NATIONALISATION OF THE INSURANCE INDUSTRY?

by

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HOW INSURANCE BEGAN – 3000 YEARS OF HISTORY[1]

Insurance has a history that dates back to the ancient world. Over the centuries, it has developed into a modern business of protecting people from various risks. The industry has been profitable for many years and has been an important aspect of private and public long-term finance.

In the ancient world, the first forms of insurance were recorded by the Babylonian and Chinese traders. To limit the loss of goods, merchants would divide their items among various ships that had to cross treacherous waters. One of the first documented loss limitation methods was noted in the Code of Hammurabi, which was written around 1750 BC. Under this method, a merchant receiving a loan would pay the lender an extra amount of money in exchange for a guarantee that the loan would be cancelled if the shipment were stolen. The first to insure their people were the Achaemenian monarchs, and insurance records were submitted to notary offices. Insurance was also noted for gifts of substantial value. These gifts were given to monarchs. By recording their gifts in a register, givers would receive help from a monarch by proving the gift's existence if they were in trouble.

As the ancient world evolved, maritime loans with rates based on favourable seasons for traveling surfaced. Around 600 BC, the Greeks and Romans formed the first types of life and health insurance with their benevolent societies. These societies provided care for families of deceased citizens. Such societies continued for centuries in many different areas of the world and included funerary rituals. In the 12th century in Anatolia, a type of state insurance was introduced. If traders were robbed in the area, the state treasury would reimburse them for their losses.

Standalone insurance policies that were not tied to contracts or loans surfaced in Genoa in the 14th century. This is where the first documented

1 Whit Thompson, 'How Insurance Began: 3000 Years of History' (*WSR Insurance*, 13 September) http://wsrinsurance.com/how-insurance-began-3000-years-of-history/.

insurance policy came from in 1347. In the following century, standalone maritime insurance was formed. With this type of insurance, premiums varied based on unique risks. However, the separation of insurance from contracts and loans was a major change that would influence insurance for the rest of the time.

The first book printed on the subject of insurance was penned by Pedro de Santarém, and the literature was published in 1552. As the Renaissance ended in Europe, insurance evolved into a much more sophisticated form of protection with several varieties of coverage. Until the late 17th century, many areas were still dominated by friendly societies that collected money to pay for medical expenses and funerals. However, the end of the 17th century introduced a rapid expansion of London's importance in the world of trade. This also increased the need for cargo insurance. London became a hub for companies or people who were willing to underwrite the ventures of cargo ships and merchant traders. Lloyd's of London, one of London's leading insurers, is still a major insurance business in the city.

Modern insurance can be traced back to the city's Great Fire of London, which occurred in 1666. After it destroyed more than 30,000 homes, a man named Nicholas Barbon started a building insurance business. He later introduced the city's first fire insurance company. Accident insurance was made available in the late 19th century, and it was very similar to modern disability coverage.

In US history, the first insurance company (alternatively to be known as 'Insurer' in legal term) was based in South Carolina and opened in 1732 to offer fire coverage. Benjamin Franklin started a company in the 1750s, which collected contributions for preventing disastrous fires from destroying buildings. As the 1800s arrived and passed, insurance companies evolved to include life insurance and several other forms of coverage. No type of insurance was mandatory in the United States until the 1930s. At that time, the government created Social Security. In the 1940s, general insurance surfaced. It helped ease the financial difficulties of women whose husbands died while fighting in World War II. It wasn't until the 1980s that the need for car insurance grew enough that steps were taken to make it mandatory. Although insurance is an established business, it is still changing and will change in the future to meet the evolving needs of consumers.

GENERAL INSURANCE INDUSTRY IN MALAYSIA

There is one General Insurance Association of Malaysia (also known as 'Persatuan Insurans Am Malaysia' ('PIAM') in Malay language) consisting of 21 direct general insurance and four reinsurance companies being set up in June 1961 to maintain tariff discipline, respond to new insurance legislations and promote sound insurance practices. Subsequently, PIAM was incorporated in May 1979 as a statutory trade association recognised by the Government of Malaysia for all registered insurers who transact general insurance business.[2]

Insurance contracts that do not come under the ambit of life insurance are called general insurance. The different forms of general insurance are fire, marine, motor, accident and other miscellaneous non-life insurance.[3]

According to the PIAM Yearbook 2020, the General Insurance Industry registered a total gross premiums of RM17.24 billion for the year of 2020 while the Net Claim Incurred Ratio was 52.9%. The industry's underwriting margin was at 11.5% amounting to RM1.5 billion underwriting profit and the management expenses & commission was 35.6% in 2020.

