

# Medical Liability Crisis moves up US Health Agenda

October 2002

**Diana Dennett, Executive Vice President of the American Association of Health Plans (AAHP) describes increasing medical litigation and the AAHP response.**

As healthcare costs rise across the United States, consumers and employers alike are taking a closer look at the factors threatening the affordability and accessibility of high-quality healthcare. No issue has received more attention in this new environment than frivolous lawsuits and, more specifically, the medical malpractice crisis that is gripping numerous states.

All across the United States – medical malpractice reform has raced to the top of the political agenda. As news reports focus on physicians forced to abandon their practices and patients driving long distances to see an obstetrician/gynecologist, the medical malpractice crisis has touched a nerve with patients and politicians.

Despite the objections of personal injury lawyers, the factors fueling the medical malpractice crisis are clear. Thousands of lawsuits annually against physicians – more than 70 percent of which result in no payment to the plaintiff – and skyrocketing jury awards are forcing medical malpractice insurers to raise premiums. In some extreme examples, doctors who paid \$50,000 for malpractice insurance last year are now facing doubled or tripled premiums.

The results of today's broken liability system can be disastrous for patients. Many older physicians are retiring early, while many younger physicians are changing careers or leaving states with adverse malpractice environments. Moreover, fear of litigation is a significant factor for students choosing careers outside medicine. Since 1996, the number of applicants to US medical schools has declined by more than 25 percent.

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# EU Threat to Health Budgets

Draft laws to allow US style direct-to-consumer advertising of prescription drugs are moving through the European Union legislative process. Following strong lobbying by the pharmaceutical industry for these changes which they claim would assist "disease management" programmes, a strong body of opinion has emerged in the European Parliament that the resulting benefits to patient information and choice would outweigh other disadvantages.

Evidence from the United States would however appear to suggest otherwise. The authoritative New England Journal of Medicine reports (14 February 2002) that in the period between poorly drafted 1997 amendments to FDA regulations and 2000, direct-to-consumer advertising for prescription drugs tripled to \$2.5 billion.

This does not take in to account the less easily quantifiable effects on spending on the

● *continued on page 2*

## In this Issue

<b>Editorial</b>	<i>page 2</i>
<b>Healthcare funding – an issue worldwide</b>	<i>page 3</i>
<b>Medical Affairs</b>	<i>page 5</i>
<b>iFHP update</b>	<i>page 6</i>
<b>Conference Update</b>	<i>page 6</i>
<b>Federation News</b>	<i>page 7</i>
<b>Companies</b>	<i>page 7</i>
<b>People</b>	<i>page 8</i>
<b>For Your Diary</b>	<i>page 8</i>

## Editorial

As we reached the anniversary of the dreadful events of 9/11 the world's attention seemed fixed on Johannesburg, where a collective examination of the political conscience about the future of the planet was taking place, and Washington, where a decision loomed on a pre-emptive strike on Iraq.

The last is clearly of most immediate importance. At worst, protracted conflict could re-ignite old hatreds between Muslim and Christian from a millennium ago. At best, it could rid the Middle East of a dangerously destabilising force. But with the flames of anti-Americanism being fanned from Paris to Riyadh by politicians whose prejudices blind them to the fact that the existence of a powerful USA, governed as it fortunately is according to democratic principles, represents our best hope for a free and peaceful future, a rational debate seems unlikely.

My last health screen was supervised by a young South African surgeon. He was filling in between his real vocation, missions for *Medicin Sans Frontieres*, the organisation which organises doctors and nurses to treat the sick and wounded of natural disasters and war zones, and was clearly not someone who would give blanket approval to US military exploits.

This doctor had spent the immediate aftermath of the Gulf war working in what became the Kurdish "safe haven" of northern Iraq. He told me that those he was treating had been convinced it was the West's firm



intention to depose Saddam and liberate the victims of his tyrannical regime.

When through a failure of nerve in London and Washington, alliance forces suddenly withdrew, his patients and their allies found themselves in an appalling situation, at the mercy of a vengeful Iraqi army on a reign of terror. The apparent change of strategy seemed to many at the time inexplicable. For the victims it was more, it was an unforgivable betrayal.

