



# Concern over Medical Inflation in the US

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**In recent months, concerns about rapidly rising medical costs have moved to the forefront of the healthcare debate in the United States. Ingrid Reeves of the American Association of Health Plans reports.**

Healthcare costs have long been a significant concern for employers, as most working families in the United States receive health coverage through their employers. Recently, however, this concern has been replaced by deep anxiety for a growing number of employers who are struggling to stay afloat during the current economic recession. According to a survey by the William M. Mercer consulting firm, the average cost of employer-based health coverage increased by 11.2 percent in 2001, and is expected to increase by 12.7 percent in 2002.

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# Tulips from Amsterdam

**Tom Sackville previews our biennial conference in Amsterdam, June 16th to 19th.**

After September 11th, we were told the world had changed forever. It now looks as though this was a somewhat over-dramatic conclusion, reflecting much media hyperbole. World stock markets have not crashed. Afghanistan has not imploded. With luck, there will be no repetition of 9/11. President Bush is riding high at home and abroad and (quite rightly) taking little notice of protests from various European leaders against his "axis of evil" line on the remaining pockets of state terrorism. Despite, or perhaps thanks to, the action of recent months most of the world has been but marginally affected, though dictators like Robert Mugabe have used the shift of the spotlight from their own misdeeds to inflict further suffering on their people. In fact, we may even have changed back to whatever we were before.



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### *Tulips from Amsterdam continued*

In the midst of these developments, our Amsterdam conference programme provides a forum for discussions on a range of problems and opportunities affecting the industry. But before turning to our own self-interest, I will highlight two sessions designed to test our sense of responsibility towards those less fortunate.

World Bank Chief Economist for Health **Alexander Preker** will remind us that much of the world's poverty and misery, and perhaps wider problems, derive from lack of access to healthcare. While there are no quick solutions, developing countries could benefit hugely if a fraction of the risk sharing expertise we deploy daily were applied to their billions of unpooled health expenditure. Dr **Brian Brink** of Anglo American will describe his company's struggle to alleviate the effects of one of the greatest ever human catastrophes, HIV/AIDS.

Despite the difficulty of finding a coherent common thread, we have entitled the conference *Going for Growth*. Beyond the schmaltz, growth surely remains a precondition for most of the other good things we are trying to do. Any CEO who maintains he or she is not interested in growing the business, whether for profit or otherwise, must be preparing for early retirement.

Among the ingredients for growth is good governance. In a session which should be of great interest to non-executives, Dr **Jim Rice**, president of the Governance Institute in La Jolla, California, will remind us of the varied and growing responsibilities, and liabilities, of board members. He will be supported by **Alastair Ross Goobey**, senior adviser to Morgan Stanley. Over many years of running leading UK pension fund Hermes, Goobey became the scourge of poorly performing major companies, and an outspoken critic of the supine behaviour of board members.

On the wider governance front, Professor **Guus van Montfort**, health economist and senior board member of our Dutch host and major conference sponsor Achmea Health, will speak on an issue which is live in the

Netherlands and elsewhere, the public/private relationship. A German perspective will be provided by Dr **Karl-Josef Bierth**, newly-appointed chairman of Berlin-Kolnische, Cologne, who will deploy specialised actuarial expertise to emphasise the need for action to address the healthcare needs of a growing elderly population.

From the US, **George Halvorson** of HealthPartners in Minnesota is well known to our members for his trenchant realism on medical inflation, and on the price inflating exploitation of insurers by predatory healthcare providers. A distinguished figure in US healthcare, **Cleve Killingworth**, CEO of Health Alliance Plan in Detroit, will emphasise the role of quality in managing utilisation. **Willy Palm**, director of AIM, representing European mutuals, will describe European health policy and the vexed issue of portability of health benefits.

Turning to operational topics, we will address globalisation and the potential for savings from outsourcing claims processing to make wage economies. **David Clarke**, IT and operations director of AXA PPP Healthcare in the UK, will report on AXA's operation in Bangalore, India, while **Anton Roux** CEO of Medscheme, South Africa's largest administrator, will propose an African alternative.

**Fred Lingg**, who runs Achmea's health education operations, including its Netherlands-wide chain of health clubs, will sketch the interface between fitness, health club membership and health insurance, a theme to be developed by one of South Africa's best known broadcasters and writers on fitness and women's health, Dr **Linda Friedland**.

