for a product. These are the only two economic forms of operating for which a price can be demanded. Thus the stock companies and their academics have actually developed a “production theory of insurance” on which to base their profit justification by means of the “production of insurance”. They describe “insurance, insurance protection, promises of payments and bearing risks” as their products, which they “sell” for the premium. The premium, as a price, should pass over into the property of the stock companies with the result that damages just as costs are paid with the “money of the stock companies”.

Production is the producing of means through the creation or the processing of natural products with a view to covering requirements.

The requirement, that should be covered by insurance, consists

of the means required for compensation for damages. This compensation for damages was formerly provide by mutual practical help and then by help performed in advance and provided in the form of money. Thus money is nowadays the product that is necessary in order to cover all requirements with particular reference to compensation for damages.

Money is produced by human work an could, in as much, be seen as a natural product and one could define insurance according to the formula for production:

Insurance is the production of money by means of work with a view to the covering of all requirements in the event of loss.

The peculiarity in “insurance by stock companies” is that the covering of all requirements by a fixed premium is limited and the stock companies make their own capital available in as much as damages go beyond this limit. This capital consists of money which the shareholders originally have “produced”. This money and the contributions for loss pooling provided by the insured must be the same product and must have been “produced” in the same way with a view to the covering of requirements in insurance.

The “production theory of insurance” overlooks the following:

Production of money for loss pooling cannot possibly happen profitably through stock companies, because insurance is, by nature, gratuitous help. Insurance and the need for money for the compensation of losses can only be produced and covered gratuitously by the insured themselves (like practical help in former times).

On account of the uncertainty of the future it is impossible and uneconomical that a person buys himself substitutes with a view to covering his requirements for insurance before any loss occurs. It is also often impossible and uneconomical, when someone saves alone, in order to be able to buy substitutes whenever a loss occurs. He must receive this compensation as a gift from the group of the insured in the context of mutual, gratuitous aid. otherwise insurance loses its sense as a corporate loss pooling.

The shareholders, however, have certainly not produced their money in order to make a gift to those who suffered a loss. The money of the shareholders is not provided for the gratuitous cover of requirements in insurance and the performance of the stock companies cannot be the gratuitous production of money for insurance. This money is and must be produced by the insured.

The production theory overlooks completely that no one can claim profits for having produced something until he has sold and transferred the product. Even if the shareholders had produced their own capital for the cover of all requirements in insurance they could not, for two reasons, claim any profits,

because they have never transferred their own capital to the customer,

because this transfer must, in accordance with the nature of insurance, take place gratuitously.

The shareholders do not wish to cover any requirement by the investment of their money. They merely wish to make profits. This money never “works” in the stock company itself, but is, in the form of stocks and shares, invested in other organizations or real property, in order to make profits outside the stock company itself.

This capital, invested externally, can only fulfill the function of a guarantee for the stock company itself. This means, however, that no requirement for money in insurance should be covered, since this “gift of capital” would signify loss. Therefore cover of a requirement and profit making are excluded from “insurance production”. Insurance and the profit making goal and profit making production are mutually exclusive. There can be no production which is not aligned to some cover of a requirement. A product is not transferred except among the insured. And “mutual gratuitous help” cannot possibly be sold ! –

The stock companies in the field of insurance, indeed, provide work in the same way as the traditional institutions but they do not wish their performances to be understood as service, since they would have to quote a price and divide the premium. They would have to deal with the contributions for loss pooling of the insured as external factor and property and would commit embezzlement if they retained any surpluses of money entrusted to them. Since however, the stock companies retain all surpluses of the contributions for loss pooling as profits and apply it to the “self financing” of the “own” capital, the stock companies and their academics attempt to represent “insurance” as their product and the premium as the price. Indeed it is out of the question and in no way corresponding to the aims of the companies, that they should wish to cover the money requirement for insurance with their own capital. “Insurance production”, profit aim and gratuitous aid are mutually exclusive in insurance.

Neither service nor production nor sale is the economic performance of the stock companies in the field of insurance, upon which they would be able to justify for applying all surpluses as profit.

The premium is neither a price for a service nor for a product. Insurance – as gratuitous aid – cannot be produced and sold in a profit making way.

“Mass speculation without risk” through stock companies in the field of insurance

The particular feature of “insurance by stock companies” is the guarantee function of the capital stock. If this money of the shareholders is introduced neither for a service nor for a production process, then there remains only one “performance” possible, which brings in profits – the speculation. In fact there is much evidence that “insurance through stock companies” is speculation:

- The object of every speculation is the uncertainty of the future.
- Professional speculation is the acceptance of a risk of loss through the exchange or promise of uncertain performances with a view to chance winnings.
- Thus the undertaking of the stock companies in the field of insurance would be the acceptance of a risk of loss through the exchange of an uncertain promise of payment against a fixed premium with a view to chance winnings.

In fact the stock companies themselves describe their performance as the “bearing of an insurance (technical) risk”. And the stock companies justify taking all the surpluses of premiums as profits by this risk bearing.

This “insurance risk” is, without doubt, the basis of speculative business, of business with the uncertainty of the future; for insurance at a fixed premium means, for the stock companies a

risk of loss in the case that premiums are insufficient for payment of losses. Insurance at a fixed premium, however, offers the stock companies at the same time a chance of profit when more premiums are paid in than are necessary to cover the costs and damages. And this surplus of premiums would be a chance winning, because it depends on the chance-related outcome of the losses, which nobody can influence and – not even according to the law of averages – exactly determine in advance. Furthermore nobody can judge in advance the relation between the promise of payment given by the stock companies on the one hand and the fixed premium on the other.

The surplus of premiums which the stock companies describe as their profit, are without doubt not the outcome of an economic performance. They are not based on performance, but on chance. There is still today the impossible situation, that a favorable course of damages and every reduction or rejection of claim, compensation lead to the enrichment of stock companies.

The stock companies speculate on chance-related surpluses of premiums, which they take in as profits (mass speculation).

The stock companies and their academics are victims of a dilemma when they argue on the one hand against the suspicion of speculation and on the other hand for their “risk bearing” as their performance and profit justification. One moment they maintain that they bear an “insurance risk”. The next moment they maintain that their performance cannot possibly be speculation, since they so steadfastly calculate that this risk cannot exist, since this risk would also mean danger for the insured. If the premium are over a period of time insufficient to pay compensation and the capital of the companies were applied towards the costs and compensation, the persons suffering a loss

would not in the end receive the promised payment of compensation. Thus insurance and speculation are mutually exclusive, since insurance should overcome financial risks. The insured at the conclusion of the contract of insurance and through the readily disposable money thereby assigned wishes to overcome all financial risks. The stock companies, on the other side, want a “remnant risk” to continue through the agreement of a fixed premium in order to draw speculative profits from this risk and to be able to show the “risk bearing” as justification for the profits. The continuation of this “remnant-risk” is not to the liking of the insured. They want security. That however is attached to a condition:

In “fixed premium insurance” the premiums, in order to achieve the security aimed for, must be so calculated that surpluses always exist, whose amount is only dependent on chance.

The stock companies speculate in the surplus of premiums. However since these are secure and only the amount is fortuitous, the most important element of speculation is missing – the risk ! – Thus the performance of the stock companies in the field of insurance is no longer speculation, but goes beyond the limit of unjustified enrichment. There is absolutely no legal or economic justification for the stock companies to take all surpluses from “fixed premium insurance” as profits.

The stock companies collect the certain surpluses, the amount of which is subject to chance, as profits without having performed any service, without having produced or sold anything and without having born any risk for this profit. They carry on a business which involves the uncertainty of the future, which is indeed speculative, but which may not be subject to risk, if

“fixed premium insurance” should be insurance and should provide security. Islamic companies are not permitted to carry on “fixed premium insurance” since this is seen as “gambling” and “usury”, both of which are prohibited by the Koran.

As the last 100 years have shown, the premiums of the stock companies were so over-calculated, that the companies have never born, with their “own” money, the insurance or speculation risk with which, however, they have justified their profits.

If insurance becomes speculation, then this “speculative insurance” is no longer insurance.

If speculation becomes insurance, then this “secure speculation” is no longer speculation.

Insurance is not service, but the performance (the product) of the group of insured.

Insurance cannot be produced by the “guarantee function” of the capital of the stock companies.

The performance of the administration offices and stock companies in the field of insurance can only be a service towards the production of insurance as the product of the group of insured.

There are no “insurance industry” and no “insurance companies” (just as there are no “saving industry” and “saving companies”. Insurance and saving are economic performances of the consumers, which cannot be produced and sold in an profit making way).

In the event it must be stated, that in “fixed premium insurance” it is necessary that the premium be calculated so that surpluses exist. There is no longer any reasonable excuse or correspon-

ding performance exchange for which the stock companies collect these surpluses as profits, pay dividends thereof, accumulate their “own” capital thereof, claim further profits for this “guarantee capital” and aim at additional yield and increased share value from these deposits of capital.

The stock companies justify their method of achieving profits not on the basis that they have earned a profit with a performance, but on the basis that they need surpluses in order to stay solvent. The argument that surpluses are necessary in order to make “fixed premium insurance” certain, is absolutely correct. Quite impossible to understand, however, is the fact that the stock companies and their academics exchange the word “surplus” with the word “profit”, and say: profits of the stock companies are necessary in order to make “fixed premium insurance” certain. In this case profits are not based on a performance, but on the necessity to overcome the uncertainty of the future in insurance. But the uncertainty is overcome not by the stock companies but by the over calculation of the contributions for loss pooling; that is, through the performance of the insured. And from these surpluses of the insureds’ money the stock companies enrich themselves unjustifiably.