How is this connected with what was happening (or was supposed to be happening) at the famously expensive eco-jamboree in Johannesburg in September? Because it is becoming ever clearer that having survived the Cold War, if we do avoid the threat of an Islamic nuclear bomb, our

current behaviour is anyway hastening the destruction our civilisation.

The unwelcome scientific facts have been around for some time. Our planet is becoming terminally sick, from a rapidly growing population attending its wants and needs for food, transport, heat and consumer goods, without reference to the effects on climate or sustainability of resources. The trend is likely to accelerate, as billions of poorer people try to emulate the perceived advantages of their richer brethren.

And while the government of even the world's greatest consumer nation still finds itself with no political mandate for basic "green" policies such as energy taxes, and the Vatican cannot bring itself to drop its self-indulgent doctrinal opposition to birth control, it is fanciful to expect those millions whose daily priority is access to clean water and basic healthcare for their children, to focus on long-term threats to their environment.

Against this bleak background it is appropriate that the Federation, which represents some of the healthiest people in the world's apparently wealthiest countries has taken its own small step in the direction of world development.

The iFHP World Bank Fellowship, reported elsewhere in this issue will act as a liaison between our industry and the Bank, to help identify and promote non-governmental health projects benefiting poor communities. But its success will depend on whether it has the support of our members.

## EU Threat to Health Budgets

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actual drugs. However, according to the National Institute for Healthcare Management (November 2001) increases in sales of the 50 drugs most heavily advertised to consumers were responsible for nearly half of the \$21 billion increase in US retail spending on prescription drugs between 1999 and 2000.

The most heavily advertised drug to consumers was Vioxx, whose maker, Merck, spent \$160 million in 2000 promoting the drug in the mass media.

A leading EU insider and health adviser commented "if the campaign by healthcare interests against this is unsuccessful, it could be extremely bad news for European health systems: the evidence from the US on recent effects on doctors' ability to prescribe appropriately and reduce excessive treatment is overwhelming. One can only hope that our Euro politicians are acting out of naivete, but I regret to say there are signs of undue influence by the industry."

## HEALTHCARE FUNDING AN ISSUE WORLDWIDE

In this regular feature on the worldwide debate on healthcare funding we feature articles from the USA and Denmark.

### DENMARK Six week treatment guarantee introduced in Denmark

Johannes Due, managing director of Danmark Sygeforsikring reports on changes taking place in the Danish Healthcare system.



In February 2002 I wrote a short article for this newsletter on the expectations connected with the rather dramatic shift in government from a centre-left to a liberal-right government.

In this article, I would like to expand on the possible consequences of this political shift in Denmark especially concerning the "window of opportunity" for the private health insurance sector.

Denmark maintains a truly socialized public healthcare system, as national law requires that most healthcare be provided free of charge to all Danes. There are some payments for drugs, vitamins, dentistry (free until the age of 18) and other therapies. These self payments constitute the marketplace for Sygeforsikringen "Danmark", who provide almost one third of the population with reimbursement of their health expenses.

Patients are entitled to free access to GPs and surgeons. Despite some shortage of physicians and nurses, a new law guarantees that patients see specialists and have surgical treatments within a very short period if a life-threatening illness is diagnosed and within 8 weeks concerning more common elective surgery (e.g. knee surgery, hip replacement and cataract surgery). If a hospital cannot meet those targets, it is required to make a referral to another public hospital, a private hospital or a hospital in another country.

As with any socialized healthcare system, Denmark is susceptible to excessive utilization. Some incentives are evident, for example, the freedom of patients to choose any hospital in the country induces competition on a national level. To facilitate an eventual choice of hospitals in other counties, the Ministry of Health runs a website where people needing treatment can search for the hospital with the shortest waiting list. Most patients are however, rather reluctant to choose a hospital other than the nearest. They obviously prefer a slightly longer waiting time thereby gaining a minimum distance between home (and family) and the hospital.

