



international
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iFHP NEWS

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Risk Equalisation Deferred

The Irish Health Minister Mary Harney announced in June that she had decided not to accept the recommendation of the Health Insurance Authority to activate Risk Equalisation 'at this time'.

She said "the Irish Government is committed to the maintenance of community rating" and stressed that risk equalisation is a necessary support, in certain circumstances, in a community-rated market.

She said an introduction of risk equalisation payments 'at this time' would be premature in advance of a

Government decision regarding the commercial status of the Vhi.

She said she intends to bring proposals to Government on the status of the Vhi shortly.

She added that deferring a decision on risk equalisation would allow time for further corroboration of trends both in risk profile and competition in the market, and in this regard she looked forward to receiving the Health Insurance Authority's next report on insurance market trends in Ireland. The HIA prepare a report every 6 months. The next report is due in

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Boost to Canadian private health?

A landmark decision by the Supreme Court has overturned the long-standing ban on private medical insurance in Quebec. The ruling will potentially have major implications for the health insurance system in Canada.

To date Canadians have been prohibited from taking out PMI or purchasing private treatment for basic medical services provided under the state system known as Medicare. The

Medicare system effectively committed the Government to providing free healthcare to all citizens and although the system is considered to be one of the most equitable in the world it too has seen a significant increase in waiting times over the past few years. Many who are on waiting lists undergo treatment in the USA instead. The Supreme Court decision allows Canadians to purchase PMI policies to avoid having to wait for surgery. The

decision applies at present only in Quebec but is expected to have implications also for other parts of the country.

Pierre-Yves Cullen President and CEO of Medavie Blue Cross, Canada said; "over the next ten years, Medicare, the fabric of Canadian culture is poised to undergo a major mutation in order to adapt to the new spectre of private health care".

**Source Laing and Buisson,
AHIP Solutions Smartbrief**



Editorial

It suddenly struck me during a recent presentation in Boston, part of our current EDP programme, that I had discovered one reason for the mysteriously high cost of US healthcare. We were listening to the head of a practice association representing over a thousand local doctors: he was unapologetically boasting of his success in negotiating with payers, mainly insurers and Medicare, to improve the pay of his members. When I (perhaps less than tactfully) suggested to the next speaker, a health writer from the Globe, that his predecessor was acting clearly against the public interest, he seemed perplexed.

Of course I probably got the wrong end of the stick. If I have learnt anything during the few last years of attending healthcare events, whether organized by ourselves or others, it is this: when you hear someone pontificating about health systems of countries other than

their own, especially yourself, look out for the possibility that they are talking through their hat.

Health economists will always come up with a set of slides on any part of the world you like, replete with statistics and flow charts. But the finer points often seem to escape them: as with a foreign language learnt in adulthood, we only seem to only have a feel for the nuances of the health system where we have spent most of our working lives. Which of course makes the science of comparative health systems rather uncertain: but it does allow me to offer no apology for basing the rest of this piece on my perceptions of the UK.

The winning of the 2012 Olympic Games for London made the British people very happy, though sadly only for a few hours, before the gloom of the ghastly events occurring in our tubes and buses.

But while it lasted, it was remarkable for several things. It caused people to hug complete strangers in the street, something we have never felt was quite proper behaviour. It led to a sudden outpouring of a repressed (for at least 60 years) emotion, namely sympathy for the French, for being so disappointed at losing. It also was a huge surprise, having been brought about through a brilliant feat of salesmanship by a small group of politicians and the sporting establishment, against a background of almost complete indifference (until we won) on the part of the population at large, especially that of the host city.

Let me suggest an explanation for the latter: staging the Olympics, British style at least, is managerially and financially in the hands of the government. It is one of those prestige projects about which, like declarations of war, ordinary people are not consulted. In rare cases, such projects will serve a purpose. Mussolini's *autostrade* at least still get us

peckish north Europeans down to Naples for a decent slice of pizza in the blink of a pair of RayBans.