Security reserves should have been accumulated from these surpluses, which would have remained the property of the group of the insured. In just this way are the surpluses of the traditional insurance institutions dealt with, which companies conformed, in their method of operating, to the stock companies and, in time had built up such large security reserves that they – like the stock companies – were able to waive the duty of additional payments and offer insurance for a “fixed contribution”. However all the money of the insurance institutions remained the property of the group of insured.

The origins of the existence of “fixed premium insurance”

How a whole “industry” could come into existence which pretends to “produce insurance” and be able to “sell” it for a fixed premium as a price, and in which for more than 100 years stock companies have drawn chance-related profits from – necessarily – over-calculated premiums, without equivalent performance, is only understandable when one reviews the nature and development of insurance.

Insurance can only arise from the money of the insured (contributions for loss pooling). The costs of the traditional insurance institutions were also paid with money (contributions for expenses). The particular feature is, in this case that a service is performed “on” money and paid for with money, whereby there was naturally the possibility to mix, indivisibly, the price for the service (contributions for expenses) and the “external factor” (contributions for loss pooling) – that is, money and money. For the traditional insurance institutions this meant no danger, since they did not claim for profit, all the contributions were dealt with as the property of the insured and at the end of the period of insurance any surplus was refunded. The insured became used to this system which gave the impression of a contract of sale, although in this procedure the service of the administration office and the insurance as a performance of the insured were bound up together.

The insured mentally separated themselves from their money when paying their contributions because they were conscious that they had to give this money to the persons suffering a loss, if they themselves wanted to receive compensation from the other persons insured in the case of loss. The insured has quite a different idea of this corporate saving of money for compensation of loss from the person who saves for himself.

The individual saver is naturally far more interested to know what happens to his money, since he wants his money back. The idea of a person who saves alone is that he entrusts his money to a bank to be managed and that the money remains his property and only he can dispose of it. The saver, such as the owner of a giro account would not allow the bank to take over the remnants in his accounts as profits at the end of the year.

The idea of the individual who saves in a group of insured for a common loss pooling is, on the contrary, that he must give his money for the corporate compensation for losses and only gets something back when he suffers a loss. He gives his money away and entrusts it to an administration office. This office should manage the corporately saved money in a fiduciary way.

The founders of the stock companies, in their business with the uncertainty, took advantage of these particular circumstances:

- the fact that the “external factor” of service and the service price arise from the same material
- the traditional mixing of contributions for expenses and loss pooling
- the giddy trust of the insured
- and their mental separation from the contribution “given away”.

The stock companies could, without difficulty, introduce their novel “fixed premium insurance” which corresponded exactly with the (mistaken) idea of the insured of the “insurance process”. In this procedure, too, the insured give away their premiums and also receive, in the case of loss, compensation as a present. Since, however, the stock companies had done away

with the “group of savers”, its cooperation and control as well as every subsequent account or refund, the insured were quite unaware, that they were making presents of certain surpluses of money, which the insured give away, there is absolutely no performance exchange from the stock companies.

The mixing of insurance and service

Nobody realized that also the stock companies like all administration offices in the field of insurance could only provide a service, because neither production nor speculation could be reconciled with insurance. On account of the particular traditional circumstances the stock companies were nevertheless successful in mixing in insurance, service and speculation together and created therefrom a “mass speculation without risk”, which leads to unjustified enrichment.

In reality “fixed premium insurance” consists of these three procedures:

1. Insurance, which is produced by the insured with their contributions for loss pooling,
2. a service of the stock companies by the management and distribution of this money of the insured,
3. a “speculation without risk” on the certain surpluses from this money, whose amount is only determined by chance.

Accordingly the premium consist of these three parts:

1. the contribution for loss pooling (the external factor of the service),

2. the contribution for expenses (price for the service),
3. the security surcharges, which, with the surplus from the contribution for the loss pooling, lead to the certain profits of the stock companies, the amount of which is only determined by chance.

All problems in the field of insurance have arisen for the following reasons:

- that insurance as the performance of the insured and the service of the administration offices were mixed up so that the mistaken idea arose that insurance could be a “product” of a stock company,
- that the contributions for loss pooling and the price for the service were mixed into an undivided premium so that the mistaken idea arose that these mixed procedures and premiums could be the object of competition,
- that the surplus from the contributions for loss pooling and the surplus from the prices for the service were mixed and the mistaken idea arose that all surpluses from these mixed procedures – including the surplus from the insureds’ contributions for loss pooling – could be profits of the stock companies,
- finally that the stock companies, through this mixing obtained a grip upon the surplus from the performance of the insured and thereby all problems of insurance, which are connected with the uncertainty of the future, became the profit problems of the stock companies.

No competition pre-requirements in the insurance field

The unfortunate result of the confusion of “social insurance performance” with the “commercial service performance” of the stock companies is that competition is thereby made impossible.

As to insurance itself, there can be no competition because the loss contributions are dependent on the chance-related development of losses and not on a performance. As long as the insurance and the service, the loss contributions and the service price as well as the insurance surplus and the price surplus are inseparably mixed with each other, there can be no competition as to service.

Competition is a regulation system of the economy through a free market. This regulation ensues on the side through laws and officials which are concerned with the competitiveness and visibility on the offerors' side which thereby at the same time creates freedom and ability of decision-making on the consumers' side. In addition, the efficiency and innovation of the offer is regulated through the free decision of the informed consumer supplying his needs.

This second requirement, the participation of the consumer in competition as a decision-making factor, is in many fields and above all, in the insurance field, not yet realized. Rivalry of companies alone is by no means competition. This is the essential perception and basic principle of consumerism (promotion of the consumer position in the market), that in addition to several offerors, competition above all includes visibility of the market and a free consumer capable of making his own decisions.

With the decisive participation of the consumer, competition

above all should prevent single firms from unilaterally taking advantage of the free market system and to achieve profits that are not performance-related. For this reason, competition in the insurance field is not realized because the stock companies demonstrably achieve profits that are largely determined by the chance-related development of losses. There is no economic performance upon which the profits are based. These profits arise above all from inevitable over-calculation of the premium, from thereby resulting surpluses and from the reduction or refusal of loss payments – all without any economic performance ! – Only a very small part of these profits can perhaps contain a surplus from an efficient method of operation. But no one can determine whether such a surplus really exists or in what amount.

It is impossible that there can be competition as to procedures that lead to profits not based on performance, but on chance occurrences which competition is supposed to prevent. It is impossible that there can be competition as to procedures through which someone is unjustifiably enriched from the surplus that arises from someone else's performance. The surplus of the contributions for loss pooling arises from the payment by the insured and no one is permitted to appropriate these surpluses. Or it has to be specifically permitted in the insurance field and even left to competition which otherwise is considered embezzlement ! –

It is not the question – which is asked, examined and answered wrongly again and again – whether there is competition in the insurance field, but the question should be: which performances, mixed up in the fixed premium insurance, and which parts of the premium are spheres which can and may be influenced by competition. If the question is asked in this way, the answer can only read:

Competition as to the insurance and mutual, gratuitous

aid, competition as to mutual loss pooling, as to the rates and classification of the contributions for loss pooling cannot exist. No one can be so foolish as to believe that competition in these spheres can reduce the payments for losses or can have any other economical effect.

This is also proven by the fact that throughout the world, associations or “rate bureaus”, without competing ascertain the money requirement for losses and determine uniform “basic premiums” by working together with the same statistics. But the consumer never learns the level of these contributions for loss pooling because every company individually changes these contributions by adding costs and profits surcharges as well as by creating separate classifications and terms and conditions. What is noteworthy in this context is that the companies determine their basic premiums without competition, but that the stock companies then take in all the chance-related surpluses of these basic premiums as profit as though the calculation of the basic premium were a sphere of competition.

Competition as to the undivided premium can never lead to the situation where the companies receive exactly the contributions for losses that they later pay out in damage claims. If they receive more contributions, then the companies have profits that are not performance-related. If they receive a lesser amount of contributions, then the companies go bankrupt. Any form of competition that can lead to the bankruptcies of the companies can be of no interest to the insured so long as the loss contributions are mixed with the service price of the companies.

As long as the “insurance of the insured” is mixed in with the “service of the companies”, then the bankruptcy of the service-firms will occur at the same time as the bankruptcy of the “insurance”.

With the payment of his contribution, the insured still has received no benefit from the insurance, but can expect this only in the future if he suffers damage in any way. This is different in the case of a purchaser of goods which are paid for and transferred. Thus it cannot be of disinterest to the insured that the company goes bankrupt so long as this also means the bankruptcy of the group of insured.

Insurance at fixed premium can never be left to free competition and must always yield surpluses. Through the confusion of service with insurance and thereby the continuing "technical insurance risk", the companies have shifted their business risk of bankruptcy onto the insured. The insured have to cover all these risks by their over-calculated premiums and must guarantee in their own interest surpluses and security for the companies.

Since the premium is not broken down and the surpluses from the loss contributions not protected from the grasp of the stock companies the companies' rivalry extends above all to the contributions for loss pooling. However, this rivalry by the companies cannot be considered as true competition, because events which lead to nonperformance-related profits, to unjustified enrichment and to unlawful appropriation cannot possibly be considered spheres of competition. There can and should be no competition as to the undivided premium because this fixed premium is based, through the inclusion of insurance and the contributions for loss pooling on chance and uncertainty, but not on a calculation of an economic performance.

There is no transparent market of services in the insurance field. The insurance customer, due to the mixture of the various services and premium components, is not in any position to understand his own contribution for loss pooling, the service of the stock company and the price for this service. He is not able to

evaluate the price/performance relationship. A price/performance relationship cannot be investigated if an undivided premium is given for a package of one's own and someone else's performances with the consumer having only this premium to compare. As the expression "price/performance relationship" already says, the individual performances must be described and the prices and contributions must be quoted. Should this happen in the insurance field, then everyone could easily recognize that there cannot be any competition and negotiation as to the contribution for the pooling of chance-related losses (in personal lines) and that competition must be limited to the service of the companies and the price for this service.