For several years, attempts have been made to make the hospital sector more efficient, by increasing the proportion of outpatient treatments and reducing the hospitalisation period when outpatient treatment is not possible.

In the coming years, Danish social and health policy will face many challenges. As in other industrialized countries, the proportion of working age people will decline over the next 20-30 years, while the proportion of elderly will increase. This development constitutes a funding challenge for a welfare system like Denmark's, which is based on the tax payments of those engaged in active employment.

This general development combined with the political emphasis on the health sector has led to a renewal of the debate on public/private co-operation in the health sector. The counties, who run the public hospitals, have made agreements with Danish (and foreign) private hospitals based on DRG-prices. These agreements and the parallel public debate will no doubt introduce private hospitals as a (small) permanent part of the health services provided to the

Danish People. This development may seem insignificant, but it represents a major breakthrough because admission to a private hospital no longer will be considered "illegitimate".

### Danes Pay a Lot for their Health Services

A new study by DSI Danish Institute for Health Services Research shows that the Danes are among the Europeans who pay the most for health services. Considering the differences in the price level in the European countries, Denmark comes in third when it comes to payment for health services, only surpassed by Italy and Greece. In Denmark there is this widespread myth that Danes do not have users' fees in the health system, so it is interesting that this study shows that we do have it and to a very high degree being at the top of the ratings when compared to other European countries. Payments are, as mentioned above, concentrated on a few benefits whereas in other countries they are mainly concentrated on hospitalisations and visits to the doctor. The high total amount of users' fees in the Danish health system is mainly due to high prices for medicine, glasses, dentists, chiropractors and physiotherapy, of which Danes pay all or part of the expenses themselves, according to the study.

In spite of some criticism concerning waiting lists and in spite of the above-mentioned high degree of self payment a Euro barometer survey in 1997 found that 90percent of Danes were satisfied with their healthcare, the greatest proportion of any European state.

This represents a widespread confidence in the Danish Public Health Sector. However the official "inclusion" of private hospitals and recent legislation giving increases in own payment for prescribed drugs will no doubt make more Danes consider private health insurance on top of the tax financed public health sector.

# Medical Liability Crisis

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In addition to causing a physician shortage in some areas, another serious concern for patients is the effect the threat of litigation can have on the way physicians practice medicine. According to a recent survey by the leading polling firm Harris Interactive, 91 percent of physicians say that the fear of malpractice liability causes physicians to "order more tests than they would based only on professional judgment of what is medically necessary." This "defensive medicine" contributes to skyrocketing healthcare costs and can endanger the health of patients.

Clearly, the medical liability system in the United States is in urgent need of reform. Rather than protecting patients and ensuring that physicians do the right thing, the current system is driving many physicians out of business and forcing others to think more about the threat of personal injury lawyers than the best interests of their patients.

## Legislative Response

To address this concern, the Bush Administration and many Members of Congress are calling for legislation to reform the nation's medical malpractice laws. President Bush recently delivered a major speech in which he expressed concern about the "unpredictability of our liability system" and cautioned that "frivolous cases, even what we call junk lawsuits, carry the risk of enormous verdicts." The President continued: "The thing that Americans have got to understand is every one of us pay for those awards. Those excessive jury awards cost us all money, and it is part of why there are rising costs in the healthcare system."

In both the Senate and the House of Representatives, lawmakers have introduced legislation aimed at scaling back litigation in

the U.S. healthcare system. On September 10, the House Judiciary Committee approved legislation that would limit:

- non-economic damages to \$250,000 ("non-economic damages" are funds that are awarded to compensate a person for pain and suffering);
- punitive damages to the greatest of either \$250,000 or twice the amount of economic damages awarded ("punitive damages" are funds that are awarded for the purpose of punishment or deterrence);
- attorneys' contingency fees to:
  - 40 percent of the first \$50,000 recovered
  - 33 percent of the next \$50,000
  - 25 percent of the next \$500,000
  - 15 percent of any amounts exceeding \$600,000
 (attorneys' in the United States are frequently paid based on "contingency fees" usually calculated as a percentage of the damages that are awarded to the client);
- the number of years a plaintiff can wait before filing a healthcare liability action; and allocate damages in proportion to a party's degree of fault.