The health insurance industry needs to constantly look to its image, both with the public and government. Following the recent launch of our Panel on Public Affairs, this vital area will be illustrated in Amsterdam by reports on two successful 'grass roots' write-in campaigns in recent elections. These are contributed by AHIA chief executive **Russell Schneider** and **John de Zulueta**, managing director of Sanitas, Spain's leading health

insurer. The need for healthcare organisations to prepare to counter Web based campaigns by 'cyber activist' groups will be discussed by **Doug Pinkham**, president of the US industry-wide Public Affairs Council.

We will be radically affected by major changes in the practice of medicine, and have invited as Ronald Grieve lecturer the leading authority on the economics of gene therapy. Professor **Juan Enriques**, head of Harvard Business School's Life Science Project, will present his vision of the potential impact of patient specific gene therapies, on levels of surgical intervention and the future cost of healthcare.

To further develop this vital topic, an interactive workshop will be led by **Ronald Plasterk**, professor of developmental genetics at the University of Utrecht, dealing with clinical aspects, and Dr **Tony McGleenan**, senior lecturer in law at Queen's University, Belfast, focusing on legal and ethical questions.

We address two further aspects of healthcare. Since the Dutch alone have dared to tackle the ethico-legal minefield of euthanasia, we have asked Professor **Cor Spreeuwenberg**, dean of the Faculty of Health Sciences at the University of Maastricht and leading authority on palliative care, to detail the background to this historic decision. Reflecting widespread fears as to the adequacy of mental health provision, and the dire WHO predictions on the future burden of depressive illness, we will hear from leading psychiatrist and commentator on mental health issues Professor **Simon Wessely** of Guy's King's and St Thomas's School of Medicine, London.

Last but not least, we have been accused before of 'doctor bashing'. Not this time. Dr **Jonathan Simon** of Southern Cross, New Zealand will discuss the alleged widespread crisis in recruitment and retention of medical staff, without whose services our industry would not exist. He will be joined by **Charles Collins**, distinguished medical advisor to Western Provident, who will give us the benefit of his wide experience, including his key role in the governance of the Royal College of Surgeons.

**See you in Amsterdam!**

# Eurocentric europe

John de Zulueta, chief executive of Sanitas in Spain, presents a case study on Influencing Government and Public Opinion at the Amsterdam conference on June 19th. Here, he discusses his company's preparation for the European single currency, in the first of two 'before and after' articles. This article was published in the Spanish press last year.

The launch of the euro has been very sad! It entered the market in January 1999 and its exchange rate against the dollar reached 1.19. Since then, it has gone downhill, and at present the exchange rate is around 0.88. From my personal experience (I have spent a significant part of my life in the United States), I grew up in a dollar environment, and it is the fundamental factor which unites the 50 states that constitute the United States. For me the ideal exchange rate is a dollar to a euro.

In Europe, the migration of national currencies to the euro *de facto* does not only represent the future constitution of the United States of Europe, but also the recognition of the urgent need to have a strong currency. The German mark used to play this role in the European economy. The English will take a little longer to remove the portrait of the Queen from the front of the sterling pound, but I am convinced that they will finally succumb.

On March 1st 2002, all the companies in the countries within the so-called euro zone should have converted all their processes and transactions to the new currency, to live in euros. While January 1st 1999 was the starting point, March 1st 2002 represents the point of no return.

At the beginning of 1998, Sanitas defined the implementation of the single currency as a strategic objective. This decision, although it was avant-garde, meant taking up the challenge as an innovative company. To be

the first provided us with a guarantee for our members. By October, our accounting had already been adapted to the euro.

Our aim was to carry out the conversion to the new currency the simplest way possible and in stages. Led by the finance department, and by creating a work-group that comprised representatives from all the departments within the company, we managed to achieve our second goal related to the change in the year 1999.

**“The migration of national currencies to the euro represents *de facto* the future constitution of the United States of Europe and the recognition of a strong currency.”**

Our experience has been useful to improve our internal systems and to make the people that constitute our organisation aware, with courses and seminars, of the repercussion that this change represents in our daily life. By doing so, we guarantee better attention and service for our clients.

As a leading company in the market, we use communication with our clients as a basic information tool: our Web page, printed matter, premiums expressed in both currencies, messages on the quarterly statements, forms, advertising and information in magazines.

In order to measure the repercussion that the decision to be the first to operate in the single currency had, we launched a product that was defined in the new currency: Mundi 1 million de euros. It was favourably received.

But this objective also included the direct participation of our professionals, hospitals and suppliers, so we asked them to collaborate with our project by issuing their invoices in euros so that we could proceed with the payment process

From January 1st 1999, Sanitas began to operate in the two currencies. We charged, invested and paid in pesetas and euros, the euro being the main currency in our systems. In order to do so, in October 1998 we implemented special software, the 7.5 version of the PeopleSoft programme, so that our accounting could be carried out in both currencies: pesetas and euros. We renamed the share capital and issued our financial statements in the single currency.