TABLE OF PREMIUMS FOR EACH GENERAL INSURANCE COMPANY IN MALAYSIA

The Writer has taken the trouble to tabulate each and every General Insurance Company in Malaysia with their Gross Premiums earned, Gross Claims paid out, Management Expenses (including commission) and Profit before Tax for 2020.

2 Persatuan Insurans Am Malaysia piam.org.my.
3 https://www.bing.com.

Annual Financial Statements for all the General Insurance Companies for the period ending in 2020[4]

No	Name of the Insurance Company in Alphabetical order	Gross Premiums earned[5] (RM'000)	Gross Claims paid out[6] (RM'000) (% out of the Gross Premium earned)	Management Expenses (Including Commission)[7] (RM'000)	Profit before Tax (RM'000) (% out of the Gross Premium earned)
1.	AIA General Bhd	291,172	73,862 (25.36%)	126,990 (43.61%)	103,978 (35.71%)
2.	AIG Malaysia Insurance Bhd	655,591	252,768 (38.55%)	226,630 (34.56%)	108,772 (16.59%)
3.	Allianz General Insurance Company (M) Bhd	2,284,122	996,117 (43.61%)	698,337 (30.57%)	428,553 (18.76%)
4.	AM General Insurance Bhd	1,567,409	977,341 (62.35%)	514,334 (32.81%)	282,543 (18.02%)
5.	AXA Affin General Insurance Bhd	1,363,579	698,718 (51.24%)	449,935 (32.99%)	117,634 (8.62%)
6.	Berjaya Sompo Insurance Bhd	881,202	360,485 (40.90%)	314,313 (35.66%)	135,538 (15.38%)
7.	CHUBB Insurance Malaysia Bhd	760,915	310,855 (40.85%)	262,942 (34.55%)	129,128 (16.97%)
8.	Etiqa General Insurance Bhd	1,345,000	407,680 (30.31%)	208,778 (15.52%)	167,305 (12.43%)
9.	Great Eastern General Insurance (M) Bhd	518,528	253,697 (48.92%)	182,236 (35.14%)	71,432 (13.77%)
10.	Liberty Insurance Bhd	594,696	322,774 (54.27%)	207,002 (34.80%)	82,454 (13.86%)
11	Lonpac Insurance Bhd	1,531,064	528,326 (34.50%)	369,546 (24.13%)	417,595 (27.27%)

4 The Annual Financial Statements for all the General Insurance Companies for the period ending in 2020 could be obtained from their respective Website except for MPI Generali Insurance Bhd, where the Writer only managed to obtain the latest Financial Statements which ended in 2018.

5 Premiums collected from all classes of General Insurance Policies.

6 Insurance Companies paid out the claims compensation.

7 The operating cost of the Insurance Company which also include the Commissions paid to the Insurance Agents.

12	MSIG Insurance (M) Bhd	1,403,123	626,037 (44.61%)	428,791 (30.55%)	371,759 (26.49%)
13	MPI Generali Insurans Bhd	626,899	357,653 (57.05%)	185,363 (29.56%)	42,300 (6.74%)
14	Pacific Insurance Bhd	523,355	376,163 (71.87%)	155,246 (29.66%)	37,916 (7.24%)
15	Progressive Insurance Bhd	127,648	45,246 (35.44%)	50,093 (39.24%)	34,658 (27.15%)
16	P&O Insurance Bhd	271,935	125,497 (46.14%)	110,388 (40.59%)	13,369 (4.91%)
17	QBE Insurance (M) Bhd	235,663	122,468 (51.96%)	91,583 (38.86%)	20,667 (8.76%)
18	RHB Insurance Bhd	695,005	349,813 (50.33%)	197,922 (28.47%)	150,601 (21.66%)
19	Tokyo Marine Insurance (M) Bhd	850,067	397,459 (46.75%)	312,414 (36.75%)	129,607 (15.24%)
20	Tune Protect	417,420	154,649 (37.04%)	173,429 (41.54%)	34,679 (8.30%)
21	Zurich General Insurance (M) Bhd	828,652	371,091 (44.78%)	279,978 (33.78%)	77,523 (9.35%)
	Total	17,773,045	8,108,699	5,546,250	2,958,011