This legislation is likely to receive a vote on the House floor later this fall. However, it has little chance of being enacted into law this year, since the Senate rejected a similar proposal in July by a vote of 57 to 42.

## AAHP's Role

Health plans have argued for years that unfettered liability in the healthcare system does not help patients get the care they need, when they need it. Whether the target is the managed care industry, physicians or hospitals, we believe there are alternatives to

litigation that can maintain accountability in the healthcare system and simultaneously ensure that patients have access to high-quality, affordable healthcare.

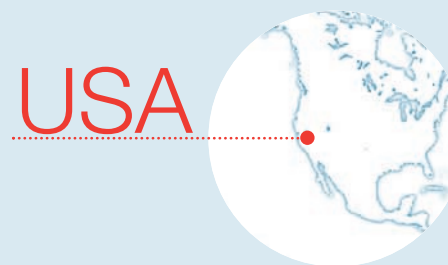
That is why we have joined physicians in the fight for medical malpractice reform. At both the state and federal level, AAHP has launched an aggressive medical malpractice reform effort designed to educate consumers on the consequences of lawsuit abuse, build new bridges with physicians, and demonstrate to political leaders that the entire healthcare community stands united behind the need for legal reform. Our state efforts include highlighting abuses of the medical malpractice system, advertising in targeted areas, direct mail to thousands of physicians nationwide, and new research projects that highlight the impact of litigation on rising healthcare costs.

At the national level, AAHP is co-chairing the American Tort Reform Association's (ATRA) Medical Liability Committee alongside the American Medical Association (AMA). This committee has come together as a group of diverse interests to urge Congress and state legislatures to address the medical malpractice crisis.

Reforming the U.S. medical liability system is a major undertaking. If successful it has great potential for improving the affordability and quality of healthcare. With this goal in mind, America's health plans will continue to work together to highlight the need for reform and the importance of placing the interests of patients first.

# Medical AFFAIRS

In this special feature we present articles from the USA and UK on developments taking place affecting Clinicians working practices



## Kaiser Permanente - a Refuge for Doctors?

**According to a report in the San Francisco Business Times, plenty of doctors are willing to replace the uncertainties of a contractual relationship with an HMO with the stability of salaried employment with an integrated healthcare system such as Kaiser Permanente. This represents a turn-round from the position of twenty years ago, when most doctors showed a clear preference for independence.**

What has changed? It appears that the new landscape of US healthcare with its burdensome regulation, red tape and haggling for payment from different health plans have finally taken their toll, and the attractions of transferring some of these duties to an administrative body have become more apparent.

According to Dr Bill Longwell, formerly of the Alameda Medical Group, who recently joined Kaiser, he and his colleagues had become disillusioned with private practice for a number of reasons. Negotiations with HMO's had become increasingly difficult, and the practice could not recruit doctors or afford to invest in the necessary new technology.

In contrast, some doctors claim Kaiser is attractive because many of its clinics are equipped with state-of-the art technology, billions of dollars having been spent installing electronic medical records and other systems allowing access to patient information online.

There are other inducements. Two years ago, Kaiser put together a package that would help doctors cope with the Bay Area's high cost of living offering a housing incentive that forgives a \$100,000 loan over 10 years.

Whatever the reasons for the trend, Permanente Medical Group, which already employs 5,000 doctors in Northern California and has been hiring at least 400 doctors a year for the last few years is clearly confident that it is here to stay. Associate executive director Dr Sharon Levine reports that applicants for Kaiser positions now include not only doctors who have just finished training, but those with a decade or more of experience.

According to Larry Levitt, vice President at the Kaiser Family Foundation, a think tank in Menlo Park unaffiliated to the HMO, "Kaiser offers a bit of a refuge: you get your pay check and you have a job. It is a bit of a bureaucracy but at the same time they give doctors greater control."



