

iFHP NEWS

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the newsletter of the International Federation of Health Plans

German Health Insurance at the Crossroads

The German health system is widely regarded as one of the best in the world. However, faced with financial pressures, the German government has established a "Commission for Sustainability in the Financing of Social Security Systems" under Professor Bert Rürup to consider the whole future of healthcare.

The remit of this 'Rürup Commission' is in two parts. The first deals with short-term measures to reduce contribution rates and costs of employment. The Commission has proposed a number of cost-

saving recommendations in this area, including changes to sickness allowance, maternity and certain other benefits being financed from general taxation, reduction in subsidies for medicines, greater competition among generic manufacturers etc.

The second and more fundamental part will determine the future shape of health financing in Germany. Two options are being actively discussed.

One of them, known as 'Working Population Insurance' promoted by Professor Karl Lauterbach,

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National Bioterrorism Syndromic Surveillance

'Early-Warning' System

Soon after the tragic events of September 11 and the anthrax attacks in October 2001, American Association of Health Plans (AAHP) began discussions with member health plans about the skills and experience the health plan industry could contribute to public health preparedness.

It became clear that health plans had a unique set of skills and competencies based on their integrated care coordination systems, large defined populations and comprehensive data sets that could provide a substantial public health benefit and possible early warning health surveillance system. Much of the information needed for a

surveillance system is available from health plans – such as coded diagnoses in automated medical records, information collected by telephone assistance/triage centres, and other data sources. Analysis of this aggregated, de-identified information is sufficient to identify, within a day, at least some new clusters of respiratory,

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Editorial

from Tom Sackville

On a recent trip I found myself having lunch with two top health insurance chief executives. I was supposed to be telling them about the virtues of joining the iFHP. They were however quite content to compare notes on how much weight each had lost over recent months, with or without the assistance of Dr Atkins. In the tradition of a service industry, if the customer was happy, so was I.

I was also rather impressed. These days health insurers spend a lot of time, whether from self-interest or concern for the welfare of their members, telling everybody to adopt a healthier lifestyle. It was encouraging to hear of the leaders of our industry practising what they preach.

Whether from simple vanity, worry about my family's genetic proclivities in the girth department, or a desire to set a good example when involved in health politics, I started taking serious regular exercise about ten years ago, and have kept it up, supplemented recently by weekly personal training sessions. Trekking round the park with dogs in tow, or pounding away in the gym, I am constantly struck by the fact that I am between ten and thirty years older than those around me.

This is bizarre. First, most of these people look pretty fit already, though one must assume that they have their reasons to want to look even fitter. Second it is older people,

especially the 50+ who have the really urgent need for exercise. As the years go by, we naturally put on weight whether for metabolic reasons, or an increasing consumption of corporate hospitality, with all the attendant health risk.

Clinical trials concerned with age and illness are apparently beginning to agree that the greatest single cause of heart and other disease in the over 50's is not smoking, drinking or over eating, but lack of regular exercise. But does anyone take any notice?

A feature of state run health systems is that things happen which seem to bear no relation to either business sense or health gain. At a time when people are waiting weeks for treatment for life threatening conditions including cancer, due to inefficiency and shortage of resources, UK health ministers are planning to procure the largest central health IT system the world has ever seen. It aims to integrate all clinical and administrative functions, and provide a 'spine' which will provide a confidential medical record for each NHS patient to any authorised user who requests it, anywhere in the system. A very worthy aim to which any health service should aspire, but in reality a pipe dream.

Unfortunately, decades of bureaucratic interference in health IT procurement has ensured that very few hospitals have the sort of new generation systems that could support the production and management of such data. Furthermore, long experience has shown that where NHS staff are told from on

high to operate a new IT facility, especially when it comes straight from the US, they won't, and don't.

A look at the record of UK government and major IT projects will reveal a series of horrendous failures, followed by official enquiries. If you're looking for examples of successful major process re-engineering, don't look in the public sector. You are more likely to find it where the careers of those responsible suffer when it doesn't work.