From the above tabulation, it is very obvious that the main components of expenses for each Insurer consisted of Gross Claim paid out and the Management expenses both of which made up of between 64.29% to 95.09% of the total expenses for the respective Insurer. As such, it is very logical for the management of each Insurer to contain the expenses by reducing the Gross Claims paid out and also the Management expenses. By minimising the expenses and naturally flowing from there, the Insurer would have obtained gross maximum profit. For the purpose of this article, the Writer intends to examine whether the Insurers in minimising the Gross Claims paid out have excessively unreasonably repudiate the innocent genuine claims (also commonly known as 'unfair trade practice' or 'malpractice trade practice') lodged by the Insurance Policy Holders (alternatively Policy Holders are also known as 'the Insureds in legal term)? As a result of which, wouldn't the Insureds suffer hardship and prejudice while the Insurers are enjoying maximum profits? While the Writer takes note of prevalence fraudulent claims being lodged by fraudsters against the Insurers in the recent years with the intention to cheat the insurance compensation from the Insurers but on the other hand, unfair trade practice certainly would cause financial hardship on the innocent Insureds too. This would go against the very purpose of buying an insurance ie, to protect the Insured against financial loss.

As you could observe from the above tabulation, for the period ended in 2020, all the Insurers in Malaysia made profits. While this is great news to the shareholders of the Insurers where they could enjoy the fruits of dividends from the profit which would benefit the class of shareholders, would the majority of the innocent Insureds at large suffer as a consequence of such unfair trade practice? We have the shareholders' interest versus the Insureds' interest to balance.

According to the PIAM Yearbook 2020 mentioned above, the industry's underwriting margin was at 11.5% amounting to RM1.5 billion underwriting profit for the year of 2020. With simplistic assumption, it is presumed that such RM1.5 billion underwriting profit is to be disbursed to the shareholders of the Insurers. Would it be more beneficial if such RM1.5 Billion underwriting profit would be put to good use if we were to nationalise the Insurance Industry to channel such RM1.5 Billion monetary benefit to the State for the benefit of the people?

The Writer would share a few examples of case law to demonstrate the point that there is a new trend of unfair trade practice for the primitive motive of maximum profit and would also further examine whether should we modify our current Insurance Industry practice by nationalising it so that the profit arising from such exercise could be enjoyed by the State and the people?

CLAIM PROCEDURE

Before sharing the case law to drive home the point that there is a new trend of unfair trade practice, perhaps it would be helpful if we could understand the Insurance Claims procedure first. In the consequence of an Insured suffering an event of loss against the risk insured for, the Insured is required to lodge a police report of such event of loss and then follow by notifying the Insurer whereby the Insured is required to fill up the Claims Form given by the Insurer detailing how the event of loss occur. Such process of Insurance Claims procedure is expressly spelled out in the Insurance Policy.

Having received the Insurance Claims Form, the Claims Department of the Insurer would have two options of either to approve the Insured's insurance compensation sought or to repudiate/reject the insurance claim. In the event of such repudiation of insurance claim, if the sum insured is less than

RM250,000,[8] The Insured has the option to either refer such dispute of repudiation to an Organisation known as 'Ombudsman for Financial Services' for adjudication of dispute or directly proceed to initiate legal proceedings with the Court of Laws.

Ombudsman for Financial Services

The Ombudsman for Financial Services (formerly known as 'Financial Mediation Bureau') was incorporated in 2004. The Ombudsman for Financial Services is a non-profit organisation that serves as an alternative dispute resolution channel resolving disputes between its Members, who are the financial service providers licensed or approved by Bank Negara Malaysia, and financial consumers. The Ombudsman for Financial Services provides free service to adjudicate the dispute of repudiation.

Ombudsman for Financial Services' Members are the Financial Service Providers ('FSP') who are licensed persons under the Financial Services Act 2013[9] ('FSA') and the Islamic Financial Services Act 2013[10] ('IFSA'), prescribed institutions under the Development Financial Institutions Act 2002,[11] and FSPs who are approved persons under the FSA and IFSA. As at 31 December 2020, the Ombudsman for Financial Services has a total membership of 213 consisting of Licensed Commercial Banks, Licensed Insurers, Prescribed Development Financial Institutions, Approved Financial Advisers and Islamic Financial Advisers, Licensed Islamic Banks, Licensed Takaful Operators, Approved Insurance/Takaful Brokers, Approved Designated Payment Instrument Issuers (Non-Banks).