## Private Practice Under the Knife

**Adrian Bull, Medical Director of PPP Healthcare, reports on the latest moves in the UK Government's controversial attempt to restrict private practice**

The UK Government's biggest political challenge is to meet its commitment to deliver efficient and effective public services. Its biggest gamble is to pour extra billions of taxpayers' money into a re-organised NHS to drive standards up and waiting times down.

A key obstacle is the lack of skilled and experienced staff. In particular, the Government feels hampered in its efforts to reduce waiting lists by surgeons' time spent on their private practice. The majority of surgeons with private practices also work in the NHS. The Government believes this presents a conflict of interest, since private practice benefits from long NHS waiting lists.

In its five year plan the Government stated their intention to prevent specialists from undertaking any private practice in their first seven years as a consultant. Despite an outcry from the profession at this perceived restriction of their freedom, negotiations were entered into between the Government and the British Medical Association: the proposed new contract is now being presented to its consultant membership, who will vote on it later this year. Junior doctors have already voted against.

## The Existing Contract

The broad framework of the existing contract has remained unchanged since the inception of the NHS, having been devised in 1947 to meet doctors' demands that private medicine be allowed to continue.

Consultants are paid a fixed annual salary with automatic merit awards at certain

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### ● UK Private Practice Under the Knife – continued

seniority points, the allocation of which have traditionally been determined by their peers and the medical hierarchy, with the top award doubling the basic salary. Use of time is determined primarily by consultants themselves, with a few sessions each week “fixed” for operating lists and out-patient clinics.

Consultants may undertake private practice but, if full time, cannot earn more than 10 percent of their NHS salary. If part time, private practice earnings are unlimited. The week is considered as 11 sessions of 3½ hours each, with the 11<sup>th</sup> being a notional session to allow for on call work and similar commitments. A consultant is able to take a “maximum part time” or 10/11<sup>th</sup> contract, which overcomes the 10percent limit on private practice earnings. There is a final salary pension scheme.

### The New Contract

The standard working week would be considered in terms of ten four hour sessions for which there is a standard rate of pay. Annual mandatory job planning requires all contracted sessions to be “fixed” and allocated to on-site specified activity. Onerous on-call duties can count as up to two of the ten sessions. A minimum of seven sessions will be for direct patient care.

Annual salary will increase across a number of seniority thresholds, but annual progression will be subject to hospital management approval and will depend on satisfactory fulfilment of job plans and conditions pertaining to private practice. No additional item of service payments for NHS work (such as domiciliary visits) will be made. Clinical excellence awards will be available but not exclusively determined by the medical hierarchy.

If consultants feel they have additional private capacity they must first offer one additional session to the NHS if they have been a consultant for seven years or more, or two additional sessions if they have been a consultant for less than seven years.

The terms of the contract provide for a significant increase in a consultant’s expected lifetime earnings from the NHS. This will be achieved by an agreed pay increase of 3.3 percent in each of the next three years. It is proposed that the new contract will be phased in from April 2003,

being optional for consultants on existing contracts but mandatory for newly appointed consultants.

### The Issues

A heated debate is underway, with opponents pointing to loss of professional autonomy and further scope for managerial and political interference. Those in support point to continued freedom to undertake private practice for consultants with less than seven years experience compared with the Government’s original intentions.

It is hard to predict the effects if the new contract is approved. However, many consultants work far more hours than the expected 40, and the NHS may lose some of that goodwill extra contribution. Those earning relatively little from private practice could find it no longer worthwhile to continue. Those who increase the size of their private practice and reduce their NHS commitments would need to consider pension implications. The division of labour into explicit aliquots may provide an additional incentive for consultants to set up chamber partnerships and contract on a sessional basis rather than remain in direct employment

A key issue will be the provision of cover for private hospital in-patients, since consultants will be committed to on-site attendance at the NHS hospital during their working hours. There will be less flexibility for specialists to meet the combined demands of private and NHS patients

Furthermore, if the medical profession’s current exemption from the European Working Time Directive, limiting employers to requiring no more than 48 hours work, is withdrawn, consultants of less than seven years standing and fully employed by the NHS would effectively lose their private practice, while fully employed senior consultants could undertake only one private practice session.