On my travels I hear a lot of people saying the Americans are too powerful, out of control and likely to make the world a more, not less, dangerous place. This is the 'politically correct' view, even in the US itself. I respectfully submit that an opposing view should be given consideration.

George Orwell published '1984' immediately after the second world war, against the background of Stalinist genocide, and perhaps bitter memories of craven appeasement of the Nazis in the 30s by democracies weary of slaughter. He foresaw a new nightmare world, run by three great military powers blocs, evil dictatorships dedicated to the oppression of their own subject peoples through the perversion of truth, for the enrichment of their leaders.

If he was alive today, he would see one, not three, great uncontested superpower, enjoying a huge concentration of economic and military power, but run on democratic principles by people who profess to govern according to Judaeo-Christian principles in the pursuit of individual freedom. He would note that the stated policy of these people was to use their muscle to liberate oppressed people from their oppressors, and replace dictatorial regimes abusing their power to threaten their neighbours, with democracy.

I think he would be pleasantly surprised.

Australia



A Fairer

Australian Medicare

Richard Bowden, Managing Director of BUPA Australia Health, outlines the key points arising from the Australian Governments recent health care reform package.

On 28 April 2003 the Federal Health Minister, Senator Kay Patterson, announced a program of health care reforms ("A Fairer Medicare") designed to strengthen the Medicare arrangements in Australia. Medicare is the comprehensive private health system which supports Australians.

The major program initiatives are designed to:

- (i) increase the number of doctors by increasing the number of places in medical schools throughout Australia;
- (ii) provide financial incentives for general practitioners to bulk-bill pensioners and concession card holders;
- (iii) provide a guaranteed payment cycle for bulk-billed patients;
- (iv) increase the number of nurses in general practitioner practices in areas of workforce shortage (outer metropolitan) where bulk-billing is utilised;
- (v) provide a safety net to assist pensioners and concessional card holders who have \$500 or more in annual out-of-pocket costs;

(vi) allow private health insurers to insure annual out-of-pocket medical costs exceeding \$1,000 for non in-patient medical services.

In the past, private health insurers have been prohibited from providing coverage for non in-patient medical services and thus this reform provides a range of opportunities for Australian private health insurers to extend and enhance the value of its products to all Australians.

The Government has agreed to allow the 30% premium rebate to be applied to the cost of this product, which must be established on a stand alone basis.

The legislation required to enact these reforms is currently being vigorously debated in the Australian Senate.

If the legislation is passed, the 'new' medical insurance product will be available from 1 December 2004.

The private health insurance industry, whilst wary of some elements of this new product, is generally supportive of this important Government initiative as it will provide all Australians with the opportunity to insure against rising medical costs and therefore reinforce the value of the private health insurance.

News



Historical Medicare reform passes

The House and Senate passed separate versions of a \$400 billion Medicare reform bill, the most expensive changes in the history of the health program for seniors. A final vote of 216-215 was reached.

Abbott settles for \$622 million on marketing charges

Abbott Laboratories announced it will pay \$622 million to settle an investigation on its marketing tactics on nutrition products for tube-fed patients. The investigation stems from allegations that some hospitals received the products for free but then charged the government for them through Medicare and Medicaid.

Cost of Uninsured Americans

A panel assembled by the National Academy of Sciences' Institute of Medicine reported that leaving 41 million Americans uninsured is costing the nation between \$65 billion and \$130 billion every year. The uninsured receive inadequate healthcare, which leads to a lower quality of life and a shorter life-span.

Source: *The Washington Post* (6/18), *San Diego Union-Tribune/ Associated Press* (6/17)

Drug sales increase

Global pharmaceutical sales rose 6 per cent in the year to April 2003 – below the double-digit levels the drug companies target according to healthcare information firm IMS.

Sales in France and Italy slowed which meant that Europe's main markets grew four per cent in aggregate one percent point down on March and well below the 11 per cent rate in the USA.

Total sales through retail pharmacies in 13 leading markets which account for 60 percent of global sales were \$285.5 billion.