But in Britain we have a long and proud record of civil service brainchild, stretching from the post-war Ground Nuts Scheme, an attempt to provide modern agriculture and employment for the then Tanganyika, to the Millennium Dome, a large tent-like structure in east London, at nearly a billion pounds perhaps the most expensive encampment in the history of mankind.

We have come to accept that where the first-class intellects in government are deployed, any project will cost far more than it should, and produce less.

IT schemes are now prominent in the hall of fame of our official triumphs. And we're not done yet. With the best of intentions, the English (not the canny Scots, note, nor the Welsh nor the Northern Irish) have set about computerising the 400+ major public hospital sites, digitalising and linking fifty million patient records. This will enable doctors removing a pair of tonsils in North Manchester to know that the patient stubbed his or her toe on Southend Pier last September, at the touch of a button. Value of contracts signed to date, US\$10 billion.

All of which is of course, like Kaiser Permanente's less ambitious and far better rehearsed HealthConnect project, in a good cause, the more efficient provision of healthcare. It is also ground breaking stuff which is potentially of great relevance to the future of our industry. So watch this space, or better still come to our Barcelona conference when these matters will be discussed at more length.

Walter J. McNerney

We are sad to hear of the death of former iFHP President Walter J. McNerney who passed away on 29th July 2005.

Walter was former President and CEO of

Blue Cross Blue Shield Associations and Professor of Health Policy at Kellogg Graduate School of Management, Northwestern University, USA.

He was a founder member of the Federation and spent 13 years as a member of the

Council of Management. During this time he served two terms as President, the first in 1970 - 72 when he succeeded Sir Ronald Grieve and again in 1980 - 81.

We send our sympathy to his family at this time.

Facing the challenge of HIV/AIDS

Cimas Medical Aid Society

Macdonald Chaora & Dr. Maria Mupanomunda of Cimas Medical Aid Society, Zimbabwe, outline an initiative taken by a not for profit medical insurer operating in a high HIV/AIDS prevalence environment.

Background

In July 2003 CIMAS Medical Aid Society launched the Chronic Diseases Add-on in an effort to reduce the morbidity and mortality associated with HIV/AIDS among the Society's membership.

The Cimas Chronic Diseases Add-on is an additional contribution available to members at employer level to cover the costs of treating HIV/AIDS. Once an employer decides to join the Add-on scheme, all beneficiaries ordinarily covered under that employer should be enrolled. This maintains confidentiality at work and helps keep costs down by maintaining cross subsidy.

The Society supports treatment regimes that are in line with the National Guidelines for Antiretroviral Therapy in Zimbabwe. Generally, first line treatment for adults consists of two nucleoside reverse transcriptase inhibitors and one non-nucleoside reverse transcriptase inhibitor. Second line treatment contains two reverse transcriptase inhibitors that were not included in the first regime and a protease inhibitor (e.g. lopinavir/ritonavir).

Patients are attended to by their usual doctors who have received additional training on the use of antiretroviral drugs. An arrangement between Cimas and some pharmaceutical wholesalers and pharmacies enables covered members to access antiretroviral drugs, after paying only a small service fee to the

dispensing pharmacist. Members can also access viral load and T cell profile tests for monitoring therapy or disease progression.

Cimas Coordinated Care Department maintains a register of antiretroviral use and utilisation of laboratory tests. Information so obtained is used in procurement planning and also enables identification and follow up of inactive members.

To date there are over 60,000 lives covered under the Chronic Disease Add-on and nearly 300 beneficiaries have accessed antiretroviral drugs.

Observations

Utilisation has been low and we suspect this is due to a combination of factors including lack of information and stigma associated with the disease as well as costs. Cimas has stepped up information dissemination targeting those who are in regular and direct contact with members. Cimas also encourages employers to have workplace HIV/AIDS policies and programs.

Cost of treatment is affordable for many on medical aid if the scheme is structured under the principles of managed care. The medical aid must be involved in setting up a network of providers and drug and laboratory logistics.

The additional contribution for Add-on is ZW\$3,600.00 per adult per month and ZW\$2,400.00 per child per month. Average monthly costs for treating patients on the standard regime (first line) is currently ZW\$230,000.00 (about US\$33.00)

For further information please contact Macdonald Chaora CEO of Cimas Medical Aid Society.

