SOCIETY OF ACTUARIES

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FES cont'd

Canada and in the U.S. Course P-561C, Social Insurance in Canada, comprehensively covers the major Canadian social insurance programs. Course P-562U, The OASDI and Medicare Programs in the U.S., thoroughly describes these programs with emphasis on OASDI. Course P-363U, Executive Compensation, discusses various deferred compensation schemes. It includes readings on available funding/security vehicles. To date there is no comparable Canadian course.

Course P-560, International Pension Issues, provides an overview of how retirement programs work outside North America. Readings cover the design, financing, taxation and accounting for retirement programs in such key overseas countries as the United Kingdom, West Germany, France, Japan, Brazil and Mexico. These countries were chosen because North American clients of pension practitioners are likely to have subsidiaries or affiliates there. Course P-564, The Actuary as Expert Witness, introduces a growing area of actuarial practice involving an increasing number of pension consulting actuaries.

As part of the FES system, the E&E Committee created new volunteer positions called Course Content Officers. Each specialty track has an Education General Officer responsible for the Course Content Committee for that Track. The Pension Track has two such individuals, one for Canadian courses and one for U.S. courses, who are active as pension consulting actuaries. The Course Content Officers are responsible for the development and ongoing maintenance of the courses of reading. Of the 14 Pension Course Content Officers, 12 are pension consultants, one is the Deputy Chief Actuary of the Social Security Administration, and one is Vice President, Pension Investment Division, for a large insurance company. Each Course Content Officer is responsible for a particular course in his or her area of expertise.

With this structure in place, we are confident that the syllabus can be kept current and that new courses can be developed as the pension practice evolves.

Wayne R. Berney is Vice President and Consulting Actuary with The Alexander Consulting Group Limited. He was formerly Education Actuary on the SOA staff.

Thoughts of a morbid *gaijin*

by Charles Barry H. Watson

Let me make one thing clear at the start. By "morbid," I mean physically sick, and hence obsessed with health (not death). And for the record: a *gaijin* is a non-Japanese (myself) in the Land of the Rising Sun.

Some years ago, I became ill while on a business trip to Japan and spent a month in the intensive care unit of a Tokyo hospital. Now illness is no pleasure anywhere, and certainly not a healthy state to be in. And medicine is medicine, at least at the top of the line, whether in Tokyo or Helsinki. Nonetheless, the conditions and forms of medical care vary tremendously depending on the society, and these can affect dramatically the hospital experience.

So it was with me in Japan. Although the general form of treatment was what I would have expected in this country, there were enough differences to create a vastly different environment which, to my mind, had much to recommend it. At least, I was a far happier patient there than I have been here, and I suspect this carried over into the healing process.

What follows is a nonorganized listing of what I saw as the major differences between the Japanese and American hospital worlds.

- To begin with a negative, language was a problem. My attending doctor spoke excellent English and appeared to understand it equally as well, but this was not true of all the doctors and certainly not of the nurses. They wanted to practice English and carried a well-thumbed dictionary of medical terms, which I ended up using as well, but to little avail. Fortunately, I had two bilingual associates who visited me every day and smoothed the ruffled feathers. I recommend at least one such associate to everyone as the essential item to take along to a Japanese hospital.

- The language problem was one reason why I ended up staying in a private intensive care room for much longer than I needed. That got the *gaijin* out of their hair.

- Speaking of doctors, mine was superb. Young (late 20s), head of his department, vitally interested in my case. (He told me later that he had only by chance been at the hospital when I came into the emergency room, and he had asked to take me on as he had never before treated anyone with my form of illness. Nice to hear this, afterwards.)

- Despite his virtues, he initially suffered from a common flaw. He, like everyone else in the hospital, would not discuss with the patient (me) what was being done or why, and I, like the typical American, wanted to know everything. We argued. He, to his credit, eventually gave in and told me at least enough to make a coherent story.

I was told later by my associates that Japanese patients are "very tender" and do not want to know anything about their illness. Their doctors oblige. This was exemplified by a recent court case in Japan, where surprisingly a doctor was sued for refusing to reveal the fatal nature of a patient's illness. The doctor defended himself on the grounds of medical propriety and, not surprisingly, won!

- Passing on to pluses, the hospital was extremely high tech. Test results were passed from place to place by a form of robot, and the clinical thermometer was a thing of wonder. Some of the tech was perhaps a bit too high; a miniaturized camera was thrust down my throat and clicked away for some time. ("Just a deep down smile, please.") Disconcerting, to say the least. Fortunately, though, it was not a CAT scan; they couldn't have got even a kitten down there.

- The big plus was the food. All fresh, and new and different to my eyes. (Remember, I couldn't read the menu.) This was a remarkable change from the low-tech cardboard, "nuke and puke" warmed-over meals we get in hospitals here. I actually looked forward to meals and not just because of boredom.