Source: *CNN Money*



The Informed Patient is a less costly patient

The following was compiled for the iFHP Newsletter by Peter Singleton of Cambridge University Health. It summarises the findings of a recent Europe-wide research project aimed at guiding future policy on the provision of information to patients. The project was led by Professor Don Detmer of the Judge Management Institute, University of Cambridge, UK.

Better informed patients offer potential to reduce healthcare costs. This was one of the main conclusions from The Informed Patient study by Cambridge University Health. However, there is little evidence of best practice being identified or shared at a national or European level. There are a number of related projects promoting specific aspects but no coherent health policy across Europe to ensure the economic gains that would be available.

The study identified from studies from the literature as well as expert opinions that informed patients:

- are likely to start treatment earlier and so require lower levels of intervention.

- are likely to be more committed to following drug and other treatment plans.
- may feel a greater sense of control and suffer less anxiety.
- may well choose less intrusive interventions.
- in chronic cases, are more likely to be involved in their own care.
- are more likely to be satisfied with their treatment and litigate less.

It is also clear that patients are looking for wider information about illnesses and treatment options, e.g. support for care-related questions, which clinicians often omit. Patients like to know how the condition or effects of treatment will affect their lives or their families, rather than just medical or nursing technicalities.

This issue is relevant for health insurers, who ultimately bear the risks and costs of healthcare. However, meetings with representatives from the insurance industry

and state/social insurance funds showed that there are few direct incentives for them to get involved directly in information provision. Issues include:

- reducing healthcare costs might reduce premiums.
- informing policyholders may not lead to direct benefits for a given insurer.
- co-insurance is dependent on state provision of services and information.
- the ultimate benefits may only arise in five or ten years time.

However, the informed patient movement is upon us and must involve the health insurance industry as a whole.

The full report is available at www.jims.cam.ac.uk/research/health/tip/pdf/crstudy.pdf and more information on the project, as well as other supporting documentation, can be found at www.jims.cam.ac.uk/research/health/tip/html

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German Health Insurance

involves widening the scope of health insurance to cover the entire population, taking all forms of income into account, further increases in the earnings limit and standard cover for all. Under this proposal, private insurers would be able to offer supplementary cover only.

The other, promoted by Professor Rürup himself, and known as the 'Health Premium Concept' is oriented towards a mixed private/public system. Financing would be separated from earnings to prevent the

negative effective on employment costs. Private insurers would offer comprehensive cover, with far greater competition in the market between private insurers as well as between private and statutory health cover.

Depending on the government's decision on the various proposals, and especially the two options described above, the consequences for health insurers may be considerable: in the worst case, that they will no longer be able to offer comprehensive health cover.

Furthermore, despite a proposal by the industry for the exclusive provision of sickness benefits insurance, the government appears minded to leave this within the statutory sector. On the other hand, discussions are taking place on greater flexibility, such as portability of age reserves between one provider and another.

The government's response to the Rürup Commission is awaited.

Dr Karl-Josef Bierth



BOOK REVIEW

Epidemic of Care

by George C Halvorson
and George J Isham MD

Jossey-Bass pp 271
ISBN 0-7879-6888-9

George Halvorson's fan club around the world who have heard him at our events will immediately recognise the style: solid conclusions, simply argued in plain English, free of the jargon so beloved of health economists.

Written with his distinguished former colleague from Minnesota, George Isham, Medical Director of Health Partners, George's latest book represents something of a landmark. It opens the lid on what is wrong with US healthcare, in particular why it is so hugely expensive, in a way which is as

accessible to the informed layman as it is to those involved in the industry. It contains important lessons for us all.

The first half analyses the factors which have annual health spending of nearly US\$5,000 per head, at least double that of comparable systems, despite more than forty million Americans holding no formal health cover. Cost inflation from quasi-monopolistic mergers among both providers and pharmas, shortage of health care workers, and HMO's retreat from cost saving measures at the hands of hostile opinion are described in detail. As is the fundamental problem of consumer attitudes, the assumption that we are all entitled to receive any treatment or product we hear about, even if plainly experimental, and that someone else will pay for it.