The funding structure of Ombudsman for Financial Services consists of annual levies and/or case fees imposed on their Members. The annual levy charged is based on Ombudsman for Financial Services' annual budget requirement, which is shared equally among the Licensed

Members and the Prescribed Institutions.[12] While the initiative by the members of the Ombudsman for Financial Services to fund the operation cost is lauded and complimented but since the funding come from its members, the

8 Ombudsman for Financial Services, '2020 Annual Report' 16 https://www.ofs.org.my/file/files/OFS_2020_AnnualReport.pdf.
9 (Act 758).
10 (Act 759).
11 (Act 618).
12 Ombudsman for Financial Services, '2020 Annual Report' 26 https://www.ofs.org.my/file/files/OFS_2020_AnnualReport.pdf

neutrality of such dispute adjudication process is questionable? Would the outcome of the dispute adjudication more favourable towards the members of the Ombudsman for Financial Services rather than the financial consumers? Unfortunately we do not have any data analysis on the outcome of the dispute adjudication process, how many percentage of the outcome are in favour of the members of the Ombudsman for Financial Services and how many percentage of which are in favour of the financial consumers?

In order to alleviate such fear of biasness, perhaps it is the Writer's humble opinion to 'nationalise' Ombudsman for Financial Services and convert it into Tribunals such as Housing Tribunal,[13] Strata Management Tribunal,[14] Consumer Claims Tribunal[15] under the purview of the government.

The Ombudsman for Financial Services after having adjudicated the dispute and if the Insured is not satisfied with the outcome could proceed to initiate his/her legal proceedings with the Court of Laws against the Insurer.

Case Law No 1: Loh Swee Liang & another v Am General Insurance Bhd[16]

The Plaintiffs are the administrators of the estate of one Tay Guan Song ('Deceased') pursuant to the Grant of Letters of Administrations dated 2 October 2018. The first Plaintiff is the wife of the deceased while the second Plaintiff is the father of the deceased.

The Deceased husband had driven his vehicle, Mazda CX-5 bearing vehicle registration number WXQ8399 ('the said Car'), from Prima Duta Condominium (where both the Deceased and the first Plaintiff lived) to Changkat View Condominium (another property belonging to the first Plaintiff and the Deceased nearby to their residential home) on 3 July 2018. The Deceased had gone to Changkat View Condominium with the intention to clean it up after the unit was left vacant by the previous tenant.

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13 It is a special tribunal set up by the government to adjudicate dispute between homebuyer and housing developer.

14 The Strata Management Tribunal is established pursuant to the Strata Management Act 2013 (Act 757) s 102 to resolve strata management related disputes.

15 The Tribunal for Consumer Claims established under Consumer Protection Act 1999 (Act 599) s 85.

16 Court of Appeal number W-04(NCVC)(W)-325-07/2021; Nurbaiti Hamdan, 'Woman succeeds in appeal over claim for late husband's car insurance' *The Star* (1 December 2021) https://www.thestar.com.my; V Anbalagan, 'Insurance firm told to pay RM85,000 to widow over husband's stolen car' *Free Malaysia Today* (1 December 2021) https://www.freemalaysiatoday.com.

The first Plaintiff, being the wife of the Deceased, had waited for her husband's return but when there was no sign of him returning to their residential home on the fateful day of 3 July 2018. The first Plaintiff began panicked and started calling the Deceased's hand phone but the calls were left unattended to and unanswered.

The first Plaintiff, together with her family, then rushed to the Changkat View Condominium and was shocked to find out that her husband had passed away. Immediately discovering the Deceased, the first Plaintiff went on to lodge the first Police Report on the same day itself without realising the said Car had gone missing. Subsequent to the burial ceremony of the deceased, the 1st Plaintiff only realised about the missing said Car and proceeded to locate it but to no avail. She then went on to lodge two more Police reports on 22 August 2018 and 1 September 2018.

At the material time, the Deceased is the registered owner of the said Car which was insured with the Defendant at an agreed Insured Sum of RM85,000 under an Comprehensive Car Insurance Policy.

On 13 September 2018 the first Plaintiff submitted a Claims Form to the Defendant in relation to the missing car. On 3 January 2019 the Defendant repudiated the Plaintiffs' Insurance claim on the ground that the Plaintiffs were not able to prove the said Car was stolen and therefore it was not covered under the Comprehensive Car Insurance Policy as it does not cover a missing car.

The Defendant issued two repudiation letters both dated 3 January 2019 but with two different grounds of repudiation of Insurance claims. On one hand, the first Repudiation Notice addressed to the Deceased stated that :

> Our investigation reveals that the loss of your vehicle did not fall within the ambit of theft. Your wife Loh Swee Liang ['*the 1st Plaintiff*'] has no knowledge on the vehicle whereabout and did not witness the loss as the vehicle appears to be missing after insured demise.
>
> In view of the above, we regret to advise that we are repudiating all liabilities in respect of your claim and any other claims which may arise due to the loss and shall be closing our file accordingly.