Since there is no premium breakdown nor corresponding quotation of prices, there is no competition in the insurance field as to the actual service by the companies, because the insured doesn't know the price of the service, because he doesn't know which services he is paying for this price and since he cannot judge nor evaluate the efficiency of these services. And – last not least – he cannot prove whether these services have been performed for him.

Thus it is impossible for the consumer to take over his "decision-making function in competition" in the field of insurance-services. The stock companies have thereby acquired a "monopoly on premium-calculation and on the use of costs, profits and surpluses". The insured only knows, that with his undivided premium he pays the losses of the group of insured as well as the costs and profits of the companies.

Due to the complete invisibility of the insurance field the insured does not know,

- that the stock companies unjustifiably appropriate

the chance-related and over-calculated surpluses of his contribution for loss pooling without any performance in return,

- that in many branches the expensive stock companies consume up to 50 % and more of the premium for costs and profits (the costs of the non-profit mutuals are on the whole not half as high),
- that capital life insurance is one of the most unprofitable investments, because some stock companies consume over 20 % of the paid-in premiums for business and administration costs, so that only 80 % of the premium (diminished still more through the risk premium) is saved for the insured, that from the income of this saved money the stock companies appropriate part of it as additional profit and realize for themselves (and not for the insured) all increases in value from the investment of this saved insureds' money (for example, real estate).

The insured cannot see,

- that he is paying the profits and costs of reinsurance with his premium, which is absurd in some personal lines, but is undertaken by the stock companies (especially within groups of companies) to a great extent in all branches in order to defer the costs and profits,
- that his contract is burned with costs that have not been occasioned by this contract, that the costs and profits are deferred in various ways within companies and groups of companies (also between personal and commercial lines), which do not lie in the interest of the premium-payor,

- that he is paying commissions from his premium that are not performance-related, that these commissions are used by the agents for completely different activities, (above all for acquisition of new contracts and the solicitation of customers from other portfolios), but not for performances which the premium and commission payor has paid for, so that he receives no corresponding service,
- that he finances with his money an absurd battle by the companies for their portfolios and that all these exchanges among the portfolios are burned with costs that amount to several times the real acquired new premium,
- that with his premium he is paying the costs for an inefficient regulation of small damages that he could much more economically insure himself by fixing a deductible and saving by himself up to that amount,
- that the agents' commission is dependent on the level of the premium (not on performance), that for example the acquisition of his automobile police costs him 100 dollars whereas for the acquisition of the same car another insured pays only 20 dollars because this insured is classified in another premium-classification. The price difference is 500 % ! – The acquisition procedure and expenditure of work by the agent is the same however ! –

The administration offices and the agents could provide many different kinds of services to the insured (advice, conclusion of contract, management of the insurance protection, claim settlement, administration of contracts and money). These individual services could be separately calculated and priced after they have been actually performed. Or they could be paid for in

advance when it is certain that the service will actually be performed. The minimum requirement must be however, that at least the total service be exactly described and a special price therefore stated. That prescribes that the premium will be broken down.

In the insurance field the erroneous theory prevails that the performance of the companies is not a service but a “production of insurance” and the unbroken-down premium is a “price” which the companies can do with what they like. Since the actual service of the companies and their price is hidden in a mixed up “product” and in a mixed up “product price”, the insured doesn’t know that he has given his money for services that he can neither recognize nor claim and which in part he does not receive. The companies (because they can do as they like as to the “price”), don’t need to perform any services they are paid for. No insured can sue any company or agent to force him to advise him or to supervise his insurance protection. No insured is entitled to a commission or premium refund, if an agent or a company did not perform a corresponding service to him.

The performance of the companies and agents in the insurance field can only be service. And service must also be forthcoming for the calculated costs and paid prices. Costs must be put in for the calculated services just as the contributions for loss pooling of the insured must really be spent for the loss pooling and for the damage payments. “Insurance” is not a “product” that a “manufacturer” can “sell” at an “end-price” and do with the price what he will.

Since the consumer cannot judge the economic value of the insurance and the related services and cannot articulate his true needs, since he cannot see the misuse of his contributions for loss pooling nor the waste of the costs, no one can compel (nor can competition) the companies to use fairly and correctly the

contributions and to reduce the inefficiency of acquisition, of re-insurance and of fighting for their portfolios and to reduce the inefficiency of small-claims-insurance and –settlement and of the commission system.

Rivalry over the surpluses of the insurance

There is thus no competition in the insurance field as to the single possible economic performance – as to the services of the administration offices and agents. On the contrary, there is a rivalry of the companies with each other in which the uniformed consumer merely has the role of a victim of contracts and premium payor. And this rivalry takes place in a completely wrong field; that is to say, in the field of insurance, which as a performance of the insured and mutual gratuitous aid cannot possibly left to competition.

The companies battle with each other over the surpluses from the mutual financial aid with which they cannot have anything to do. They battle over the surpluses from the loss pooling of the insured, over surpluses from someone else's performance ! –

This rivalry was not only created by the stock companies' struggling for profits, who unjustifiably enrich themselves on the surpluses of the "insurance". The mutuals, too, battle over these surpluses through which they can gain a market advantage over their rivals – the stock companies.

Consequences of rivalry over "insurance-surpluses" on premium-classification and selection of risks

This rivalry has more and more hollowed out the social foundations of insurance. Insurance not only has to solve a financial

problem: to cover the loss payments with the necessary monetary contributions. Insurance must also solve the social problem of distributing these monetary contributions among the individual insured and determining who has to pay how much. Both problems are the true problems of the group of insured. Through the unbroken-down premium, however, they became the profit- and rivalry-problems of the enterprises.

The premium surpluses and the profits of the stock companies can be influenced not only by the over-calculation of the premium, but also by the distribution of the premium among the insured (classification) and by the selection of the insured and risks. A stock company, that accepts only "good risks" and keeps the "bad risks" away through overly high premiums or by not contracting with them at all, makes good profits. A mutual insurer that also only writes "good risks" can offer its members favorable contributions and can achieve a market advantage by advertising with these contributions and high repayments.

The question is simply, what is a "good risk" and what is a "bad risk" and who shall decide this question – the group of insured or a profit striving stock company or a mutual insurer striving after market advantages. The question as to "good and bad risks" cannot be answered in advance because it is based on chance just as the course of damages is. The problem of the uncertain future can only be solved jointly by the insured. According to the social idea of insurance as mutual aid, all risks of the same character must be treated equally until they prove to be unequal in the future. This un-equality can be retroactively adjust or equalized in many ways by regradings, additional payments or increased future contributions.

The principle of the "non-divisibility of the premium" and the

consequent misunderstandings in the field of insurance have led to the fact that no longer the group of insured decides on social factors, to whom under what conditions and what contribution insurance protection shall be provided. Now firms decide these questions, who strive after the surpluses of the insurance, after market advantages. And thus these firms decide the question of classification and insurability of a risk naturally under completely different factors than social ones.

Stock companies and mutuals don't want to wait for the certainty that if a risk should prove itself a bad one, because in this moment of certainty the surpluses are already diminished and the losses occurred. They want to greatly limit the uncertainty of the rate of losses and have therefore increasingly refined their statistics to find more and more indications which will tell them in advance if a risk is "good" or "bad" for them and if there will be surpluses, profits and market advantages or losses for them. According to these statistics, the firms have established their classifications and premiums. This must inevitably lead to social injustice because the individual insured is classified according to the commercial loss statistics, which he can in no way influence, and not on his personal characteristics, abilities and situation.

The best example of this is the classifications and premiums of the automobile insurance. Normally every automobile driver who uses the same car in the same way should pay the same premium so long as he drives accident-free. The firms however, discovered that young, unmarried male car drivers from large cities cause more damage and bring in fewer surpluses to the firms than any other. If, therefore, someone is young, has not had his license very long, is male, unmarried and lives in a large

city, he is a “bad risk” and a “bad driver” for the firms and has to pay high premiums or will not even be insured, although he may be the best driver in the world. But he can only prove this much later retroactively.

All these future-related problems of insurance need have no influence on the classification, but can be easily regulated subsequently and retroactively if the statistical suppositions are confirmed. But if these problems about the future turn into profit problems for the companies and to rivalry problems for the mutual insurers, then these all inevitably try to exclude in advance the uncertainty and the risk statistically, which then leads to social in-equality and must destroy the social idea of insurance.

If this absurd rivalry continues in the wrong area of insurance, the statistically good risks would increasingly approach a freedom of contribution and the statistically bad risks would increasingly approach self-insurance and self-payment of their damages. That proves the clear necessity of regulation “insurance”, classification and the contributions for loss pooling universally valid for the entire group of insured. And it proves the necessity of withdrawing these problems from the influence of the firms.

The insured alone shall and must produce the loss pooling and remove all financial risks and problems about future with their money. When one finally recognizes that the stock companies cannot bear and should not bear any speculation risk, when they cannot make any losses in the field of insurance, when the firms no longer have anything to do with the formation of classifications and contributions for loss pooling and when they can no longer obtain any economic advantages and profits from the surpluses of the insureds’ money, only then can every consumer join a group of insured at a justified contribution. The

firms only have to bring forth a service for this group of insured, which service has nothing itself to do with insurance.

Of course discrimination in insurance is not excluded. The mutual and gratuitous aid in a group has, as a prerequisite, that the insured, who themselves suffer no losses, pay for the losses of others. But unequal treatment within a group of insured should not be based on the attempts of the firms to achieve economic advantages but must strive for a social balance.