But the overall message is far from negative. The authors combine these criticisms with a wealth of examples showing how, in return for high cost, those Americans who are covered (and many who are not) enjoy the best care in the world.

The second half of the book spells out an action plan of seven common sense points, including population health, choice, best

practice guidelines, anti-trust regulation, removal of bureaucratic barriers to Medicaid enrolment and the desperate need for an automated medical record.

I was particularly grateful for the analysis of public attitudes to health: entitlement variations and high costs are widely assumed to be the fault of the health plans who send out the bills. Greed and monopolistic behaviour among providers and professionals go largely unchecked and unrecognised. Their perpetrators are protected by both media prejudice against "suits" as well as by weak legislators reinforcing misconceptions in the scrabble for votes. Enlightened health plans who would like to make the necessary reforms then find themselves discouraged or even prevented from doing so.

It is not every day that a thinking man finds himself in a top job. George's appointment at Kaiser Permanente brings him not only a broad health canvas on which to put ideas into practice, but huge influence within his own industry, as well as on Capitol Hill. This manifesto (for that is what it is) could be the start of something big. And not a moment too soon.

Tom Sackville

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'Early-Warning' National Surveillance System

gastrointestinal, neurological, and other illnesses experienced by health plan members.

This assessment led directly to the collaboration of several health plans and AAHP with the Centres for Disease Control and Prevention (CDC) to create a national bioterrorism syndromic surveillance demonstration program utilizing existing automated data maintained by health plans covering more than 20 million people in 50 states. The national demonstration program involves AAHP, and four health plans or physician groups – Harvard Pilgrim Health Care/Harvard Vanguard Medical Associates (Massachusetts), Health Partners (Minnesota), Kaiser Permanente Colorado, and United Healthcare's nurse call centre, Optum. The work to develop and evaluate the effectiveness of this early warning health surveillance system is being funded through a grant from CDC. Through additional funding

from the Texas League of Health Departments, Scott and White Healthcare System (Texas), and the Austin Regional Clinic (Texas) are participating in the demonstration project and are included as additional sites providing data to the project.

The demonstration program includes a rapid response capability to identify unusual clusters of symptoms or illness from daily encounters, to notify the right public health officials of these clusters, and to facilitate the ability of public health officials to obtain detailed clinical information about specific cases when needed. Health plans maintain patient privacy by reporting only aggregate de-identified data to the surveillance system thus providing maximum protection of member confidentiality. In cases where unusual clusters are identified, the state or local public health team will decide if additional information is needed and contact the health plan directly for additional

information. This system is being developed in a manner that will facilitate participation by other health plans and medical groups that possess real-time encounter level information.

The project data centre, located at Harvard Medical School, is evaluating daily count data against historical counts and refining the analytical tools necessary to identify an early indication of a bioterrorism event (or an emerging infectious outbreak such as SARS). AAHP President and CEO Karen Ignagni testified on the initiative before the US House of Representatives Committee on Government Reform, Subcommittee on National Security, Emerging Threats, and International Relations on May 5, 2003. To view the press release and testimony, visit AAHP's website at <http://www.aahp.org/redirect/testimony.htm>



Surveys:

Many health care professionals ignore recommended steps for treatment

Physicians and nurses don't follow nearly half the guidelines for treating common illnesses such as bladder infections, diabetes and high blood pressure, a recent study published by the New England Journal of Medicine says. Doctors contend that there are too many steps and changes and not enough time to complete them. The survey adds to the growing body of research showing a gap between what is known by medical scientists and what is done by medical practitioners.

Mediterranean diets helpful in health promotion

A new study finds those on a Mediterranean-style diet, one that is heavy in fruits, vegetables, olive oil and fish, are 25% less likely to die of heart disease or cancer. The findings show diet is more important to overall health than previously thought, researchers say.

