

# LIFE INSURANCE MEDICINE IN CANADA

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The first Canadian life insurance company was started in Hamilton, Ontario in 1849 by an enterprising citizen who felt it was an imposition to have to travel to New York to apply for and be examined for a policy. There are no central archives for the industry for many years after and only a few items came to hand for the next 100 years. There was a Canadian branch of Standard Life soon after and later in the 1880s a series of Canadian companies appeared.

At the first meeting of ALIMDA in 1890 three Canadian medical officers were present, one of whom was the first professor of Pharmacology and Therapeutics in the University of Toronto, the second a university instructor and the third a distinguished physician in his community. Indeed high qualities of academic achievement and medical leadership were the norm for the early recruits into this field. Long before I had any connection with life insurance medicine I was familiar with the names and medical reputations of many of my predecessors from Montreal, London, Waterloo and Toronto.

Their insurance medical skills were advanced through their membership in ALIMDA. From its early days ALIMDA has graciously welcomed Canadians as members and as contributors to its goals.

For a number of years it was the custom of Canadians to book a hospitality room in the hotel where the meeting was held and to meet there, entertain their American colleagues and exchange ideas. The correspondence dealing with the financial reckonings that followed these affairs should have served as a warning of impending shortages in our pulp wood forests.

At the end of World War II a group of retired medical officers was the stimulus to the formation of a Canadian group which, about 20 strong, first met in the Kitchener Armouries in 1947. For two years it was called The No Name Society (ALIMDA Canadian Division having been rejected). One early consideration was to share the writing of an impairment manual - hard to believe! More believable was the determination that the time of the annual meeting should coincide with blossom time. At any rate we emerged as Canadian Life Insurance Medical Officers Association (CLIMOA) with our objective "The promotion of the science of medicine and its application to life insurance".

In 1951 the papers that had been given annually began to be collected but when the Equitable Life Assurance Society of United States started to organize a medical library CLIMOA had no published proceedings to contribute. This was remedied in 1956.

In 1957 there were 71 members. In 1958 Dr. T.C. Routley then General Secretary of Canadian Medical Association (CMA) saw a role for CLIMOA as a liaison between Canadian Life Insurance Association (CLIA) and CMA to negotiate concerns common to insurance companies and Canadian doctors. High on the list of subjects were the ever unpopular claims forms. Affiliate status for CLIMOA with CMA in 1958 was paralleled by a linkage of CLIA with CLIMOA as the treasurer of CLIA became secretary of the Public Relations Committee of CLIMOA. In the next years Public Relations Committee members visited Provincial Medical Associations across Canada in an effort to develop insurance forms that would be uniform and acceptable to the practicing physicians.

This liaison setting was a fortuitous preparation for the ill-matched struggle looming on the horizon, the introduction of provincial government health insurance in Saskatchewan and later the rest of the provinces. Here was CLIMOA, an affiliate of CMA with a seat on its Council, and firmly linked by a standing committee with CLIA and and CHIA (Canadian Health Insurance Association (established 1959).

A new constitution was approved in 1960 :

- a) to advance the science of medicine as applied to insurance, and now
- b) to provide liaison and promote good will between the medical profession and the industry.

In 1962 Mr. Justice Hall headed a Royal Commission on Health Services. CLIMOA presented a brief appended to that of CMA itself. It is a sour recollection that CMA made its presentation with no reference to the CLIMOA brief and when asked by Justice Hall to comment on it (he having read and appreciated the suggestions that came from the insurance experience) was put off by the CMA spokesman with the aspersion that our brief was only the opinion of the industry, not of medical professionals.

Currently we are reading and hearing a great deal about the need for changes in medical practice in the United States. One can only hope that ALIMDA's voice in the struggle will be less strident than current pronouncements from the American Medical Association (AMA) but more effective than CLIMOA's was in 1962 toward establishing a universal system of the highest quality with financial safeguards so that it would be affordable by the country in times of escalating costs accelerated by technological advances and an ever aging population of patients.

At the beginnings of CLIMOA Harry Kirkland, Prudential of America, became a regular attendee at the annual meeting, later joined by his associate, Ed Dewes. In 1960 they became Honorary Members. Interest in Canadian medical insurance activities grew and in 1967 the constitution was amended to accept to full membership any medical director whose company was actively in business in this country. Later in the 70s ALIMDA started the practice of holding an executive council meeting in conjunction with CLIMOA's annual meeting. Many of the council have stayed to enrich our meetings with their interest, wisdom and congeniality.

In the early 1960s we had to come to grips with the different slant on risk classification that developed with the emergence of thriving and competitive reinsurance companies. Before this, primary companies arranged to exchange large blocks of business above individual retention limits according to reciprocal agreements, but the reinsurers as they burst on the scene caused a refinement of risk assessment that benefitted future policy holders with challenging standards for actuaries and Medical Directors to absorb and accommodate. The old automatic treaties were doomed.