World News

Australia

Mayne Group has said it is considering a break-up of its pharmaceutical and other health care divisions. Its pharmaceutical division has been valued at \$3.1 billion with the remaining radiology, pathology, pharmacy and consumer operations worth \$2.1 billion. The Group has said that it is determined to demerge and separately list its international business Mayne Pharma and its local businesses made up of Mayne Diagnostic Services, Mayne Pharmacy and Mayne Consumer Products. It has also decided against listing its international pharmaceutical business on the London or New York stock exchanges due to the high costs involved.



Source The Weekend Australian Financial Review.

UK

BUPA announced the acquisition of two insurance businesses in July. They are the Danish business IHI danmark and AMEDEX which has its head office in Miami, Florida.



IHI danmark employs 450 people and supplies health insurance and well being services to 240,000 individual and corporate customers in over 190 countries. It is the world's largest international health insurer for the personal market.

AMEDEX provides health and life insurance to more than 100,000 people in Latin America and the Caribbean. International Businesses managing director Dean Holden said "over a third of BUPA business now comes from its international operations. These acquisitions will give us a market leading position in Latin America and a strong position in Europe."

Source BUPA Today



Sale of Medibank Private “on the agenda”

The Australian Government has put the sale of Medibank Private “back on the agenda” according to recent reports in the Australian press. Medibank Private has 1.6 million memberships covering more than 3 million lives which represents 30 per cent of the health insurance market. The sale value has been estimated at \$1billion.

The Government had previously commissioned a scoping report on the sale of Medibank Private in 2002 but decided against a sale at that time due to the losses incurred by the company in 2001-2002. Last year however the company reported a \$44.8 million operating profit and the government

has reportedly revised its consideration of sale. The federal opposition has accused the government of “fattening up” the non-profit Medibank for sale instead of returning its profits back to members by way of increased choice of providers and lower gap fees.

The health insurance industry meanwhile has been encouraging the government to privatise Medibank Private on the basis that “it would create a level playing field for the industry.”

MBF and BUPA Australia have apparently both expressed an interest in acquiring all or part of Medibank Private if it does come to the market.

In a recent media report Tony Abbott Federal Health Minister played down reports of a sale saying “there had been no further scoping study on a sale.”

Also in a recent Standard and Poor’s health insurance report, it was stated that the private health insurance industry was “ripe for a period of takeover activity” especially if the sale of Medibank Private went ahead. Australian Prime Minister John Howard has also said that selling Medibank was “way down on my list of priorities”.

Source *The Australian Financial Review; The Australian.*

Risk Equalisation Deferred *continued from front*

September following a review of returns for the 6 months to 30th June 2005.


If risk equalisation had been triggered, BUPA, which has a younger and less high-risk patient profile, would have had to pay the Vhi up to 34 million euro p.a. in compensation (based on returns for 6 months to 31st December 2004). Clearly this amount would

change as the risk profile of respective companies changed.

BUPA had already indicated it may have to consider pulling out of Ireland if it had to make transfers to a risk equalisation fund and is currently challenging the risk equalisation scheme in the courts. Martin O’Rourke, Managing Director BUPA Ireland welcomed the Minister’s commitment to community rating and competition. He said: “This is good news for consumers. We have always said that risk equalisation makes competition unviable. We remain committed to community

rating and note that competition has brought to the market, unprecedented stability as well as consumer benefits never previously enjoyed”.

Vhi said “the Minister’s decision left unanswered the question ‘who will finance community rating in Ireland?’ Between 1997 and 2003 Vhi has passed the full cost of this on to its members but in September ’04 decided this was inequitable and unfair and would absorb the cost out of its reserves. Clearly this is not sustainable for very long.”



US Study Tour Examines Value of New Health Technologies

In late June under the aegis of the Medical Affairs Panel, chaired by Dr Andrew Vallance-Owen, senior iFHP members from six countries enjoyed presentations on aspects of US state-of-the-art health technology.