It is the writer's respectful view that if the first Plaintiff was aware of the vehicle whereabout, it will no longer be missing and the first Plaintiff would not bother to lodge an Insurance claim with the Defendant. If any of us were to witness the item (the said Car) being stolen in front of us, this is no longer called a 'theft', it is a 'Robbery' or 'Burglary'.

The Defendant's second Repudiation Notice ('2nd Repudiation Notice') is being reproduced herein for easy reference:

> We regret to note that Tay Guan Song ('Deceased') had failed to respond to our adjuster's (M/s Darmani Adjusters & Investigators (M) Sdn Bhd) request for an interview despite their letters dated, _____ and _____

Again it is the Writer's humble view that how do one expect the Deceased to respond to the Defendant's Adjuster's request for interview when he is already dead?

Flowing from there on 21 June 2019, the Plaintiffs appealed to the Ombudsman for Financial Services with regard to the repudiation. The Plaintiffs' appeal was rejected by them on 11September 2019. The Ombudsman for Financial Services concurred with the stance taken by the Defendant.

Subsequent to that, the Plaintiffs initiated a civil Suit against the Defendant with the Kuala Lumpur Magistrate Court in October 2019 and the Magistrate delivered a decision dismissing the Plaintiff's claim and thus has the effect of affirming both the first and second Notices of Repudiation. The Plaintiffs thereafter appealed to the Kuala Lumpur High Court which dismissed the appeal and thus affirmed the Magistrate's decision. As a result of the Magistrate Court and High Court decisions in dismissing the Plaintiff's claim, this would have the effect of validating these grounds of repudiation contained in both the Defendant's letters of Repudiation. Among the main grounds given by the Magistrate Court and the High Court were that the Plaintiffs could not prove the said Car was stolen but it was missing therefore did not fall within the scope of coverage under the Comprehensive Car Insurance Policy. The relevant ground of the High Court judgment is reproduced herein for easy reference:

> 24. The evidence given by PW1 (the police Investigation Officer) is this. In his Witness Statement, PW1 had used the word 'kehilangan' (loss) numerous times and not 'kecurian' (theft)'. PW1 agreed that the word that was used in the 2nd Police Report is 'hilang' and not 'kecurian kereta'. PW1 also agreed that the word 'disalahguna' in the 1st Police Report is not the same as 'dicuri'. PW1 stated that he had no choice but to open an investigation for a missing car under section 379A of the Penal Code (the provision concerning theft of a motor vehicle) as there is no provision for missing cars in the Penal Code.
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> 25. The result of PW1's investigation is this. There were no further details available to detect the missing Car and no suspect had been arrested. The case status notification dated 15.11.2018 stated: 'Setelah siasatan dijalankan, didapati tiada keterangan lanjut bagi mengesan *kenderaan yang hilang dan tiada*

> *tangkapan saspek yang terlibat'. PW1 agreed that he investigated concerning a missing car and not a stolen car. The result of the investigation did not show that the Car had been stolen*. (Emphasis added)

The above grounds of judgment certainly had set a precedent in the Insurance Industry and if not being reversed would set a new trend of requirement to be fulfilled by the Insured in order to successfully make an insurance claim. All future Insured whose vehicles are found to be 'missing' must prove (1) car thief suspect has been arrested and (2) the 'missing' car must be located before the Insurers would compensate the Sum Insured for the 'missing' car. In the Writer's view, this is a perfect proof of a new trend of unfair trade practice.

Not deterred by such failures, the Plaintiffs appeal to the Court of Appeal which, on 1 December 2021, delivered their decision to overturn the Magistrate and High Court decisions. The brief oral grounds given by the Court of Appeal were that based on the overall circumstantial evidence, the Plaintiffs had proven on the balance of probability the said Car was stolen and therefore the Defendant is under the obligation to compensate the agreed sum insured of RM85,000 to the Plaintiffs.

The Court of Appeal's decision in reversing the Magistrate and High Court decisions would have the effect of reversing the Ombudsman for Financial Services' decision who had earlier on rejected the Plaintiffs' claim. This would put us to wonder whether they are neutral in their role of adjudicating the dispute between the Insured and the Insurer. I think it is high time for the authorities to consider converting the Ombudsman for Financial Services into government Tribunals just like the Housing Tribunal, Strata Management Tribunal, Consumer Claims Tribunal mentioned above to avoid such misfortune from repeating. In order to instil confidence in the neutrality of the Ombudsman for Financial for Services, perhaps it is best to 'tribunalise' them into a Tribunal for Financial Services to be chaired by government servants and/or qualified individual without any nexus link to the Ombudsman for Financial for Services and/or the Insurers.