Because the firms even today set their classifications and loss contributions largely according to economic interests, approximately 3 % of the consumers in the USA would have no insurance protection if it weren't for these rejected and cancelled "bad risks" established by national insurance institutions. Many insured (especially in the automobile insurance) pay unjustified and un-socially high premiums (and premium-related commissions !) because they are classified not according to their personal situation but according to statistical anticipation of surpluses.

All these are problems which are caused by the undivided premium because thereby the solution of all future-related financial and social questions about the insurance is transferred to the firms ! – And the ways in means they solve these problems which are really problems of the group of insured, influence the degree of their economic advantages and profits – arising from the social and financial performance of the insured ! – One describes such a situation with the proverb: The wolf has been made the shepherd ! –

Thus there is only a rivalry in the insurance field. In Germany,

even this rivalry is largely impossible because, in the personal lines, contracts running for ten years are the norm (with premium adjustment clauses). The possibility of the insured to change to a more favorable company is thereby greatly removed. In the United States, on the other hand, every insured at any time can cancel his short-term-contract and even gets back his unused contribution. Whereas in the USA it is overwhelmingly risk-life insurance that is taken out, in Germany the companies and agents offer almost exclusively only capital life insurance that is so arranged that the insured is bound to the contract almost for life. The companies namely use the first three years' contributions for their costs so that an insured who prematurely cancels his contract experiences considerable financial losses.

It is incomprehensible that in Germany above all one speaks again and again about a hefty competition in the insurance field and that the general opinion prevails that in the insurance field it is enough for competition purposes if the companies quote an undivided premium and the consumer is only able to compare this premium with others (without being able to compare the corresponding performances and services). The result of this misunderstanding of competition is that the stock companies with the highest costs make the highest chance-related profits ! – And they offer for their completely overpriced premiums no other or no better services than the cheaper “insurers”. But how should the consumer know this ? –

Just as the profit justification of the stock companies can first be established when the premium is broken down and the price for the services quoted, just as competition for services in the insurance field requires the break down of the premium, so can the financial and social problems of insurance first be solved when insurance as a perfor-

mance of the insured is separated from the service of the firms and when insurance is regulated for the general benefit of the group of insured – without the influence of competition, rivalry and profit-struggles ! –

Consequences of the undivided premium and profit-struggle in the insurance field

The stock companies had taken over the tradition of not breaking down or separating the contributions and performances 100 years ago and cemented the principle of the “indivisibility of the premium” which they have been able to hold onto until today.

Through the undivided premium, the profits of the stock companies depended neither on an economic performance nor on competition, but above all on their premium calculation and the course of accidental damage.

And this manner insurance – formerly “mutual aid of insured for loss pooling” – has become a profit problem of the stock companies, above all, a problem of “premium-over-calculation”.

While the traditional insurance institutions approximately had estimated the contributions for loss pooling according to the law of averages, while they had apportioned this on the insured and corrected fluctuations in the rate of losses through subsequent refunds or additional payments, the stock companies had had to calculate their fixed premiums from the beginning so high that extensive surpluses remained. This was checked by no one, neither at the calculation stage nor at the close of the individual business year.

Where this freedom to calculate premiums lead to can be measured when on reads even in the economic essays and official documents: “raids by the stock companies, unscrupulous speculation, unrestrained conduct by wheeler-dealers, unfair methods of doing business, damaging consequences from profit struggles in the insurance field.”

An example from one of the largest German stock companies lets us look and see how it still calculated its premiums in 1900. In its chronicles it is described as a “sign of solid operating” that “all branches continuously brought in a stable surplus that ranged between 11,5 and 13,8 %. In this regard it is noteworthy that tax expenditures have already been deducted.” From premium income of 10 million “Reichsmark” (RM), this firm, in the 10th year of its existence, had a net surplus of 1 million RM form a “fund” of its own capital of 1 million RM. In this example, the premium calculation can only have run thusly: a money requirement of 9 million RM for losses and costs and 1 million RM in security surcharges for fluctuations, i. e. 10 million RM, has been apportioned to the customers and these completely alone covered the security of the loss pooling with these over-calculated premiums. The stock company’s own capital fund was never included in the calculation so that the company bore no risk and therefore had no “profit justification”. But it nevertheless appropriated the net surplus as profit. The shareholders received 24 % dividends (at this time 4 % interest was normal), and the remaining premium surplus was transferred into the reserves, in this case its own capital fund – what one called “self financing”. By this means the company additionally increased the market value of its stock or gave bonus shares to its shareholders. The market value of this company’s stock, five years after is establishment, was already 300 % without the shareholders having paid in any additional capital. And for the “self-financed capital of its own” that was created out of the chance-related premium surpluses without any profit

justification or corresponding performance, the stock companies demanded further profits from the insured at the same time that they realized additional proceeds and value increases through the investment of this money in other firms.

It does not have to be pointed out further that “insurance at a fixed premium” was made more expensive through the necessity of surpluses. A further increase in expensiveness arose because the stock companies, to carry through their over-calculated premiums, required costly acquisition-organizations. The agents received no service-related remuneration, but were only paid commissions when the agent brought new premiums to the companies. This commission system led to very aggressive methods of acquisition that especially in the field of insurance can be very dangerous because here no concrete product or service can be offered, but only words and numbers that the insurance customer of the agent has to believe if he doesn't want to remain uninsured. There was no competition and no “insurance market”. The consumer was intimidated and bewildered by the aggressive acquisition and the invisibility. It became customary for the customer to be sought out at home by the agent rather than himself take the initiative to cover his insurance and of the entire insurance field is limited in general to the four walls of his home.

State regulation in the insurance field

All of these abuses produced calls by the consumer for nationalization, legal regulation of insurance and state control of the stock companies already in the last century. Here there exists unity even among the insurance academics that the method of operation of the stock companies required state control.

Similarly in the investigation of competition in the insurance field, the lay legislators here also approached the problem of insurance supervision with a false formulation of the questions. When these abuses came to light, it should have been investigated what the cause of these abuses was and exactly why they were caused by the special method of operation of the stock companies. Unfortunately, these questions were never investigated and the government merely reflected as to what could be done about the symptoms. This wrong procedure may be based on the fact that the legislative bodies didn't see through the increasingly complicated events in the insurance field and therefore had to consult the stock companies and their academics. So the companies and their lobby themselves arranged their own laws.

If the legislators had researched the cause for the uneasiness and mistrust of the consumer and understood the "damaging consequences of the profit struggle in the insurance field", then they would have had to determine:

- that insurance can only be produced jointly, mutually and gratuitously by the insured themselves,
- that stock companies can only bring forth a service for the economic production of insurance (by the insured),
- that through the mixing of these two performances all competition is made impossible and profit-orientated companies without competition are enabled to achieve profits from certain surpluses of "insurance", the amount of which is only chance-related, without giving any corresponding performance in return,
- that through the mixing of insurance and service a rivalry for surpluses from the "insurance" is caused

which leads to socially unjustified classifications and contributions for loss pooling which in turn leads many consumers into difficulty in obtaining and keeping insurance protection.

Then it would be the task of the legislators to separate insurance and service and to require a breakdown of the premium, All problems in the insurance field would thereby be solved and the requirements for competition over services in the insurance field and for a universal regulation of insurance would be accomplished.

Regulation of the insurance contract

The separation of insurance and service could have been achieved by legal regulation of the insurance contract, which could have lead to the definite description of insurance as performance of the insured and its placement under stat regulation. These regulations should have also regulated the service-performance of the administration offices and should have transferred to officials all tasks that have any connection with the financial, social and chance-related problems of loss pooling and with the fundamental ideas and goals of insurance (conditions, insurability, rate classifications, contributions for loss pooling, use of surpluses, supervision, creation of a compensation fund as a substitute for reinsurance). These fields cannot possibly be areas for competition because an “appearance of competition” must here lead to in-transparency, social inequality of treatment, waste of costs and to nonperformance-related costs and profits, in fact, even to endangering the insurance coverage through the creation of the risk of bankruptcy.

These relation have not been recognized and the insurance contract was only incompletely regulated. Based on this, the insured has to pay his premium. And the firm is only obligated

to perform the agreed-upon payment if there is a claim. Premium and loss payment, after such regulation, face each other as performance and counter-performance which accords exactly with the false idea of the insured that insurance is a “purchase contract” and with the false method of operation of the stock companies who claim to be able to “produce and sell insurance.”

The insured have to bring out their performance in advance and pay the premium. On the contrary, by this regulation, only chance determines who receives a “counter-performance” just as it determines the profits of the stock companies. The less “counter-performances” the stock companies bring forth, the more chance-related profits they make. There can be no doubt that this regulation of the insurance contract has not set aside the speculation of the stock companies but sanctioned it; for the uncertainty of future and chance, the problems of insurance, could flow into the peculiar contracts of the stock companies through these regulations and have not been blocked off. In such a contract, these regulations made the entire relationship of “performance and counter-performance” chance-related and uncertain – speculative ! – The insured, who happen to suffer no losses, receive no “counter-performance” according to this regulation, even not the pretended “risk-bearing” by the stock companies (page 25).

The above-mentioned questions as to the performance of the stock companies in the insurance field, as to the price for this performance and as to the ownership of the premium will not be answered by these inadequate regulations. Insurance and service are here, as before, just as mixed as loss contribution and service price. Above all, the ownership of the premium is completely unregulated. Otherwise, two completely different methods of procedure couldn't have developed; namely that the

traditional insurance institutions regard all contributions as the property of the group of insured, whereas the stock companies treat all premiums as their own money by which they perform loss payments as their “counter-performance” and from which they take the surpluses as their profit and the property of the shareholders.