Starting in Kaiser Permanente's Rockville, Maryland operation, the group received a comprehensive presentation of the ground-breaking HealthConnect deployment. The largest healthcare IT project of its kind in the world, HealthConnect seeks to digitalise the medical records of over 8 million members and establish a paperless system linking thousands of health professionals and facilities across the Kaiser system in 9 states. Most striking was the extent to which the programme involved tried and tested technology with few technological surprises. The accent was clearly on implementation and the need to achieve management focus at every level, and high levels of user engagement. An example was the use of "black out" periods 4 weeks before and 4 weeks after each go-live, during which staff are not asked to participate in other initiatives. In view of the numbers of health IT initiatives around the world which have failed on implementation in recent years, this was judged to be an admirably pragmatic approach!

The Washington DC part of the tour involved in-depth discussions with the NCQA, leading accreditor of US non-governmental health

enterprises, on the evidence available for the success of disease management and complex case management programmes deployed by health plans. NCQA is acting as adviser to the US government in identifying programmes which would be beneficial to their Medicare and Medicaid populations. A working lunch followed covering similar topics with Carmela Bocchino, Medical Director and Diana Dennett, EVP of America's Health Insurance Plans (AHIP), and a discussion on likely future governmental action on the vexed issue of the uninsured (and underinsured). The conclusion was that the case for a real ROI on disease management was as yet unproven, despite evidence of significant health benefits for plan members most affected.

The tour concluded with a visit to ECRI, America's leading non-profit health technology assessment provider, located in Plymouth Meeting, near Philadelphia. ECRI provide a number of services to healthcare enterprises in the USA and elsewhere, principally reports on the available clinical trials data for drugs, medical devices and procedures. Subscribers to ECRI are eligible to receive an annual quota of reports, as well as to request customised technology assessments or commentaries on health trends. The group was clearly impressed by ECRI's stringent standards of independence from provider or other interests, and several members indicated interest in a continuing relationship.

World News

UK

WPA has launched the 'first of its kind' insurance product in the UK which provides cover for elderly patients discharged home from hospital. ParentCare will provide relatives with 7 to 21 days of home care services through WPA partner Allied Healthcare and will include domestic and nursing duties.

WPA Chief Executive Julian Stainton said "many people say they cannot not easily take time off work to travel often hundreds of miles to look after recuperating parents much as they want to. This new plan can help organise professional homecare with just one phone call."

The scheme starts at £7 per month with up to 75% of the cost of care paid by the insurer to a maximum of £300 a day.

Source Laing and Buisson

UK

BUPA Results

BUPA reported a surplus before tax of £182.2 million (£134.5 million) for the year to 31 December 2004.

Announcing record results, chief executive Val Gooding said that all major business divisions within the group performed. Growth was largely organic and the increase in surplus before taxation included strong performances in BUPA's overseas insurance businesses (including those in Spain and Australia), UK care homes and a better year for BUPA Hospitals. BUPA's care homes portfolio was expanded in the year with the acquisition of 13 homes in the UK. In Spain, it opened two new care homes and took over the management of one other.

Group income was £3,627 million (£3,368 million). Income from insurance activities in the UK and overseas grew to £2,464 million (£2,281 million) and income from non-insurance activities including hospitals, care homes, occupational health and health screening, was £1,163 million (£1,087 million). Reserves grew by £103 million to £1,409 million.



Kaiser's new South California boss takes up EPR challenge

Kaiser Permanente America's largest nonprofit health insurer has started work on digitalising the medical records of its 8.3 million members. Eventually all of Kaiser's 8.3 million members nation-wide will find their records available electronically.

Dr. Benjamin Chu the recently appointed president of Kaiser's Southern California region, which serves 3.1 million members with a budget of more than \$11 billion and runs 11 medical centres from Bakersfield to San Diego has made the initiative a priority. Dr Chu said that it was Kaiser's unique integrated model which attracted him to his new job.

"We're not just an HMO plan, we're a provider as well," he said. "That's a powerful model."

As a result, he said, "All the pieces are here," not only for computerising records, but for using that system to cut costs and improve care.