Case Law No 2: Naza Motor Trading Sdn Bhd v Malaysian Motor Insurance Pool[17]

This was an appeal against the decision of the High Court in dismissing the Plaintiff's claim for RM263,779.34 against the Defendant under a policy of

17 *Case Law No 2 Naza Motor Trading Sdn Bhd v Malaysian Motor Insurance Pool* [2011] 2 MLJ 597; [2011] 1 CLJ 332.

insurance. The Appellant (Plaintiff), a car dealer, had procured from the Respondent (Defendant) a policy of insurance, known as Motor Trade Policy providing cover for, inter alia, loss of vehicle by theft. During the currency of the said policy a vehicle, a Mercedez Benz E230, while being test-driven by a potential buyer, was stolen, presumably by the said potential buyer as he had vanished with the car on the day it was test-driven on 20 November 1998. The Plaintiff's claim for the loss of the motorcar under the said policy was rejected by the Defendant, who repudiated liability solely on the exclusion clause B of the policy, namely the loss was due to cheating and not theft. The only issue for determination was whether the events leading to the loss of the Mercedes Benz constituted theft or cheating.

Mohamed Apandi Ali JCA, delivering the judgment of the Court of Appeal, said there was not a single element to show that the Plaintiff's salesman was deliberately courting danger. He also could not be said to have thrown caution to the winds. In the circumstances leading to the situation where the potential buyer of the test-car had driven off with the car, was beyond any reasonable expectations. The salesman was deceived into leaving the car with a view to oblige the potential buyer who had requested the said salesman to buy fried chicken from a Kentucky outlet. Upon the salesman's return, he discovered that both the said customer and the car had disappeared. No reasonable man would have foreseen that such a potential buyer, who had portrayed himself as a man of some standing in society, would have acted in such a manner. The deceit by the potential buyer was indicative of his dishonest intention to take the car out of the possession of the salesman, without the latter's consent. This situation was similar, by analogy, to Illustration (b) of s 378 of the Penal Code.[18] What transpired on that day was a theft per se of the Mercedes Benz, by the potential buyer. In such circumstances, under the insurance policy, the defendant could not deny liability and therefore correspondingly they were liable to the insured plaintiff.

In the Writer's view, this is another classical example of unfair trade practice by the Insurers.

Case Law No 3: Wong Kon Poh v New India Assurance Co Ltd[19]

This is an appeal against the decision of the Magistrate's Court dismissing the Appellant's claim against the Respondent insurance company for the loss of a

18 (Act 574).
19 *Case Law No.3 Wong Kon Poh v New India Assurance Co Ltd* [1970] 2 MLJ 287.

motorcycle in a robbery. The Appellant was a person earning only $3 to $4 as a daily-rated labourer. In September 1967, having purchased a new Yamaha 100cc motorcycle BS. 8942 for $1,200, he insured it for $1,000 under a comprehensive policy whereby the Respondent company undertook to indemnify him 'against loss ... by burglary, housebreaking or theft'. On 24 November 24 1967 the Appellant rode to Templer Park for a dip in the river. There he suffered misfortune of *being robbed* by four persons of $5 in his pocket and his *motorcycle* as well.

The Appellant reported the matter to the police the same day and notified the insurance company of his loss on 4 December 1967. The Insurers repudiated liability on the ground that 'robbery' was not 'theft'. Compelled to pursue his claim in the Magistrate's Court — which was defended on the ground that 'the loss was not caused by any of the perils insured against' — the Appellant suffered the second misfortune of having it dismissed with costs simply because the learned magistrate considered that 'robbery' was distinguishable from 'theft'.

The Appellant then appealed to the High Court on two grounds (1) error in law on the part of the magistrate and (2) that the loss 'could not be the result of both theft and robbery'. In other words, the Appellant's contention was that, theft being an essential element of robbery, robbery is still theft, although in an aggravated form. Aggrieved by such decision of the High Court who also dismissed the Appellant's claim, the Appellant appealed to the Federal Court.