For Sanitas, this project ends on February 28th 2002. During the period, from the time it was implemented until it ends, we will have been able to continue to improve and perfect our systems for the benefit of our members, professionals, hospitals, suppliers and personnel.

We hope to be able to avoid the errors that will take place at the beginning of 2002. In my bank account, which is in euros, of course, a payment for 27,046 euros for a book was debited 27.046 euros, which put me in the red. Imagine the book I could have bought for four and a half million pesetas!



# HEALTHCARE FUNDING

## AN ISSUE WORLDWIDE

Many countries are debating their levels of healthcare provision and sources of funding. In this article we outline current developments in New Zealand, Denmark, the Netherlands, and the UK.

## New Zealand – missing an opportunity?

**Andrea Pettett, executive director of the Health Funds Association of New Zealand (HFANZ), supports the call for constructive use of the private healthcare sector.**

In its report *Future Health Care Financing* and the *Public-Private Interface* the New Zealand Institute of Economic Research (NZIER) concludes that the opportunity to improve the quality of the New Zealand health system is being missed. The report, launched in Wellington by HFANZ, overviews the co-existing public and private healthcare systems, and the options open to the Ministry of Health. It concludes that the route to an overall improvement in quality lies in the interface between public and private financing.

The New Zealand public and private healthcare systems coexist due to their different strengths. As the public system manages population risks it must inevitably ration access to services, and cannot satisfy the preferences of every individual. By contrast, private health insurance meets individual health needs by paying for quicker access, choice of timing, and additional health services. The two systems are complementary, yet the private health care system is largely ignored by the Government.

The Government has promised more money for primary care, at a time when district health boards are facing huge deficits – but where will the extra funds come from? A dedicated Health Tax is not the answer. Introduction of such a tax in Australia led to a significant decline in health insurance, placing further demands on the public health system there. The Government introduced a tax rebate to encourage Australians to purchase health insurance.

The pressures on public health systems will continue to grow due to increasing expectations and an ageing population. This is at a time when governments will be hard pressed to meet superannuation costs. The NZIER report makes it clear that it is unrealistic to believe that the public purse will ever be able to satisfy the level of demand for health services.

People with health insurance leave more public resources, and shorter waiting times, for those who remain in the public system. Waiting for health services has a significant impact on the economy and the wellbeing of New Zealanders. People with health insurance have less than half the time off work than those without, and suffer less stress. It therefore makes sense to make better use of health insurance.

The HFANZ strongly urges the Government to take notice of the recommendations in the NZIER report for improving the interface between the public and private health sectors. The first step is to recognise explicitly that the public health system cannot aim to satisfy individual preferences; health insurance can do this. More realistic messages about the strengths of the public health system will help manage expectations and assist people to make an informed choice about their need for health insurance. Tax rebates or credits should be introduced to promote the uptake of health insurance.

These steps would not mean the Government abandoning its aim to secure access to acceptable healthcare for all New Zealanders. They would make more constructive use of the private health sector to absorb the pressure of a publicly managed care system under duress.

## Private health sector to expand in Denmark

**For the first time in decades Denmark foresees radical changes in Government institutions and regulations which will include the public health sector.**

**Johannes Due, managing director of Danmark Sygeforsikring, reports.**

Following last year's general election, a liberal to right wing Government replaced the previous centre left Government. The new Government is keen to establish individual choice within public sector service provision. It is also encouraging private provision with a more competitive public service. Freedom for individuals to use private hospitals when the public sector cannot provide treatment within a given period of time has also been suggested.

Since 1973, the National Health System has provided health insurance for all Danes, financed through taxation. The cost of healthcare in Denmark in 1999 was 79.1 billion DDK (10.6 billion euro), 60 per cent being in the hospital sector.

Private health provision in Denmark is still relatively limited, with two sources of private health insurance:

- Danmark Sygeforsikring, a non profit mutual insurance company founded in 1973. A third of the population are policyholders. It handles only individual health plans, not group plans.
- Life insurance companies providing group health insurance. This market has grown from 20,000 members in 1999 to 100,000 in 2001.

With the traditionally efficient public health sector, this growth has been surprising. Further subsidies under the National Health System are unlikely because of tightening economic conditions and increasing fiscal controls, and there is likelihood of cutbacks leading to payments of healthcare expenses on an individual basis. The previous Government was outspoken in its criticism of the use of the private health sector, but it is now likely to grow in both provision and funding.