The Government and the profession now await the results of the ballot – with both sides of the debate predicting success. If the vote is no, a key part of the Government’s NHS plans will have to be rebuilt. If the vote is yes, the new incentives introduced will gradually take their effect over the next few years.

# iFHP UPDATE

## Conference Update

### Amsterdam Conference Rated a Success

**The delegate survey circulated during the Amsterdam conference resulted in 96 percent of respondents giving the event a “good” rating.**

Accompanying the survey ratings were a wide variety of suggestions for improvements to future conferences, concerning the need to reduce focus of sessions on the US and UK, and increase thematic clarity. Several sessions, on the other hand, earned high praise. There was general approval for the overall organisation, and for the social programme, in particular the evening at the Rijksmuseum. But while not reflected in the survey, there were a number of complaints voiced during the conference about the Krasnapolsky Hotel, whose advantages of central location and convenient conference facilities were not matched by quality of management.

Tom Sackville, iFHP Chief Executive commented “Staging a conference in a big busy cosmopolitan city, especially one with an important cultural heritage, appeals to some of our members: others will always prefer a resort, with a more relaxed atmosphere, beaches, pools and other leisure facilities. You can’t please everyone all the time. However, I think we saw Amsterdam at its best with the sun shining, and we were greatly assisted by the huge generosity of our sponsors, especially Achmea, and a very professional local organiser in Gaby van Notten of LGCE.”

The next iFHP biennial conference will be held at the famous Del Coronado Hotel in the Southern Californian resort of San Diego in September 2004. A CEO Forum is scheduled for Sydney in November 2003.

## Federation News

**In November the iFHP Panel on Public Affairs** will hold its second substantive meeting, following the successful launch in Santa Fe in July 2001. Heads of health insurance trade associations and Directors of Public Affairs from member plans from around the world will converge on London for two days of exchanges of views on how the industry should seek to improve its relations with governments, regulators and consumers. These will be accompanied by presentations from public affairs specialists from politically sensitive industries such as nuclear power and financial services, as well as contributions from leading local commentators.

Negotiations on terms are at an advanced stage for the establishment of the first **iFHP World Bank Fellowship**. Following meetings over recent months between Alex Preker, who heads up healthcare development projects for the Bank and Tom Sackville, the programme

will involve a senior executive being seconded by an iFHP member for a two year fellowship at the Bank’s Washington DC headquarters. This individual will act as a liaison between the World Bank and the health insurance industry and will work to further the overall objectives of the Bank of identifying non-governmental healthcare projects which will bring real health benefit to the world’s poorest communities.

Under the chairmanship of Dr Andrew Vallance-Owen of BUPA, the **iFHP Medical Affairs Panel** organised a study visit in September to New England. The visit focused on the theme of quality and variations in clinical practice. A group of medical directors from five countries met leading American authorities on these subjects at Dartmouth College, New Hampshire and in Boston, in addition to visiting local iFHP members Tufts Health Plan of Waltham, Mass.

Plans are afoot to radically upgrade the Federation’s web site [www.ifhp.com](http://www.ifhp.com). Given the growing importance of web presence in corporate image building, a decision was reached to invite a leading London website designer to put forward proposals for an entirely new site, including a management system giving iFHP staff the ability to modify content quickly and easily.

November also sees the **iFHP IT Panel** embark on a study tour of South Africa. Departing from its traditional practice of visiting IT vendors in the USA, the Panel decided to take a look at the highly innovative practical IT applications used by South African administrators on behalf of local health schemes. The tour will be hosted by Medscheme in Johannesburg and Metropolitan Health Group in Cape Town.

## Companies

### BUPA acquisition

BUPA, announced the acquisition of private health insurer AXA Health Australia based in Melbourne, for A\$595 (£227 million) in a consortium with Australia’s Macquarie Bank.

BUPA will initially have a 50 percent stake in the consortium acquiring AXA Health Australia and will manage the AXA business on behalf of the consortium. AXA Health is Australia’s third largest PMI provider and made a profit of £48.5 million for the 15 month period to December 2001 on revenues of £400 million.