It was held by the Federal Court that:[20]

> Indeed, counsel was perfectly right in his submission, for section 390 of the Penal Code enunciates that 'in all robbery there is either theft or extortion', and here it was a plain case of robbery. Theft is not severable from robbery any more than is a statue from the marble out of which it was hewed. Unfortunately for the appellant, however, the learned High Court judge considered this argument 'ingenious' but unacceptable. He agreed with the magistrate that the loss was due to robbery and took the view that 'theft' and 'robbery' were *not synonymous*. In his judgment he went on to say, 'The appellant's counsel contended that these two words should be given their legal and technical meaning'. We thought, on reading this sentence, that the negative must have been left out by a printer's error in the published report, on page 132 of [1970] 2 MLJ, but the signed copy of the judgment examined by us showed there was no such fault of the printer. It would therefore appear that counsel must have been badly misunderstood, for

20 [1970] 2 MLJ 287, 288–289.

the rule of construction in this type of cases is clearly set out in *MacGillivray on Insurance Law* (5th Ed.), 2026 as follows:-

In a policy of insurance ... the words expressing the risk covered are not always used in the strict technical sense which they bear in relation to a criminal offence.'

It is to be observed that 'burglary' is not a technical term used anywhere in our Penal Code. Burglary at common law is the breaking and entering the dwelling house of another person in the night with intent to commit some felony therein. This common law definition was embodied in section 25(1) of the Larceny Act 1916. The term equivalent to burglary in this country is 'housebreaking by night': see sections 445 and 446 of the Penal Code. Since the risk is not described in the technical sense by the term 'burglary', we do not think that, when 'theft' is used in juxtaposition to burglary and housebreaking, it nevertheless had to be construed in the strict technical sense, against the insured. Indeed we are not aware of any insurers hitherto repudiating liability simply on the ground that 'robbery' is not a risk covered by insurance against 'theft'. As Ali F.J. pointed out, where a thief attempted to sneak off on the appellant's motor-cycle and managed to do so, it was of course a case of theft, which was covered by the policy; but, if the thief, while interrupted in the act, drew a dagger and warned the appellant not to prevent his get-away, how in the name of common sense can it be argued that the taking, in the latter case, was not as much a risk insured against as the taking by stealth?

If, *contrary to common sense*, the insurance company still maintains that the perils insured against are different, so that it is not bound to indemnify the victim of a robbery where the policy covers only loss by theft, then it is the duty of the insurers to say so in plain terms, so that policy-holders may not continue to pay their premiums under a misapprehension as to the exceptions to liability. In paragraph 703 of *MacGillivray* the *contra proferentem* rule is thus set out:–

'*If there is any ambiguity in the language used in a policy, it is to be construed more strongly against the party who prepared it, that is in the majority of cases, against the company. A policy ought to be so framed that he who runs can read'.*

At all events, to *deny the axiomatic truth* of the proposition that 'robbery is an aggravated form of theft' and to dismiss the appeal on that ground is manifestly a denial of justice upon a technical defence which has absolutely no merits. A policy which insures against loss by 'burglary, housebreaking or theft', but says nothing of 'robbery', must on any reasonable construction be held to include 'robbery' within the coverage for 'theft'. Like burglary or housebreaking, robbery is merely a variation of the same theme. Otherwise its exception must clearly and expressly be made known to the party insured – not by implication to be inferred from the omission. To require that the ordinary man taking out a policy should

> read into it not only what was expressed, but also to construe omissions as exceptions, is an *absurd* proposition which this court cannot countenance. (Emphasis added)

It is to be observed that the Federal Court had used the strong words of '*contrary to common sense*', '*deny the axiomatic truth*' and '*absurd*' which reflected the feeling of the judges with the manner of which the Defendant Insurer repudiated the insurance claim. Although this Federal Court decision was delivered in the 1970, this is yet another example of unfair trade practice.

NATIONALISE THE INSURANCE INDUSTRY

The list of instances of unfair trade practice can go on and the Writer does not intend to clog this Article with many more similar examples. As mentioned above, the primary objective of any business venture is to maximise the profit and the Insurance Industry is not exempted from this, one way of doing it is to minimise the Gross Claims paid out by repudiating as many insurance claims as possible at the expenses of causing hardship to the Insured. The Insured has to go through the hardship of engaging the Solicitors to pursue his/her claim for a few years before he/she can expect to enjoy the fruit of the litigation (provided if the Insured is successful) while the Insurers have abundance of resources of engaging lawyers and adjusters to defend such repudiation of insurance claims.

What about those Insureds with genuine insurance claims without access to legal recourse for various reasons such as the Insured Sum is too small and not worth the trouble, it is too stressful and tedious for them to pursue the insurance claim and etc? This group of unfortunate Insureds will end up being the losers and the Insurers certainly would be the gainers. As illustrated by the above cases, this unfair trade practice is hurting the interest of the Insureds. It was argued that in order to eliminate such unfair trade and to better serve each individual Insured and the State, the way forward is to nationalise the Insurance Sector.