Strangely enough, these incomplete regulations have bothered nobody until today. The insurance academics can read all possible kinds of contracts into these regulations (like their “purchase contract of a product insurance”). but not the performance which the stock companies in the insurance field singly and alone can perform – a service ! – For the “premium” cannot be the price for the service so long as the premium also contains the loss contribution of the insured, And the insurance benefits which the claimant receive in case of losses are not created by a service of the stock company but by the money that the insured themselves have produced by working and provided for the loss pooling.

Thus, the regulation of the insurance contract which was brought about with the cooperation of the insurance academics brought no changes in the insurance filed and removed non of the major abuses:

- in-transparency,
- no premium breakdown, mixing of the “contribution for loss pooling” and “price for service”, mixing of the insurance and service which lead to “speculation without risk” by the stock companies,
- chance-related, non-performance-related profits of the stock companies,
- inefficiency and non-performance-relationship of the costs and commissions for the actual services,

- removal of every competition prerequisite through the inclusion of the chance-related insurance in the “competition”, whereby only a rivalry arose for speculation profits and market advantages,
- the inequality of treatment of the insured and the social injustice through the determination of classifications and loss contributions by companies struggling after surpluses, profits and market advantages.

Regulation by the state insurance supervisory authorities

Since these abuses have not been removed by the legal regulation of the insurance contract, the supervisory authorities still had the task before them to remove these abuses and to provide,

- that the stock companies no longer take in the chance-related surpluses out of the loss contributions as profits,
- that the stock companies make their profits only by the efficiency of their service-performance and their capital management (to this extent, the state authorities should have taken over the function of the lacking competition in the service field and provided for transparency and equivalency),
- that the basic financial and social principles are established for the universal benefit of the group of insured.

Still – again with the cooperation of the insurance academics – incomplete regulations passed by, concerning the state insurance supervision, that do not establish the fields and the tasks

of the state supervisors but only make general paraphrasing that abuses in the insurance field should be prevented and removed. As to the fields and tasks of state insurance regulation, people are still arguing today.

This incompleteness of legal regulation has left open a great deal of free room for “profit-striving” theories and profits which the insurance academics and the stock companies have very one-sidedly used to the disadvantage of the consumer.

The incomplete regulation of the insurance contract filled the stock companies and their academics with the untenable “production theory”. The open questions as to their profit justification and performance, as to price and ownership of the premium are answered in so far as they say that by “risk bearing they produce insurance”, the premium is the “price” therefore and all premiums become the property of the stock companies and shareholders.

“protection theory” for the state insurance supervision

For the open questions as to the fields and tasks of the state supervisors, the insurance academics have developed a “protection theory” in which the dangers of “fixed premium insurance” are stressed; namely that with too low premiums and too little security capital, the fixed premiums could not be sufficient to cover all loss payments. Therefore, the supervisory authorities had to allow the companies sufficient premium income “for the protection of the insured” so that the premiums would definitely cover the loss payments and, in addition, create surpluses that could be carried over into the security capital. And the supervisory authorities were supposed to watch over the security of this capital investment – also for the “protection of the insured”.

The supervisory authorities had to fulfill their task “for the protection of the insured” in this way, to make fixed premium insurance actually offering security. It has only been overlooked until today that, under these conditions, there was no longer any counter-performance nor any justification for the stock companies to take in profits out of the surpluses which must be certain, but are chance-related as to their amount, to pay dividends and to continually increase their “own” capital out of these surpluses. The supervisory authorities have not recognized that fixed premium insurance is speculation and that they were forced “for the protection of the insured” into removing the risk of speculation by providing this speculation with a “state surplus guarantee”. Why the supervisory authorities, of all things, permit the stock companies to take in the surpluses as profits, and why a “state profit guarantee” has been made from the “state surplus guarantee” is the biggest puzzle in the insurance field. The assumption that security capital can be created by the stock companies only from profits in the form of “self financing of own funds” is without any foundation. The traditional insurance institutions prove that security capital can be created from the money of the insured, too, and can remain the property of the insured.

The supervisory authorities are often designated as “consumer protection authorities”, but this proves true in only one area: these institutions make certain for the insured the fixed premium insurance, which is burdened with risks. But they thereby make possible chance-related profits for the stock companies and do not protect the consumer in so far from unlawful expropriation by the unjustified enrichment of the stock companies from the insureds’ money.

Consumer protection – better yet “consumerism or promotion of consumer interests” – is more than just providing that promises

of payment, which the stock companies apparently “sell” to the consumers, will be fulfilled with certainty. Consumerism is, above all, the creation and promotion of competition so that the consumer – informed and knowing – can take his position in the market and can cover his needs by making free decisions. If there is no competition – as in the insurance field because services are not described nor prices given – then it is at least the task of a “consumer protection authority” to replace the function of competition in the real fields of competition as to service.

Impossibility of task fulfillment with undivided premium

Inefficiency of insurance acquisition and administration of portfolios, wastefulness of the insurance of small risks and of small claims settlement are not recognizable through the lack of a price quotation and are not hindered by competition. By not breaking down the premium, it is not possible for the supervisory authorities to replace competition in these fields with regulation and to have direct influence on the efficiency of the services in order to create an equivalency of service and costs. With an undivided premium this would only be possible by an order to reduce the total premium. But this can lead to an endangerment of the insurance at a fixed premium (danger of bankruptcy).

Basically, the state supervisory bodies cannot have any direct influence in the true fields of competition and in the undivided premium which actually contains a completely calculable cost share. But the premium is burdened with by the mixture of the insurance and the loss contribution together with the uncertainty of the future and therefore cannot be regulated in advance. Thus, too, no one can force the stock companies to compensate their losses for inefficiency of operating from their own means as every other firm must do. The stock companies use

for this the surpluses from the contributions for loss pooling, they properly have been entrusted with for loss compensation.

The state supervisory authorities hardly bother themselves at all as to the efficiency of the services in the insurance field. They have only introduced regulations or approval procedures for the contribution calculation and ordered that in some branches (for example, the automobile insurance) the stock companies also have to pay back to the insured surpluses from the premiums and interest yields on capital investment to a certain extent. These are, in truth, steps in the right direction to fulfilling the real task of supervision – an attempt to prevent profits not performance-related. Still, these procedures are not complete, consistent and not carried out in all fields. And above all: a theoretical basis for these measures is lacking. They are not to be brought in line with the insurance academics' theories. If the premium is supposed to be the price for a product "insurance", why then are parts of these prices and of interest proceeds supposed to be paid back to the insured out of the companies' "own" capital ? – When and what part of the premium belongs to whom and why, is – just as before – not cleared up.

There are two opposing opinions that demand more or less state supervision and intervention in the insurance field. The question "more or less state supervision", first lets itself be decided when one takes into consideration the above-mentioned thoughts and recognizes that insurance at fixed premium is composed of many performances and that the insurance hidden in the premium cannot at all be a field for competition, and that an "appearance of competition" can here even lead to financial and social abuses. This area of social aid must be subject to state regulation. On the contrary, state supervision and regu-

lation of the companies' services is groundless and superfluous. Only both these areas cannot be separated so long as the premium is not broken down. And so long as this doesn't happen, the argument as to insurance supervision will continue with the understandably completely contrary argument from the two different fields – from the field of “insurance” (for more state regulation) and from the field of the “services of the companies” (for free competition). Thus the curious allegation arises from the stock companies that state intervention in the setting of premiums and classifications as well as in the use of the surpluses now hinders “free competition” (as to unjustified enrichment !? -) and hinders (chance-related !? -) “profits”.

Actually, since the introduction of insurance supervision, the level of surpluses and profits is no longer decided only by the chance-related course of damages but also by the intervention of supervision in the premium calculation and in the use of surpluses. And thus as to the “depth of penetration” of supervision in these fields, until today, there is a continuing dispute and wasteful approval and checking procedures that would be superfluous if the premium had been broken down and the loss contributions and surpluses removed from the grasp of the companies.

The battle of the stock companies with the state supervisors over the profits occurs in two stages: in a “moment of uncertainty” (premium calculation, establishment of classifications and loss contributions) and in a “moment of certainty” (statement of the yearly surpluses, use of surpluses). As been stated above, the supervisory authorities, in so far as they have any influence on the premium calculation, must allow the companies sufficient premiums to cover costs and damages with certainty due to the uncertainty of the future – “for the protection of the insured”.

Hindrance of subsequent control of the use of contributions and costs through misrepresentation in the annual statements of accounts and balance sheets

The uncertainty of the future and of the rate of damages becomes certain with the annual balancing of the accounts. In this “moment of certainty” begins the second stage of the battle against the supervisors over the profits by the stock companies. They arrange the annual accounts and balance sheets in a way so that profits and costs are suppressed and deferred so that, thereby, surpluses will not have to be repaid to the insured and the inefficiency and injustices cannot be recognized.

To present the possibilities and practices of such misrepresentations in the annual statements of accounts and balance sheets and to present detailed possibilities how the defer costs and profits, would exceed the scope of this booklet and only increase the complications and difficulties of unraveling the insurance field. Here only those items will be briefly enumerated that lead to complete invisibility of the annual statements of accounts and make it impossible to investigate the actual income, expenses, damage payments and profits of the companies.

The actual income is misrepresented in that it is increased by premiums for insurance contracts, taken in reinsurance, and is reduced again by premiums for their own reinsurance, and is reduced again by premiums for their own reinsurance (even for smallest risks), and in that yields of capital investments of the insureds' money are not taken as income.

The actual business costs are misrepresented in that they are reduced by reinsurance commissions, deferment of expenses and by costs for claim settlement.