# BUPA responds to UK report on NHS funding

**Fergus Kee, managing director of BUPA Membership, called in *The Sunday Times* for a full examination of ways to link public and private spending on healthcare, as a response to Derek Wanless' report on NHS funding. The following is an excerpt from the article, which was published in December 2001.**

When Shadow Chancellor Michael Howard challenged Gordon Brown's summary in the Commons of Derek Wanless' report into the future of healthcare in this country, he did so by saying that if you ask a Labour question, you are going to get a Labour answer.

He was drawing attention to Wanless' terms of reference, one of which was: "to identify key factors which will determine financial and other resources required to ensure that the NHS can provide publicly funded, comprehensive, high quality service, available on the basis of clinical need and not ability to pay".

In other words, the observation in the report that received the greatest prominence namely: "there is no evidence that any alternative financing method to that currently in place in the UK would deliver a given level and quality of healthcare at a lower cost to the economy as a whole", should not come as surprise. Given the terms of reference, no other conclusion was possible.

But in terms of the financing of a system that provides the best possible result for all patients, there are other solutions and the worry must be that some appear to have reached the conclusion that tax is the only

solution without ever having had the debate. As if to support that proposition, Derek Wanless says in his report: "this review is set up to estimate the resources required to run the health service in 20 years' time. It is not set up to examine the way in which these resources are financed". The Wanless report should be the beginning of a debate not the conclusion – a sentiment echoed by

commentators as diverse as the *Financial Times* and *The Sun*.

We should all welcome the additional funds for the NHS and the sea change in funding which the Chancellor announced. But we should also be examining more closely whether there is a role for more private funding. Of the seven countries whose systems were reviewed by Wanless, all have a greater percentage of private funding than the UK.

France and Germany spend more on health, use more private money, and achieve better results. We should at least explore whether there is cause and effect. As Wanless points out, in these countries, female life expectancy at 65 is higher, breast cancer survival rates are higher, and lung cancer five-year survival rates among men are higher.

The one depressing thing about the debate which has followed the publication of the Wanless report is that again it has been characterised as an 'either/or' debate: either public funding or private funding. This is not how the issue should be approached; the answer may lie somewhere between the two. Just as we managed to overcome the previous ideological separation between public and private in the provision of hospital beds, we need to examine the possibilities of a greater mixed economy in funding.

My organisation is not advocating the replacement of a tax based system with an insurance based system. Where we are certain is that we should not, at this early stage, be ruling out any options.

We would not argue with Gordon Brown that tax is an efficient and fair way of collecting core funds for the NHS, but more consideration needs to be given to means by which people can add to their public entitlements as they do in a number of other European countries.

One possibility is a system which enables patients to combine their public entitlement – paid for through their taxes and sufficient always to provide quality healthcare, free at the point of delivery, with access determined only by need – with an additional sum of money from their own insured resources.

The disadvantage of a tax based system – again acknowledged by Wanless – is "the degree of individual choice available to patients tends to be relatively limited". In other words, you can only spend what the Government believes you should spend. Many will demand the freedom to spend more, or spend it differently, if they wish.

The Wanless report makes the point at the beginning of its section on funding that in all the countries the team examined, there were high levels of dissatisfaction with health services, whatever the total amount of money spent on them and however they were financed. Our own work suggests that the levels of satisfaction are higher by a significant margin in systems which offer a degree of choice, and which can be delivered through more flexible methods of funding.

An element of mixed funding already exists. The private element pays for 20 percent of acute surgery in this country including a third of hip replacements and 11 percent of the heart surgery. Conservative estimates put the saving to the NHS of treatment carried out in the private sector at about £1 billion – precisely the amount which the Chancellor made available this week to increase further NHS spending.

*BUPA responds continued page 6*



*Fergus Kee, managing director of BUPA Membership*



● *BUPA responds continued*

At present anyone opting for private treatment has to forego his or her public entitlement, which on the one hand benefits someone else but on the other means that the private patient pays twice. What we would like to see is an examination of other equitable private/public combinations, preferably with employers included in the debate.

The Wanless report accepts that one of the key drivers in the future is going to be patient and public expectations. Perhaps there is a

way in which private funding can be used to meet some of that increased demand, thus removing that burden from the taxpayer.

The Government should be congratulated on the huge strides it has made in the area of provision. The Concordat which made private beds available to NHS patients and so helped reduce waiting lists has already achieved demonstrable benefits for patients. To quote Wanless again: "the way in which the UK health service is financed has changed relatively little over the past 50 years". Perhaps similar brave thinking now needs to be applied to funding.