News

Who turns attention to obesity

The World Health Organisation has discussed with governments, food industry executives, trade and consumer groups about how to control the sale of foods containing fat, sugar and salt. WHO met with industry giants such as Unilever, Coca-Cola, Pepsico, Nestle and McDonald's to get their ideas on how to encourage consumers to eat healthier and incorporate physical activity into their daily routines.

iFHP UPDATE

Executive Development Programme

2003 has seen the launch of an ambitious new initiative, the iFHP Executive Development Programme. Member CEO's were invited to nominate younger executives with recognised future leadership potential, whose career development would benefit from exposure to the private and public scene in five countries during two two-week sessions.

In March 2003 an initial group of ten from six countries spent a week each as guests of Terry Smith of HCF in Sydney, then George Halvorson of Kaiser Permanente in San Francisco. The Australia week included

an in depth look at the operations of the host plan, a day in Canberra with regulators and other government officials, industry lobbyists and journalists. In San Francisco, the programme included presentations by top Kaiser managers of every aspect of the business, a meeting with a senior director of the Washington-based industry association and a visit to a Kaiser medical facility.

In September the group will spend two weeks in Europe, Dublin. London and Amsterdam as guests of Vhi, BUPA and Achmea. In each case the intention of the programme will be to present a detailed picture of the host company's operations, while setting private health insurance in the political and healthcare context of the country concerned.

Reports back have been almost unconditionally positive, with deep appreciation expressed of the personal commitment and involvement of the host CEO's and their colleagues. An important secondary benefit has clearly been the opportunity for participants to form lasting relationships with their peers across the world.

INVITATIONS FOR THE 2004 EDP (TO TAKE PLACE IN MARCH AND OCTOBER) WILL BE ISSUED TO CEO'S SHORTLY

**A view from "Class of 2003"
EDP participant Monica Parames,
Head of Legal Department,
Sanitas, Spain**

So what did I think about EDP? For me a great opportunity to meet successful health organisations throughout the world. The main lesson for me? That the issues we face as an industry everywhere are much more similar than I ever thought; the same challenges and problems. And also, why not, the place and the time to make friends that could play a significant role in their organisations. See you soon for the European leg!

Banknotes

I have been asked to describe my first three months as iFHP Fellow at the World Bank.

First of all, it might be helpful to set out the background to this assignment. About 18 months ago the World Bank's Chief Health Economist, Alex Preker, approached Tom Sackville and asked him if the independent healthcare industry might be interested in seconding a representative to the Health Systems Development Team in the Bank's Headquarters in Washington. The aim of the secondment was to enhance a two way flow of knowledge and understanding between the Bank and the industry, a similar arrangement having worked successfully with the International Pharmaceutical Manufacturers Association over several years. Tom advertised the opportunity last summer to iFHP CEO's and I was subsequently invited to take a break from my usual job of Head of Public Policy at BUPA and take up a two year posting in Washington.

My main responsibility at the Bank is to address the question "Can private health financing organizations usefully play a larger role in the health systems of countries with developing and transition economies, and if so how?" My aim is to write a strategy paper on this topic for the Bank by the end of 2004.

I arrived in Washington DC at the beginning of April. After completing the Bank's induction and orientation Program I was swiftly drawn into dialogue with colleagues in the Bank's Health Systems Development Team. Tom Sackville visited us on 29 April

and met Jacques Baudouy, the Bank's Director designate of Health, Nutrition and Population. At the end of April I joined other colleagues for a successful 'Senior Management Review' of our proposed work on health financing issues. Insights into our work program can also be gained at <http://www1.worldbank.org/hnp/hsd/HSDMission&Team.asp>

During May I was able to initiate several work strands. Roger Bowie, past President of the iFHP has kindly agreed to write an early paper summarizing best practice in private health insurance in the developed world. Richard Scheffler, Professor of Health Economics of the University of California at Berkeley, will use a sabbatical with the Bank to write a technical economic contribution to my assignment. A summer intern from the London School of Economics, Dr Wael Saleh, will examine the historic contribution of private health organizations to the Taiwanese health system, as a 'country case study'.

I would like to thank iFHP, BUPA and the World Bank for offering me this assignment and look forward to advising iFHP members of progress through occasional reports such as this. iFHP members are very welcome to contact me at mbassett@worldbank.org.