Perhaps we could learn from the India's experience who has gone through the cycle of Private Insurers (pre-1956) to National Insurers (1956-2000) and back to Private Insurers (post-2000). Prior to 1956, the Insurers in India, be it Life Insurance or General Insurance, consisted of Private Insurers. But due to serious allegations of unfair trade practice and some other problems associated with it, the Government of India in 1956 set up one Life Insurance Corporation of India pursuant to Life Insurance Corporation Act of 1956 to nationalise the Life Insurance industry by absorbing all the private Insurers and

managed them by the State.[21] While the General Insurance Business (Nationalisation) Act was passed in 1972 to nationalise all private general insurance companies in India.[22]

There are always two sides to a coin, while there are some positive effect from such policy of nationalisation of Insurers, there are certainly some negative impact arising from it too. Among the positive side that the Life Insurance Corporation of India had achieved were:

(1) spread the insurance culture fairly widely;

(2) mobilised large savings for national development and financed socially important sectors such as housing, electricity, water supply and sewerage;

(3) acquired considerable financial strength and gained confidence of the insuring public; and

(4) had built up a large talented pool of insurance professionals.

While on the negative side of the Life Insurance Corporation of India:

(1) the vast marketing and services network of Life Insurance Corporation of India was inadequately responsive to customer needs;

(2) insurance awareness was low among the general public;

(3) marketing of life insurance with reference to the customer needs left much to be desired;

(4) term assurance plans were not being encouraged and unit linked assurance was not available;

(5) insurance covers were costly and returns from life insurance were significantly lower compared to other savings instruments;

(6) Life Insurance Corporation management was top heavy and excessively hierarchical, and was overstaffed;

(7) work culture within the organisation was unsatisfactory;

(8) employee trade unionism had contributed to the growth of restrictive practices; and

(9) the functioning of Life Insurance Corporation was constrained in some

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21 The Indian Economy by Arjun Bhattacharya & O'Neil Raine; 'Evolution of the Indian Insurance Industry' (*indiainsurance*) https://www.eindiainsurance.com/insurance/evolution-indian-insurance-industry.asp.

22 M Saraswathy, 'Explained | The General Insurance Business Nationalisation Bill and Opposition concerns' (*money control*, 12 August 2021) https://www.moneycontrol.com.

> respects as it was covered by the definition of 'State' as well as governmental interference.[23]

Flowing from there, the India Parliament in 2021 passed an amendment to the General Insurance Business (Nationalisation) Act 1972 to allow privatisation of Insurers again[24] and thus one cycle from the era of Private Insurers — to National Insurers — back to Private Insurers again.

MIXTURE OF BOTH PRIVATISED AND NATIONALISED INSURANCE SECTOR

Learning from the Indian experience, neither the Private Insurers nor the National Insurers could yield the desired result, perhaps we could consider to nationalise the Claims Department of the Insurers. In the insurance industry, the Insurers are made up of three main departments, there are: (1) Marketing department to expand the business; (2) Underwriting Department who will issue the Insurance Policy; and (3) Claims Department who will process the insurance compensation claims. Each department has its own objective. The Marketing Department to expand the business empire with attractive marketing strategies to attract customers while the Underwriting Department is to issue out Insurance Policy with attractive premium rate, coverage of insurance policy and lastly the Claims Department to repudiate the insurance claims to maximise the profit for their shareholders.

CONCLUSION

Since the Claims Department is the one causing such unfair trade practice, perhaps we could nationalise all the Insurers' Claim Department into one National Institution of Claims Department to be managed by a combination of professionals consisting of Claims Managers, Adjusters, Marketing Managers, Underwriting Managers, Consumers Organisation's representatives, Bankers, Lawyers, retired Judges and qualified person so that a balance view of all the relevant parties are taken into account and the interest of the Insureds certainly would be well protected. After having paid off all the administrative expenses and staff cost of both the Marketing and Underwriting departments, the balance Gross Premiums collected should be channelled into the National Institution of Claims Department. With the elimination of the

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23 The Indian Economy by Arjun Bhattacharya & O'Neil Raine

24 M Saraswathy, 'Explained | The General Insurance Business Nationalisation Bill and Opposition concerns' (*money control*, 12 August 2021) https://www.moneycontrol.com.

element of 'profit' from the equation, not only this could eliminate unfair trade practice and the estimated underwriting profit of RM1.5 Billion annually (for 2020, it was RM1.5 Billion) could be channelled to the State for better use rather than enriching a small group of shareholders.