The actual damage payments are misrepresented in that they are reduced by the participation of the re-insurer in the pay-

ments for damages and in that they are increased again by the costs for the claim settlement and by the inclusion of exaggerated reserves, made for unsettled damage claims.

Through internal adjustment within the branches, within the companies and within groups of companies, costs and profits are deferred and disguised. Costs and losses of certain commercial lines are compensated through the surpluses from the personal lines.

The balance sheets are misrepresenting in that the capital investment are not properly valued. The increase in value goes only to the shareholders through the increase in the market value of the shares, but doesn't accrue to the benefit of the insured.

The ratios of turnover-yields are disguised in that the surpluses are not set out in relation with the costs (prices) of the services, but with the total premium income which is in fact no turnover of "service firms".

Costs- and loss-ratios are disguised in that false amounts are set in relation with each other.

On the whole, it can be determined what surpluses companies and groups of companies altogether achieve, but exactly where and how the profits and costs have arisen and to what extent they are performance- or chance-related, no one (not even the supervisory authorities) can determine. Far too many items are mixed with each other, all transitory items are suppressed and only final sums are given, that, however, no longer have any evidential power.

The creation of equivalency is excluded since the supervisory authorities at the "moment of uncertainty" have to permit the over-calculation of the premiums "for the protection of the

insured” and after the expiration of the loss year – at the “moment of certainty” – still cannot judge the individual services, their costs and efficiency and cannot replace competition in the field of service-performance with supplementary adjustments of the price/service relationship. It is clearly shown how incorrectly the insurance field is structured and regulated and what difficulties the state supervisory authorities must have in recognizing their proper scope of activity and perceiving their true tasks. Also, since the premium has not been broken down, the insurance supervision and regulation remains a continuing problem and the battle with the companies as to the premium calculation, use of surplus and as to equivalency have become basically an insoluble continuing conflict.

Expensive regulation-procedures in ratemaking and controlling and all abuses and problems in making an accounting and in the control of the companies can be removed very simply by the breaking down of the premium, because then the loss contributions of the insured and the prices for the companies' services would be quite unequivocally separated in the annual financial statements. As to the use of the surpluses, as to the ownership of the loss contributions and service prices and as to the profit justification of the stock companies no more obscurity would arise. In so far as the stock companies' price income exceeds the costs, the surpluses are their profits. The surpluses from the loss contributions, on the other hand, according to an appropriate regulation of the supervisory authorities, would have to be refunded to the insured or carried over in reserves that would remain the property of the insured and whose capital investment would be regulated and checked by the supervisory authorities. The insurance authorities besides that, would have to determine the conditions and classifications for the loss contributions and establish a compensation fund as a substitute for the reinsurance in personal lines.

Closing remarks (consumer needs, innovation, competition, diversification, communication technology)

It is high time that all the problems broached here – starting with the “insurance as mutual aid of a social community” – be investigated in a neutral scientific manner and solutions found for the universal (legal) regulation of “insurance” and for a regulation of services in the insurance field and their remuneration. The consequences of a change in structure of the insurance field (agents- and commission-system, reinsurance, competition) and in other fields (diversification, merger and installation of communication technologies in the financial service field) must be investigated. Especially, all regulations, measures and changes should obtain to the needs of the consumer who, up to this point in the insurance field, only played the roll of contract victim and through the incompleteness of state regulation and legislation had to pay expensively since the stock companies enriched themselves on his money, paid dividends out of this and formed their so-called “own property” and wasted his money on inefficient methods of operation.

First when competition requirements and transparency through the truthful information has been achieved, when the consumer can recognize what is happening in the insurance field, when alternatives can be offered to him and he can profit by them, when he has the freedom to change his insurance at any time, only then can the consumer take over his function in the market and can competition also in the insurance field (in the area of services) be produced.

The stock companies above all fear competition in the insurance field and they will continue to do everything they can (jointly with lobby and academics) to prevent this. In Japan, in the course of the democratization of the economy, the stock companies have been almost completely driven out of the

insurance field. In the USA, after the second world war, their market share has steadily and increasingly gone down and runs now about one-third. In Germany, the stock companies have been able to successfully defend their two-thirds market share until now in so far as they have retained total in-transparency through suppression of information and spent huge sums for the cost of a “service field” and agents to bind the insured for long periods to themselves. They have thereby made the change to cheap insurance considerably more difficult or quite impossible.

An alternative for the stock companies – not known as such to many consumers – is the mutual insurer, who works for no profit and with considerably less costs and contributions. But these also have two faults:

The unintelligible total adaptation to the method of operating (and “production theory”) of the stock companies by also building up huge assets (burdened with taxes) and giving up the subsequent yearly adjustment of loss pooling by additional contributions or repayments. – On the contrary to the stock companies, assets of mutuals remain the property of the group of insured. But a kind of expropriation takes place, too, because no member is entitled to a refund of his asset share when leaving the mutual. The single member gives money away. But who is enriched ? – The question of the property as to the contributions and assets, the sense or nonsense of fixed premiums or contributions and of building up huge security assets (in personal lines insurance) is not yet sufficiently examined and answered for the mutuals, too.

The mutuals started and still participate in the classification battle (as to state employees and other “good risks”) to achieve market advantages. But they overlook that they are hollowing out the social idea of insurance as a mutual gratuitous loss pooling within a social community.

Nevertheless, the two remaining distinctions of the mutual insurers are:

- no unjustified enrichment
- cheaper contributions as a result of a more efficient method of operating

Because of the complicatedness of the insurance field which has been caused by the stock companies' peculiar "fixed premium insurance", by the danger of bankruptcy from this insurance form and the difficulty – when not, in fact, impossibility – in tracing the paths of the consumers' money and in protecting it, the so-called "insurance industry" in many respects has accomplished for itself a "splendid isolation". Above all, in related fields such as banking, penetration has been prevented because then the paths of the consumers' money would be even more difficult to follow and control and protection of the insured become even more complicated. Thus, the complicatedness of the "fixed premium insurance" of the stock companies has not only procured no-risk and chance-related profits, but also has held off all competition from all other fields, whereas the so-called "insurance companies", with capital-life-insurance, with the insurance of small risks and claims, have for a long time already been moving in the fields of banking and saving.

In the USA, the bank holding companies start penetrating the insurance field and, according to a decision of the Supreme Court, are permitted to offer and conclude all insurance through the bank counter of their firms in the "preserves of the insurance industry" is possible in complete scope and without danger for the insured when the premium is broken down and thereby in the insurance the saving and clearing operation are approximated:

here the money of the insured that is saved and paid for group loss pooling – here the charges by the firm for its services ! – The paths of the insureds' money are very easy to trace and to control and the service firm have nothing more to do with the insurance and the “bearing of somebody's or some kinds of risks”. The services of the firms in the insurance field are quite simply financial services (administration and distribution of someone elses' money).

The consumer has a uniform need for a comprehensive financial service, for a “one-stop financial service” for his freely disposable income and property. He wants, if possible, to be neutrally and comprehensively advised in one place and be continuously advised on all financial questions (saving, investing, insurance). He wants also, if possible, to entrust only one institution with his personal data which the bank nevertheless largely knows about. In order that his insurance protection will continuously fit his changing situation, the customer has an interest that the data and information exchange is properly and legally regulated and is conducted permanently and in writing (as some firms do it by sending out questionnaires for the renewal of short-term contracts). The consumer has considerably more trust and contact (in the future even through new communication technologies) to banks and savings banks who have more branch offices than there are agencies in the insurance field. The bank can offer considerably more an new kinds of alternatives in insurance (combination of savings contract and insurance with corresponding insureds' deductible, packaging of all insurance, monthly booking from one's account, combination of risk-life-insurance with a flexible property formation as to savings, capital or material property investment to achieve profits and increases in value.).

By breaking down the premium and an exact reckoning of the

payors' money, other financial service firms can bring forth services in the insurance field (diversification, mergers), which not only serve the consumer, but also would promote competition, innovation, rationalization, efficiency and the installation and better usage of modern technologies for an urgently essential customer welfare.

This small booklet should illustrate, that there is still much to be researched in the field of insurance, that was made complicated by the "speculating" stock companies and whose formation had been left in the hands of the so-called "insurance industry", its lobby and academics (with all the consequences and abuses for the disadvantage of the consumers, which neither competition nor state control can recline).

The starting point and subject of all research must be:

insurance which can only be effected through mutual gratuitous help of a social community and can never be the economic performance of a company.

Without break down of premiums, without separation of insurance and commercial services, without taking the insurance, burdened with the uncertainty of the future, out from the commercial business and competition, the problems in the field of insurance can never be solved and expropriation and unjustified enrichment as well as unequal social and financial treatment of the consumers will go on.