## The Wanless Report

In November 2001, Derek Wanless, former group chief executive of NatWest Bank, published an interim report on health service funding. This report was the first step of a major preview of the technological, demographic and medical trends of the next two decades that will affect the National Health Service. The report was commissioned by the Chancellor as part of the 2002 Spending Review, and can be found in full at: [www.hm-treasury.gov.uk](http://www.hm-treasury.gov.uk)

# Dutch Health Funding System encourages reform

In this article, Walter Annard and Marcel Smeets of Zorgverkeeraars Nederland outline current developments in the Dutch healthcare system.

Proposed reforms of the health system in The Netherlands, presented in July 2001 by the Dutch Government, will replace Sickness Fund and private insurance with a public general health basic insurance (basisverzekering) provided by competing private and social health insurers.

Health insurers will be responsible for the quality and accessibility of care, and competition will be encouraged by measures such as preferred provider arrangements. Proposed cover is the same as that of the current Sickness Fund, with minimal choice in the level of cover, and limited own-risk choice. The basic insurance can be complemented by private insurance, with nominal and income-related premiums. A risk equalisation system will have to be developed.

Insurers have a duty of acceptance. No-one can be refused basic insurance, while all are free to choose complementary private insurance.

More competition between health professionals is expected under the new system, matching service to demand and setting market prices. The Government will still control the operations of health insurers and professionals.

Dutch health insurers have criticised the plans, arguing that they remove the option of fully substituting private insurance for publicly-funded healthcare. Private insurers within Zorgverkeeraars Nederland, ZN, the national health insurance association, continue to defend the concept of private healthcare, although the fact that they are free to participate in the public basic insurance system does nothing to strengthen their case. ZN also says the new plan discourages entrepreneurship.

The Government is using European objections and rulings on freedom of travel and services to support its choice of a public social health system over private insurance.

The basic insurance plan will be a major campaign issue in the May 2002 elections, and the new coalition will assume responsibility for further decisions on healthcare reform. Meanwhile, Dutch health insurers' results for 2000 show losses for the eighth successive year. With performance down by 8 percent on 1999, private insurers lost 471 million guilders, against significantly improved figures for the public sector.



# Concern over Medical Inflation in the US

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Mercer found that the average cost of employer-sponsored health benefits in 2001 was \$4,924 per employee. These costs put a heavy strain on employers at a time when weakness in the US economy is hurting the bottom lines of many companies. In fact, according to the Mercer survey, 13 percent of small employers and six percent of large employers are considering terminating their health plans.

A separate US Government report in January showed national healthcare spending increased by 6.9 percent in 2000, the largest recorded annual healthcare spending increase since 1993. The largest spending categories were:

- hospital care \$412.1 billion (up 5.1 percent)
- physician and clinical services \$286.4 billion (6 percent)
- prescription drugs \$121.8 billion (17.3 percent)
- nursing home care \$92.2 billion (3.2 percent).

At the time these findings were announced, a team of government economists and actuaries cited several reasons for the recent surge in healthcare costs:

- physicians and other healthcare providers are taking a stronger stance in negotiating with health plans;
- the consolidation of hospitals has increased providers' bargaining power; and
- some health plans are discontinuing capitation payments, and adopting fee-for-service payment arrangements, in certain markets.

As these factors cause the rise in healthcare costs to accelerate, threatening to make health coverage unaffordable for more Americans, elected officials considering healthcare legislation are focusing more intensely on costs.

## Patients' Bill of Rights

On one front, lawmakers are being forced to consider the wisdom of enacting a Patients' Bill of Rights that would further increase healthcare costs through additional litigation or mandates. Last Summer, the Senate passed a Patients' Bill of Rights, with sweeping liability provisions that would create new opportunities for consumers to sue health plan providers and employers. The House later passed a separate Patients' Bill of Rights, with more limited liability provisions. Both Bills also propose 'patient protection' mandates, addressing such issues as access to specialists, coverage of emergency care, and consumer information.

Members of Congress have been meeting with White House officials in an attempt to negotiate a compromise. With increased attention to costs, at least some of the participants in these negotiations are wary about advancing legislation that would cause health premiums to rise even higher.

## Helping the Uninsured

Congress and the President are also exploring legislative options for meeting the healthcare needs of the 40 million uninsured Americans. Solutions to this problem have eluded policymakers for more than a decade, even when healthcare inflation was relatively moderate in the early- and mid-1990s. Now, efforts to help the uninsured have become even more difficult, because of not only higher costs but also a greater number requiring support.