BUPA’s Chief Executive Val Gooding said: “The acquisition in Australia extends our overseas portfolio and in particular our business interests in the Asia Pacific region,

which we have previously identified as an area of potential growth.

“AXA is a profitable, established player operating in a genuine mixed economy in healthcare where public and private funding both have a part to play in the delivery of healthcare to patients.”

### Australia – Medibank “Should Be Privatised”

The Australian Federal government has said that a \$100 million loss expected to be reported by Medibank Private “was all the more reason for privatising it”.

Joe Hockey, Minister for Small Business, was commenting on Medibank’s anticipated losses.

In February 2002 Medibank reported that it had lost \$20 million in investments in 2000 – 2001 largely arising from losses on the international stock market and this was one of the reasons the firm was granted premium increases of up to 16 percent earlier this year.

The company was also accused of signing up too many members and now not being able to match spiralling claims with levels of contributions.

Opposition health spokesperson said, “private ownership would only increase the risk of financial disaster.”

**Mercury – 3rd September 2002**

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# UPDATE People

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## Top NZ health expert to head Southern Cross

Dr Ian McPherson one of New Zealand's leading health and insurance experts has been appointed chief executive of Southern Cross Healthcare.

Southern Cross Chairman Bryan Kensington said the health insurer was very fortunate to have found a CEO of Dr McPherson's calibre.

"Ian is one of New Zealand's most experienced health professionals and has a remarkable understanding of both the potential and the challenges that exist within the health sector.

For the past two years, he has been regional general manager of health for Allianz Asia Pacific Ltd, overseeing and managing the group's health insurance operations in Pakistan, the Philippines, Singapore, Indonesia, Thailand and Malaysia.

He is now looking forward to returning home to take on what he considers "the most interesting job in the New Zealand health sector – running Southern Cross.

"With its insurance/funding side and the hospital division, Southern Cross is a very large organisation and one that is fundamental to the fabric of the New Zealand health system.

## Australia – NIB announces new CEO

NIB Health Funds Ltd announced this month, that Mark Fitzgibbon, currently Chief Executive Officer of Clubs NSW, would be the health fund's new Chief Executive Officer.

Mr. Fitzgibbon, who replaces former Managing Director Colin Rogers, will take up the appointment on October 9 this year.

Chairman, Mr. Keith Lynch said Mr. Fitzgibbon had been offered the position after a nationwide executive search that considered candidates from within and outside the private health insurance industry.

"Mark has an impressive record in change management and strategic planning, two areas on which NIB will be focusing as the health insurance industry undergoes a period of significant reform," Mr. Lynch said.

## Australian Unity appoints new Group Managing Director

Chairman of Australian Unity, Mr. Alan Castleman, announced the appointment of Mr. Ian Ferres as Group Managing Director, commencing July 2002.

"Ian Ferres joined our Board some 3 years ago as a non-executive director and has been a most active Board member," said Mr. Castleman. "His vast managerial experience, gained for the most part at the former National Mutual Group, included 15 years controlling investment management operations, in addition to National Mutual's operations in banking, building societies, finance companies and unit trusts".

Mr. Castleman continued, "I consider we are fortunate to have the commitment of such an

experienced and highly regarded executive and company director leading Australian Unity."

## Executive Development Programme Launched

**The Federation has taken an important step towards developing a significant educational role by launching an Executive Development Programme (EDP). Details of the programme were circulated earlier this year to principal contacts in each member plan.**

In the first year (2003) the programme will consist of visits to 5 countries, spread over two fourteen day sessions in March and September. A group of around ten senior managers, nominated by their respective Chief Executives, will be hosted in each country by a member of the Council of Management. The group will be exposed to an intensive series of presentations, discussions and visits on the business processes of the host plan, the local healthcare scene and private health market and the political and regulatory situation affecting health insurance.

It is hoped that the EDP will become a regular annual event and will come to be seen as an important benefit of iFHP membership. The first year's group will visit Sydney, San Francisco, Amsterdam, Dublin and London.

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**international  
federation of  
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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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