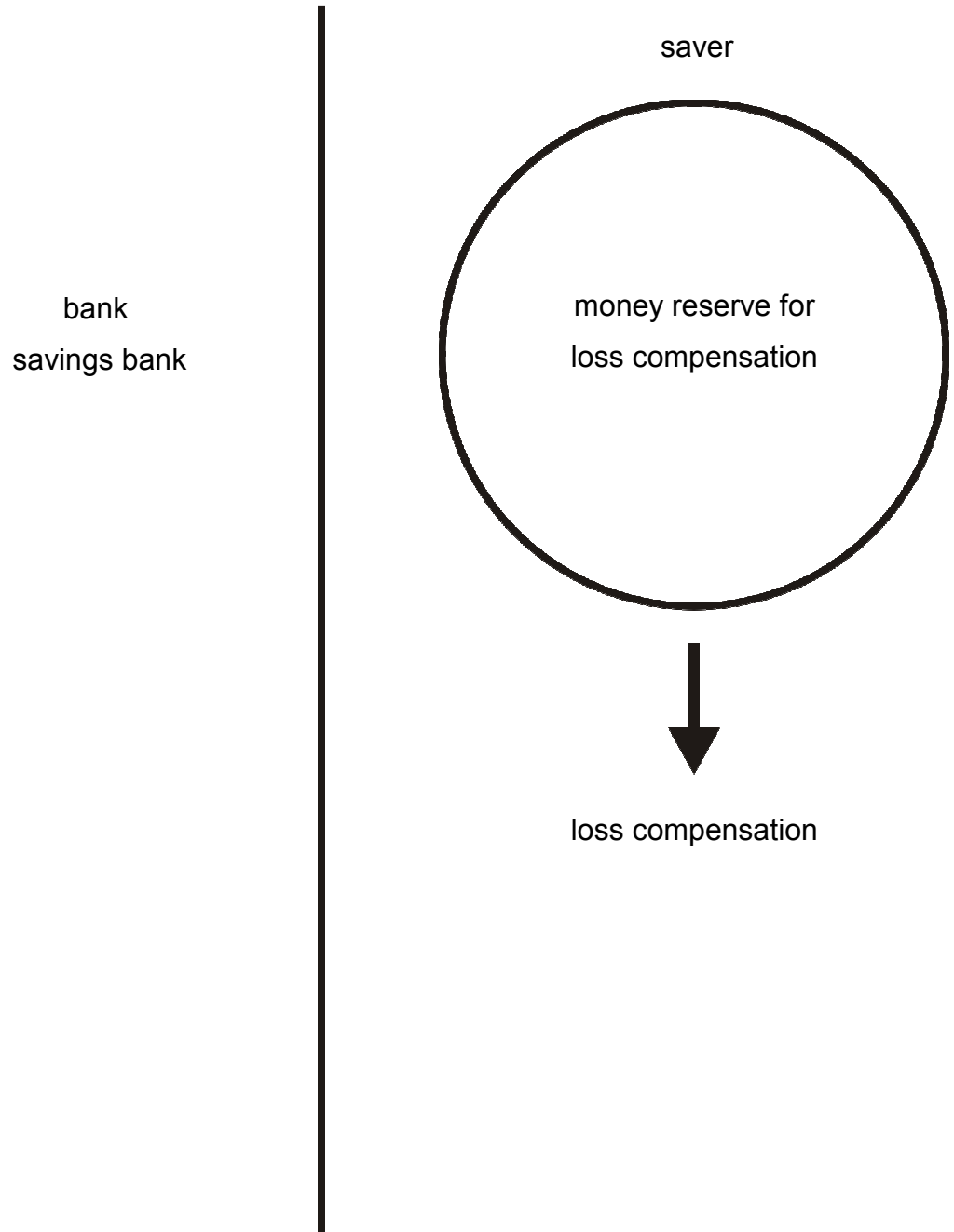
Graphic representations

In the following pages the basic problems of insurance are represented graphically. Above all the following should be observed

- the “property line” and how the property in money differs in the individual “forms of insurance”,
- the influence of coincidence and change, in particular how the problem of the uncertainty of the future in “fixed premium insurance” shifts onto the area of the stock companies, where it becomes a “profit problem” and results in chance-related profits.

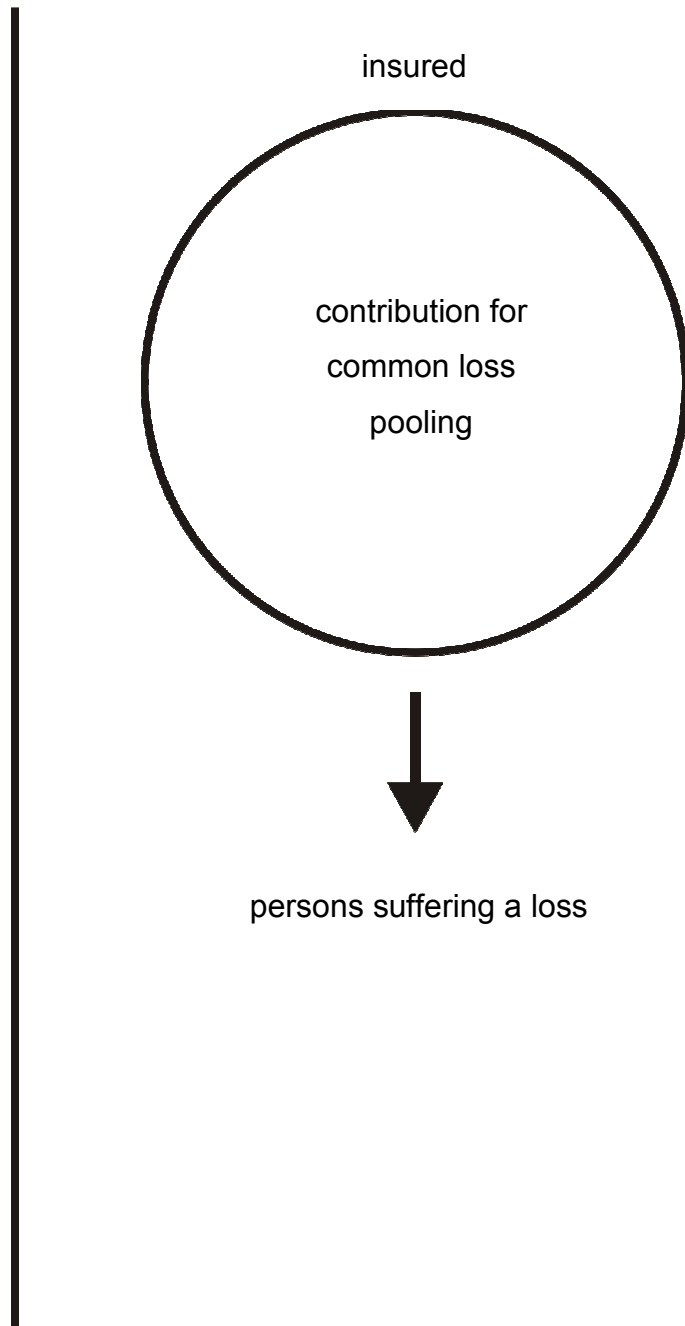
self insurance (by saving)

(property line)



**insurance in a group
(mutual gratuitous help)**

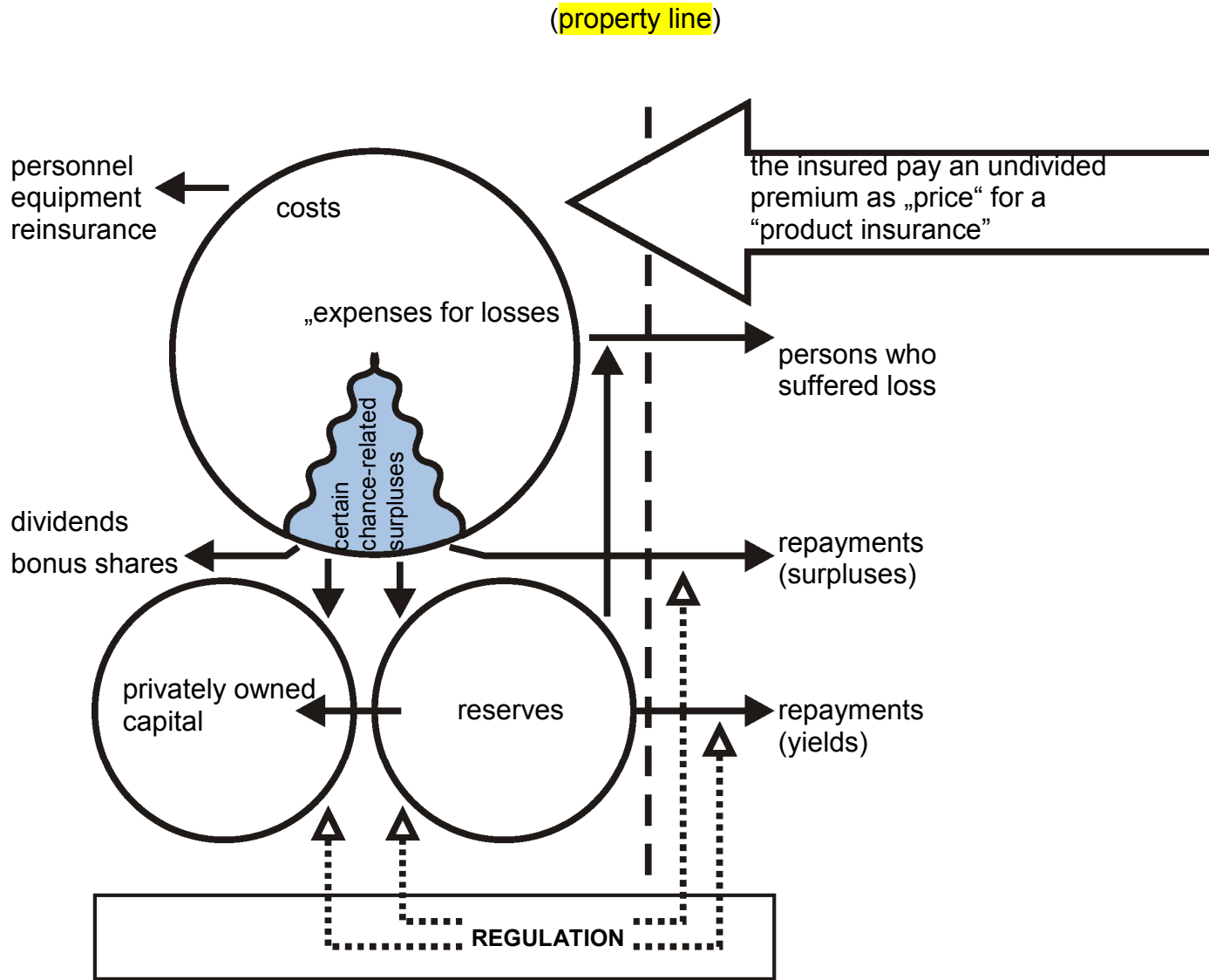
(property line)