## Medicare/Medicaid

Rising costs are causing a funding crisis in both the federally funded Medicare program for seniors and individuals with disabilities, and the jointly federal/state funded Medicaid program for low-income individuals. In many areas, Medicare and Medicaid are not providing participating health plans with adequate payments to meet the rapidly increasing cost of comprehensive, high quality health coverage.

## Prescription Drugs

Even though prescription drugs account for only about 11 percent of total US healthcare spending, they represent the largest component of out-of-pocket healthcare spending by US consumers. In 2000, consumer spending accounted for \$39 billion in prescription drugs, 32 percent of the total. By contrast, it accounted for only three percent (\$13 billion) of hospital care spending, and 12 percent (\$33 billion) of physician and clinical services. Because consumers are paying directly for a large portion of their prescription drug costs, they are closely attuned to increases in these costs. As noted earlier, prescription drug spending increased by 17.3 percent in 2000, the largest increase for any category of healthcare services.

Medicare beneficiaries, people over 65 and the disabled, are more affected by these cost increases than other segments. Recognising that seniors tend to vote in large numbers, both Republicans and Democrats are preparing plans for Medicare prescription drug coverage in the coming mid-term election year. Whilst final legislative outcome is not clear, both parties are eager to demonstrate sensitivity to seniors' concerns.





# iFHP UPDATE

## South Africa



The 3rd BHF Southern African Conference will be held from May 5th to 8th 2002 in Swakopmund, Namibia, with the theme Insuring Health – Ensuring Prosperity. The city of Swakopmund, which separates the Atlantic from the soaring dunes of the Namib Desert, will offer leading thinkers in healthcare the opportunity to congregate in a unique

environment to debate one of the world's most intractable problems – healthcare – with a specific focus on Southern Africa. For further details contact the BHF Communications Department:  
Tel: +27 11-880-8900.  
Fax: + 27 11-880-8798.  
Email: [communications@bhfglobal.com](mailto:communications@bhfglobal.com)

## Hong Kong



## iFHP Council meets in China

At the invitation of, and generously sponsored by, Luzia Hung of HSBC Medical, the iFHP Council of Management met in Hong Kong on November 19th and 20th.

The Council discussions included financial and other reports by Chief Executive, Tom Sackville on the administration of the iFHP, and plans for the Amsterdam (June 2002) and San Diego (September 2004) events. Membership dues were frozen for another year, in recognition of the currency instability in various member countries. This had been facilitated by the relatively satisfactory state of the Federation's finances.

Discussion took place on the subject of the proposed mentoring scheme under which members would be invited to put forward candidates for an executive development programme. This programme involves visits to plan providers in different parts of the world, and includes a week-long university course in the US alongside participants in the similar programme organised by the American Association of Health Plans.

The Council meeting ended with a roundtable discussion on 'What's keeping you awake at night?' at which those present were asked to summarise their principal concerns over the next year. These centred on the problems of medical inflation and unhelpful government intervention.

The highlight of the visit was a seminar on the local health insurance scene, organised by the Medical Insurance Association of Hong Kong,

and attended by representatives of ten companies offering health insurance products in the Hong Kong market. Our host, Luzia Hung introduced the meeting, which was addressed by Wolfgang Droste, head of SE Asia for General Cologne Re. He illustrated the extent of the potential for growth of pooling health risk in the region, with 75 percent of health activity in China being paid for privately, most of it 'out of pocket', against 89 percent in India and 63 percent in Indonesia.

Mr Droste explained how the population distribution in Hong Kong itself was set to change radically. Rapidly rising life expectancy combined with a falling birth rate would give rise to a Dependency Ratio of 65 percent by 2050. He illustrated some of the problems encountered in introducing managed care techniques to control health costs without adequate data for pricing, unfunded demand for long term care, and the difficulties of validating and licensing Chinese 'alternative' products and practitioners.

Dr Fung Hong, Head of the Hospital Authority of Hong Kong, described the reforms that were in prospect, or taking place, to balance the demands and interests of the private and public health sectors, against a background of a percentage of GNP at just over 5 percent. He discussed various control mechanisms, and in calling for a blending of cooperation and competition, coined the expression 'cooperation' to describe the general approach of the Hong Kong Government.

## US



### Some like it hot

The 2004 Biennial Conference, as previously announced, will be held in San Diego, where the venue will be the legendary Del Coronado Hotel.

To describe The Del, as it is affectionately known, as 'historic' would be something of an understatement. During the 110 years it has stood on the palm-shaded, sandy Coronado peninsula between San Diego and Pacific Ocean peninsula and hosted a succession of celebrities, presidents and film stars. In 1958 it provided the backdrop to Marilyn Monroe's revered performance in *Some Like It Hot*, recently named No 1 comedy of all time by the American Film Institute.