Mark Bassett

Prior to joining BUPA Mark Bassett held a senior civil service position in the Department of Health. He has a Master's degree in Health Service Management from Manchester University. From 1981-83 he served as a Pilot Officer in the RAF.



UK Health Secretary resigns

Alan Milburn Secretary of State for Health resigned in June. In a shock announcement Alan Milburn said he wanted "to spend more time with his family" - until that point he was "the youngest member of the Cabinet, a rising star with apparent ambition and propelled by Tony Blair's approval".

Mr Milburn has introduced many reforms to the health service but most have been unpopular with the Labour Left and unions. The Chancellor of the Exchequer Gordon Brown was known to have made little secret of his desire for Milburn to be removed from the Department of Health - believing his stance over Foundation Hospitals (a new round of reforms giving increased freedom to selected hospitals) has opened unnecessary splits over the Governments key policy promises on the NHS.

In an article in The Times other reasons relating to his own, longer term political ambition were alluded to;

"even with this Cabinet we should not exclude the possibility that a minister is telling the truth... it is conceivable that Alan Milburn's lifelong and driving political ambition has suddenly deserted him mid stream and that halfway through his career the scales have fallen from his eyes and he has understood the vanity of office..."

But Mr Milburn is not old, stupid, fragile, rebellious nor undervalued. He was a hard, confident, capable, rising hack. So his departure invites the question a French politician murmured on hearing of the death of a rival "I wonder what he meant by that?"

Source: The Times 13th June 2003

Obituary



Peter Smith

(1936-2003)

Chairman, Southern Cross
Medical Care Society

Peter Smith, 66, was a remarkable, energetic and visionary Chief Executive, and a Board member with insight. Quick-witted, with a sharp intellect and delightful sense of humour, Peter will be remembered for his steady hand at the helm of New Zealand's largest health insurance and private healthcare organisation.

Born in 1936 and educated on Auckland's North Shore, he graduated Bachelor of Arts from Victoria University in Wellington, working for Government in journalism and banking.

Peter later served Southern Cross Healthcare as Chief Executive for 25 defining years, from 1970 to 1995. He also served on the Board of Southern Cross Medical Care Society and Southern Cross Health Trust for 22 years. Peter's commitment and contribution to Southern Cross was fundamental to its growth.

As CEO, Peter oversaw the spectacular growth of Southern Cross Healthcare's insurance arm to over one million members. Peter catalysed the vision of the organisation — as a 'not-for-profit' Friendly Society, born out of New Zealand's golden 1960s, always with an eye on the future.

Peter foresaw the challenges that would be faced by New Zealand's public health system and moulded Southern Cross Healthcare to complement the sector and provide consumer choice. He led Southern Cross' investment into the country's only national network of private hospitals.

Peter obtained an international perspective of health insurance over the last 30 years. He spoke regularly overseas at global healthcare conferences. In 1984 he was elected President of the world health insurance body.

During the late 1970s and early 1980s, Peter served as Director of New Zealand's major home-grown IT company, IDAPS, which later changed its name to Paxus, finishing up as Chairman.

In 1988 Peter was honoured by Her Majesty the Queen and awarded an MBE for services to the community.

Last year, ill health forced Peter to resign from the Board of Southern Cross. After months of illness, he passed away peacefully at his home on 30 January. Sadly, Daphne, Peter's wife of 46 years, passed away on 5 May. They are survived by their four adult children.

Peter joined the iFHP Council of management in 1980 and was elected Deputy President in August 1982. He was elected President in 1984 and served to 1986. He served on the Council from 1980 to 1996 and was made a life member in 1996.

Bryan Kensington

New member – USA

MVP Health Care; USA

MVP Health Care is a group of companies offering a wide range of health benefit plans to employers including HMO, point of service preferred provider organisation and indemnity coverage through MVP Health Plan Inc.

David W Oliker is MVP President and CEO.

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For your diary

Sydney CEO Forum
4th – 7th November 2003

San Diego Conference
19th – 22nd September 2004

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