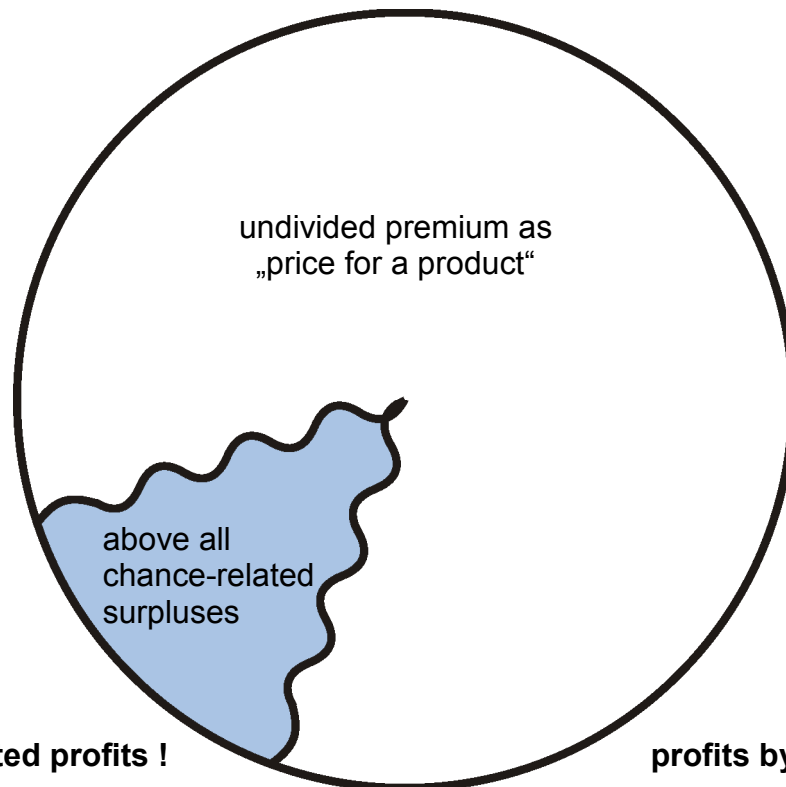
insurance in a mutual insurance association



„fixed premium insurance“ by stock companies



problems of „fixed premium insurance“ by stock companies



chance-related profits !

profit justification ? –
performance ? –
ownership ? –
equivalency ? –

intransparency ! –
no competition ! –
mistrust ! –
complicatedness ! –
regulation problem ! -

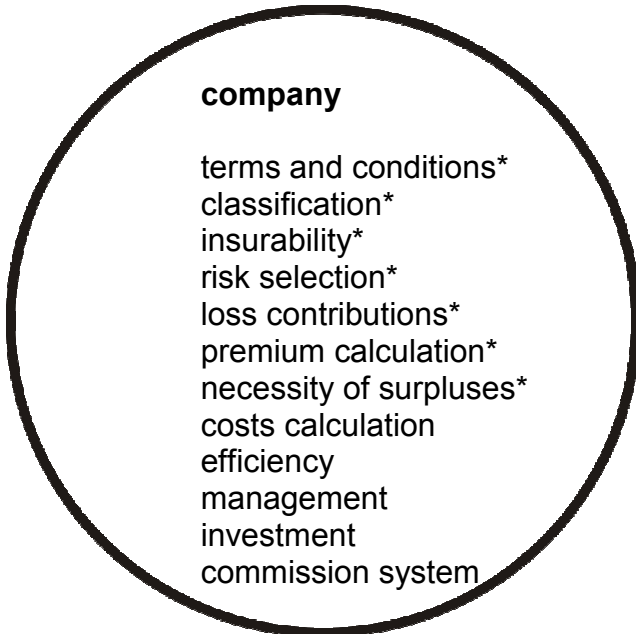
profits by:

overcalculation
rejection of claims
reduction of claims
selection of good risks
classification
cancellation of bad risks
nonrenewal of contracts

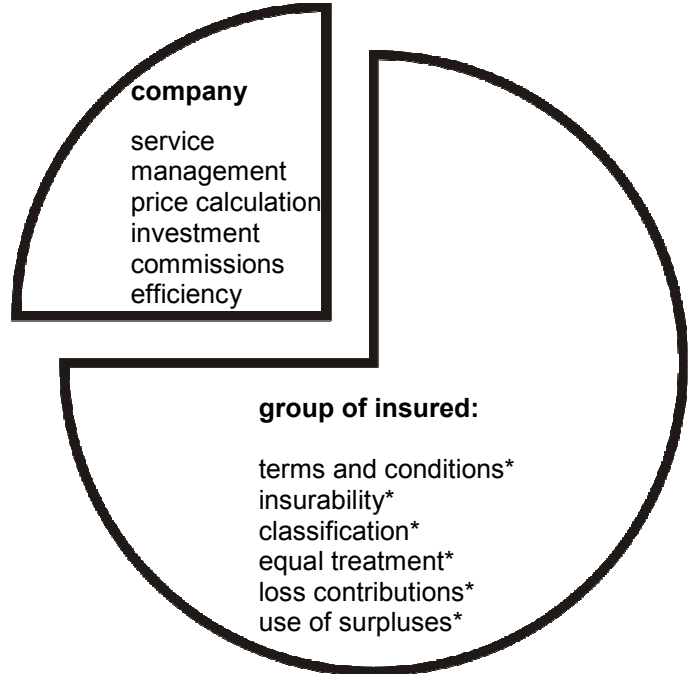
exaggerated reserves setting
exaggerated reinsurance

distribution of problems

with an undivided premium



with a divided premium

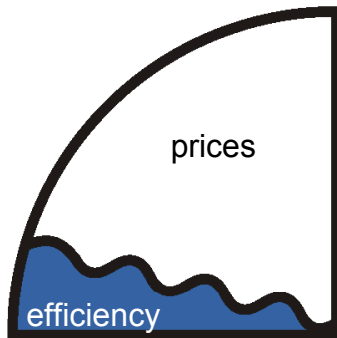


* These problems of insurance and of uncertainty cannot possibly be the problems of companies, striving for profits, surpluses and market advantages, because they will not be solved according to the social idea of insurance and chance-related profits will exist.

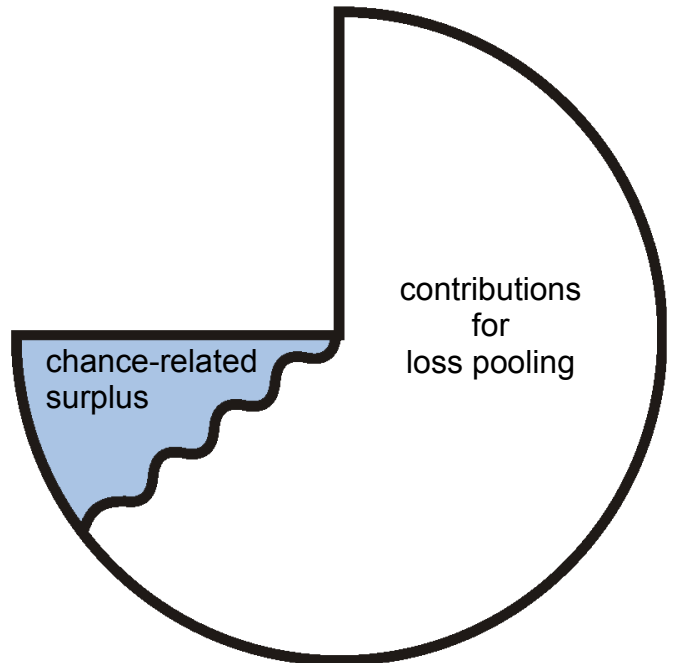
seperation of

service	—	insurance
service price	—	loss contribution
property of firms	—	property of the insured
business risk	—	uncertainty of the future
surpluses by efficiency (profit)	—	chance-related surpluses
field of competition	—	field of State regulation

service
field of competition



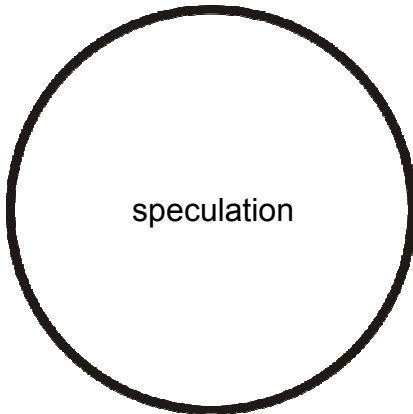
insurance
no field of competition



3 alternatives of „insurance“

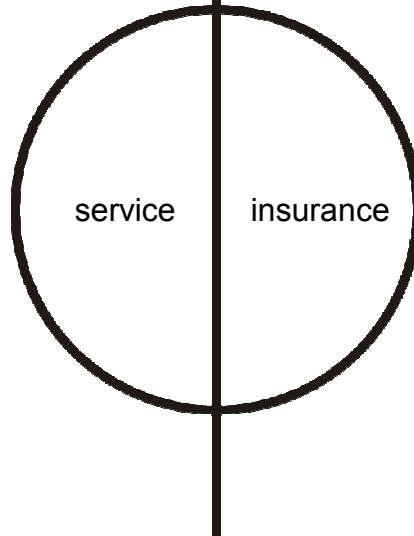
„fixed premium insurance“

(without competition
problems of regulation)



service + **insurance**

competition + **regulation**



State insurance

(without competition)