Originally conceived by two mid-Western entrepreneurs, Babcock and Storey, who acquired and developed the peninsula in 1885, the showpiece new hotel, complete with its exotic late-Victorian turrets and balconies, received its first guests in 1888. The Del Coronado has survived the Depression and two world wars, and has been designated a National Historic Landmark.

Last year a \$55 million refurbishment was completed, with the entire property being returned to its original splendour.

The Conference will take place from September 19th to 22nd 2004.

### Marketing Panel launched

Following a postponement after the events of September 11th, the US study tour marking the first activity of the new iFHP Marketing Panel went ahead between February 1st and 7th 2002. The group included marketing directors from Australia, Ireland, South Africa and the UK.

The tour started in Minnesota with a visit to HealthPartners, one of the pioneers of the HMO movement. CEO George Halvorson, who is also a deputy president of the Federation, began with a talk on the

HealthPartners philosophy, and a general outline of the challenges facing US healthcare, especially the inflationary effects of provider consolidation.

The group then met senior executives of HealthPartners to discuss detailed marketing strategy, and exchange ideas on various initiatives. This was followed by a tour of the magnificent Regions Hospital in St Paul, part of the HealthPartners group, and a presentation by its marketing director, Annette Wagener, on how the hospital maintains its high standards in a fiercely competitive local provider market.

Following a visit to a prominent PPO (Preferred Provider Organisation) PreferredOne, illustrating a somewhat different, more price driven approach to marketing health insurance in the state, the Group flew to California, where Kaiser Permanente had arranged a comprehensive and highly impressive presentation of a number of marketing initiatives, including Internet sales and maximisation of the Kaiser brand. This included an introduction from Arty Southam, executive vice president of Health Plan operations.

In California, there was time to fit in a visit to Pacificare, one of the largest health insurers in the US. Its SVP for Public Affairs, Nick Franklin, who has attended meetings of the Federation's own panel on public affairs, gave a fascinating talk on research into public attitudes to health insurance, and the challenge of improving the generally poor generic image of the industry.

Overall, this was generally agreed to be a highly successful and productive visit, in which mutually beneficial friendships across continents were established, and plans discussed for a possible joint presentation of marketing innovations at the upcoming Amsterdam conference.



# iFHP UPDATE

## People

### BUPA CEO honoured

Miss Val Gooding, chief executive of BUPA, was appointed CBE (Commander of the Order of the British Empire) in the New Year Honours 2002 for her services to business.



Miss Gooding joined the company as managing director in 1996 and has been chief executive since 1998. During that time, the company has grown significantly through a number of acquisitions, and its trading income increased from £1362 million to £2130 million in 2000.

Previously at British Airways, Miss Gooding held a number of key positions including director Asia Pacific, and director of Business Units, overseeing BA's subsidiary companies. She was extensively involved in BA's transformation to a customer-led business. Miss Gooding is also a non-executive director of BAA plc and Compass Group plc, and sits on the Council of Warwick University as well as the Advisory Board of the Warwick

Business School. She is a board member of the Association of British Insurers and a member of the leadership team for Opportunity Now.

Commenting on her appointment, Miss Gooding pays tribute to her colleagues: "I am obviously pleased to have been awarded this honour. I see this honour as recognition of the skill and dedication demonstrated by everybody in the company, and indeed the colleagues I have worked with over the course of my career."

### iFHP president resigns from Southern Cross

Mr Roger Bowie, president of the Federation, has resigned as chief executive officer of Southern Cross. It was announced that "due to differences in the way they saw the future direction of Southern Cross it was in the mutual interest of both the board and chief executive that the chief executive steps aside".

Tom Sackville comments; "Roger has made a tremendous contribution to the Federation, and it has been a great pleasure to work with him as our president over the last eighteen months. I am personally very sorry that his energy and creative approach will be lost to the Federation. I am confident, however, that we have a number of very able candidates to succeed him, and that we will have a president in place before the Amsterdam conference."