- The Japanese aim to keep hospital costs down, with the result that they concentrate on what they see as the key elements of hospital care.
  - Bedwear (robes, gowns, etc.) is provided by the patient and not the hospital – either from home or purchased (at a reasonable cost) in a hospital store. (Saves money for the hospital.)
  - Since the hospital does not own the gowns, it does not wash them (at least

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Two actuaries 'visit' IRS

by Karen Krist and Amy Viener

Since early 1989, the staff of the National Office of the Employee Plans Division of the IRS has included two "visiting actuaries," Karen Krist and Amy Viener. We are each on leave from our private sector jobs, visiting the IRS for two and one years, respectively. The program is new, and in this article we would like to give our fellow actuaries some idea of why we are here, what we are trying to accomplish, and how it's going so far.

There is a strong attraction to a temporary assignment, which is related to but different from a permanent job. Students take a junior year abroad; professors take sabbaticals. The visiting actuary program offers us a similar opportunity: the chance to work in the same field, in a different environment, in a totally different capacity. In Amy's case, it also offers the opportunity to live in Washington, D.C., for a year.

Most actuaries would shudder at the thought of taking a year off knowing all too well that in this ever changing field, it would be very difficult to catch up. But, as is the case in a junior year abroad, this program will leave us better educated than had we remained "on campus."

We expect all participating parties will benefit from the program. When we return to our consulting firms, Amy to Kwasha Lipton and Karen to Mercer Meidinger Hansen, we expect to function more effectively and intelligently when dealing with problems that involve the IRS. This is not a matter of "clout" but of understanding the process and how, realistically, one can hope to influence it from the outside.

Initially it seems that our clients are being short-changed, being tossed aside to other consultants during our absence. In reality, we're probably a lot more valuable to our clients while we're here. For no consulting fee, we can voice our opinion when an IRS official suggests yet another demographic test that would be an administrative nightmare to perform. After we return to the role of consultant, our clients will continue to benefit from the experience gained during our time with the IRS.

In the meantime, we are trying to bring our understanding of the outside world to the projects on which we are working on a daily basis. We think that we have a useful perspective to offer and that we have made at least a little difference so far.

Just what are we doing? An important function for each of us is participation in the process of formulation and drafting of revenue rulings, procedures, and notices. It has been said that no one should know how their laws and sausages are made. Our experiences have confirmed that, so we will not comment further.

Since Karen spends most of her time in Chicago, she is working on agent training and on some compliance issues. She has represented the IRS as an expert witness in some legal proceedings. Amy is located in Washington, D.C., and is more involved in the daily activities of the national office, including attending meetings to discuss forthcoming regulations and answering the "hot line." She coauthored the 412(m) notice and

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Gaijin *cont'd*

for free). A hospital subsidiary does the laundry for profit, and nearly everyone uses it. (Makes money.)
– Bed linen is changed only once a week, or as necessary. (Saves money.)
– The meals are good, as I have said. However, any food or beverage (soft drinks, etc.) over and above the defined menu must be provided by the patient; each of us had a refrigerator storage slot. (Saves money.)
– Speaking of meals, in country hospitals most cooking is done by the patient's family. I had no family there and so could savor the local cuisine. (Saves money.)
– Despite the high-tech atmosphere, the elevation of the hospital beds was controlled by hand cranks, rather than electricity – "Nothing wrong with the beds, so why throw them away." (Saves money.)
– Doctors (and nurses) came around by themselves, rather than in troops. I guess they were not afraid of being by themselves – less litigation? (Saves money.)
– Nearly all accommodations were ward style. I do not recall seeing true semi-private (two to a room), and I had the only private room in intensive care. Language of course. (Saves money.)
◦ Then there were peculiarities. In the land of electronics, there was no television in the rooms, and none could be rented. (I was reduced to a Walkman.) Perhaps the ward accommodations made this necessary.

Obviously, some of these differences can be debated on the grounds of utility or standards of care. However, there is no doubt the costs of medical care were lower as a result. I was able to determine that, on days when no major procedure was being carried out, my total medical cost (hospital, drugs and doctor) was less than the cost of my room at the Tokyo hotel where I had been staying before moving to the Medical Marriott. It was tempting to fantasize that, on my next trip to Japan, I would just collapse in the airport and book into a convenient hospital.

Incidentally, the purpose of my trip had been to explore the feasibility of establishing a consulting office in Japan. I thought of proposing that we set up our office in a hospital and staff it with sick actuaries (physically, of course). I doubt it would have been accepted, but it might have been cheaper!

Obviously, every person's experience in illness will be different. However, the differences were so striking and, to me, so beneficial, that I believe there is much we can learn from the Japanese on how to run a health system. I suggest we explore this before our health costs exceed the GDP.

Charles Barry H. Watson is an Actuary with The Wyatt Company. He is a former Vice President of the Society and a former President of the Conference of Actuaries in Public Practice.