By this time too the principle of paramedical insurance screening was on the scene. In Canada dedicated medical directors carefully scrutinized potential providers, encouraging a coordination and consistency of standards and methods. The lasting result has been a quality of recording of history and measurement that were reliable and economical. Our relationship with CMA made it possible for us to keep their Committee on Medical Practices informed and reasonably content as the numbers of medical examinations shrank. Public acceptance and satisfaction with the innovation was the key.

Again because of the existing CMA - CLIMOA relationship we were instrumental in expanding CMA awareness of the significance of certain clauses in some Provincial Consumer Protection Acts. The relevant feature common to these Acts was protection of privileged medical information of private citizens, in our case, insurance applicants. One of the results in 1973 was that CMA went on record to state that the use of consumer reporting agencies to obtain attending physicians' statements was not in the best interests of the patient (applicant).

Privacy of personal medical information emerged in 1979 in Ontario with the Select Committee on Privacy of Medical Information. Dr. Henderson presented a brief from CLIMOA defending risk classification as essential to any voluntary insurance scheme, and the vital need of personal health information for fair underwriting and claims practices. A little later in Ontario Mr. Justice Kriever chaired a Commission of Inquiry into the Confidentiality of Health Care Records. The private insurance industry answered this inquiry reasonably well and the Medical Information Bureau (MIB) received commendation for the meticulous systems in place to preserve confidentiality of their records, and for their fair and frank disclosure and correction practices. Industry in general and the Ontario Hospital Insurance Commission (OHIC) were censured for their laxity in keeping personal records private.

In the mid 70s there was great unrest in Quebec, a dissatisfaction with their acceptance by the rest of the country, which was promoted by the emergence of the province from archaic educational strictures and the language barrier between Canadians of French and English origins. Against this uneasy background it was encouraging to have strong francophone members in CLIMOA. One can recall experiencing again the charm and hospitality of Quebec at a meeting chaired by a Quebec Medical Director in the province's capital, in contrast to the trumpeted fears for the dissolution of Canada that were daily headlines across the country.

In 1974 the federal minister of health, Marc Lalonde, published a booklet on health maintenance for Canadians, a prescription of life style changes that would reduce and/or ameliorate diseases and with that public health care costs. This preceded the interests of the Canadian and United States insurance industry in the promotion of health and prevention of disease. It led to federal funds supporting two life insurance companies in a study to measure the benefits of improved staff fitness on health and productivity. It was a crude study but became a ringing endorsement of staff health promotion programs as a significant source of savings for companies which provide such benefits.

One of the side effects of a universal prepaid health insurance scheme in which balance, or extra, billing is illegal has been to generate significant increases in charges for medical services not covered by the Act. The result has been a continuing rapid increase in charges for insurance medical exams, attending physician's reports, claims reports and independent medical examinations. Against the background of consumerism and privacy concerns there is in this country increasing difficulty in obtaining complete, accurate information from the personal physician, a reluctance to provide information obtained in past consultations, even x-ray reports. There is a small but active demand that authorizations for past health records be originals, not photocopies, address individual sources and specify fairly precisely what information is being sought. This trend hangs over our heads in Canada as we seek sufficient information to assess risk fairly and accurately without prohibitive expense.

The insurance industry in Canada has long supported medical research including funds for insulin refinement and clinical studies as an early example. For many years medical directors have advised CLIA (later Canadian Life and Health Insurance Association) regarding the method of providing fellowships, scholarships and grants to assist Canadian medical schools to retain and support promising research and teaching physicians. Many of the recipients have reached high positions in Canadian universities, have made major contributions to our understanding of disease and to evaluation of newer investigative techniques and treatment procedures. One early recipient of CLIA support gave a paper at CLIMOA Annual Meeting in 1959 while he was studying here. He is now an insurance medical officer in Cork, Ireland. I met him and learned this in the Netherlands in 1989 at the International Congress of Life Assurance Medicine. Over the years we have been fortunate to have had a number of these illustrious

academics speak to us at annual meetings of CLIMOA and once or twice of ALIMDA.

Many of old problems keep recurring sometimes in altered guises. New ones emerge of varying importance, most recently the question of the responsibility of the insurance medical director to provide counsel to an applicant before an AIDS test, to ensure that positive results are promptly available for the benefit of the applicant in conformity with the public health regulations, and respecting the privacy of the patient. The issues arising from the expanding field of genetic testing are almost on our doorstep.

There are now 137 active, 22 associates, 31 emeritus and 2

honorary members. Our annual meetings are now held from coast to coast. Canadian insurance medicine has flourished and continues to do so because of some very happy circumstances. First is its close proximity to its American counterparts who so generously exchange knowledge and ideas, second to the dual cultures of our own country which provide a more extensive and varied experience than might otherwise have been possible, and finally to the continuing determination of new medical insurance recruits to bring to their positions in the industry a medical ethic and professionalism of the same high order as their practising colleagues.

*My thanks to Drs. Fleming, Parks, Ross, and Vail for information and ideas. Errors are my own.*

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