People  
People  
Members  
Members

## Members

**We are delighted to welcome four new members to our Federation. They are:**

### Tufts Health Plan

333 Wyman Street  
Waltham MA 02451, USA

Telephone: +1 781 466 9442  
Fax: +1 781 466 9430  
Website: [www.tuftshealthplan.com](http://www.tuftshealthplan.com)

Principal contact: Dr Harris A Berman  
Chief executive

### Total Health Trust Limited

2 Marconi Road  
Palmgrove Estate  
Lagos, NIGERIA

Telephone: +234 1 774 7150  
Fax: +234 1 759 6062  
Website: [www.totalhealthtrust.com](http://www.totalhealthtrust.com)

Principal contact: Dr Ladi Awosika  
Chief executive

### Medihelp

PO Box 26007  
Arcadia  
Pretoria 0007  
Gauteng, SOUTH AFRICA

Telephone: +27 12 334 2000  
Fax: +27 12 323 8886  
Website: [www.medihelp.co.za](http://www.medihelp.co.za)

Principal contact: Mr Anton Rijnen  
Chief executive

### DENIS Dental Information Systems (Pty) Ltd

3rd Floor Stone Fountain Terrace  
Klipfontein Road  
Rondebosch 7700  
Cape Town, SOUTH AFRICA

Telephone: +27 21 686 0166  
Fax: +27 21 686 0094

Principal contact: Dr Frans Coetsee  
Managing director

# Conference to focus on governance issues

**In the light of the Enron scandal, it is perhaps even more appropriate that the programme for the Amsterdam conference also includes a session on the responsibilities of non-executive board members.**

In the US in particular, this issue is becoming a live one in healthcare, where the potential is growing for patients with a grievance, or their relatives, to take legal action against any board member for negligence. In an increasingly litigious environment worldwide, two distinguished experts from the US and UK will lead a discussion on how to ensure that the full ramifications of board membership are brought home to conference delegates.

They are:

**Alastair Ross Goobey** who recently retired after nine years as chief executive of Hermes Pensions Management, one of the UK's largest fund managers.

He is now a part-time senior adviser to Morgan Stanley and a governor of the Wellcome Trust, the world's wealthiest medical charity. He continues as a trustee of the Royal Opera House pension fund, a trustee of CancerBacup, the cancer information charity, and a member of the council of Lloyd's. Goobey has held senior posts at Courtauld's pension fund and James Capel, punctuated with spells in Tory politics during which time he acted as special adviser to chancellors Nigel Lawson and Norman Lamont.

Committed to "encapsulating an idea in a stimulating way"

Goobey promises to be an entertaining speaker at Amsterdam on the importance of good governance.

**James A. Rice** PhD is president of the International Health Summit, an international conference and publication company serving the global healthcare and insurance industries.

Dr Rice is vice chairman of The Governance Institute, an organisation dedicated to enhancing the governance of health systems through knowledge generation and dissemination. The Governance Institute has over 450 hospital and health system subscribers to its series of publications and conferences on effective governance. Dr Rice is also a partner in a performance improvement consulting group focused on Web based organisational effectiveness and change management, and is co-director of the International Health Leaders Programme at Cambridge University.

Dr Rice draws upon extensive experience in the development and management of large health systems in the US as an executive with the Allina Health System in Minnesota, a \$2.5 billion structure of hospitals, physicians and health plans. He also works in international health policy research and development, with a special focus on public health finance.

To summarise the remainder of the Amsterdam programme: the role of health insurance and the public/private relationship in healthcare, HIV/AIDS, fitness, IT, mental health, and that of the Federation in influencing governments and public opinion, are among topics to be examined. The full programme is on our Web site, and you are urged to take a look and REGISTER WITHOUT DELAY.

[www.ifhp.com](http://www.ifhp.com)





## Member Interaction our objective

The iFHP Web site has been redesigned with a more up-to-date look and user-friendly navigation, but there is more to the new site than meets the eye. We hope that you will quickly become attuned to its much more interactive format.

The IT, Public Affairs and Medical Affairs pages now provide a forum for discussion and debate among members. As such they will be as useful as YOU make them. Members of the iFHP all over the world encounter similar issues and experiences – all will gain strength from sharing them. There will be a heightened focus on news, to reflect the global nature of our organisation.

Once again, we are urging you to really USE the Web site. Use the contact opportunities on it to submit your contributions, which will be posted to the site within a few days. News and views will now be updated twice a week. For the latest, go to [www.ifhp.com](http://www.ifhp.com) NOW.

### Member contributions to Web site or newsletter

The biennial conference is the iFHP's traditional forum for exchanging research and members' experiences, but this newsletter and the Internet now provide excellent opportunities for disseminating information. You are invited to contribute on any topic of relevance for healthcare

insurers, either locally or globally.

To add to the global healthcare knowledge base, in this newsletter or on our Web site, simply email a synopsis to Andrea Craig [andrea@ifhp.com](mailto:andrea@ifhp.com).



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health plans

### Disclaimer

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