"Once you know who in your population has what illnesses and how severe they are, you can think creatively about getting the healthcare system not to be just reactive but proactive," he said. "Our mission is to keep people as healthy as possible, even before they get sick."

The system will give doctors access to up-to-the minute lab results and diagnostic images,

allow instant referrals, transmit prescriptions immediately and will let healthcare workers treating a patient from different locations share information. By 2007, when the system is due to be complete, Kaiser members also will be able to access their own medical records through the Internet.

Kaiser's effort, called KP HealthConnect, is part of a nationwide information technology initiative endorsed by President Bush that includes "E-prescribing". Hospitals around the country are embarking on ventures similar to Kaiser's — but none on this scale.

Opponents to the project say electronic records may be harder to keep confidential than paper ones.

"I understand the reasoning behind this," said Beth Givens, director of the Privacy Rights Clearinghouse, a San Diego nonprofit advocacy group. But "how do you make sure people have legitimate access to just the information they are entitled to?"

Kaiser's new system is designed to resist hackers, will be password protected and will meet or exceed federal requirements for patient safety, Kaiser officials say.

This is an extract from an article by Debora Varana that appeared in the Los Angeles Times.

The iFHP Medical Affairs panel recently spent a day with Kaiser's plan in Maryland and received a briefing on progress of implementing the programme.

Meanwhile delegates at the British Medical Association (BMA) conference in Manchester, England raised concerns about the UK Government's plan to put patient health records onto a centralised computer system, saying that the plans "risk exposing millions of people to data theft and will be a greater infringement of personal freedom than the introduction of identity cards" (also being debated in the UK.)

Fears were raised at the way in which the system being developed by NHS Connecting for Health could be misused both by the Government and by computer hackers.

Initially only demographic information will be collected but this will in the future also include medication and other health details in the future.

A poll of 2,000 patients found that 75 per cent had concerns about the security of information.

Dutch insurers set out for new system

'Offering good products, creating new forms of interaction, presenting an image of social enterprise and enhancing transparency'. Achieving these four goals for and on behalf of Dutch health insurers is crucial in the coming years, according to general manager Martin Bontje of Zorgverzekeraars Nederland (ZN) in Jaarbericht 2004 (annual report).

ZN is the trade association for Dutch health insurers, which celebrates its 10th anniversary this year. The coming months are of vital importance for health insurers in The Netherlands. A major change in the insurance system is on the way as a new health

insurance system for all Dutch citizens will come into effect on January 1st 2006. The current distinction will disappear; where mandatory public health insurance covers two thirds of the population and voluntary private health insures one third. Most health insurers in the Netherlands have decided to carry out the new insurance, which can be characterised as "a private social health insurance." 'Private', because people are no longer insured by right but have to take action themselves to take out insurance. Insurers are also allowed to work for profit. 'Social', because there are some restrictions health insurers have to deal with, like mandatory enrolment (every person who applies has to

be accepted) and no risk adjusted premiums (average premiums).

ZN will support its 37 members during this huge reform. Our aim is to realise a smooth change between the old and new system. One of the products ZN offers is an e-mail helpdesk for employees of health insurers. Furthermore, ZN has launched a website for consumers to inform them about the new health insurance system.

Walter Annard
Director Public Affairs Association Dutch Health Insurers
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On the Move

South Africa

Rod Gush has retired as CEO of Bankmed, Capetown SA. He is currently acting as Chief Executive of BHF South Africa whilst a new appointment is sought. **Len Deacon** is acting General Manager of Bankmed.

Penny Thalbi formerly CEO of BHF, SA has joined the Board of Discovery executive committee in South Africa.

Also joining Discovery is **Dr Jonathan Broomberg** formerly of Praxis Capital which he founded, a private equity and venture capital firm investing in healthcare and education in Southern Africa.

USA

Cleve Killingsworth Jr. has been named as President and Chief Executive Officer of Blue Cross Blue Shield of Massachusetts (BCBSMA) effective July 5, 2005. He is taking over the role from Bill Van Faasen.

Bill Van Faasen had led BCBSMA as CEO for almost 13 years. Cleve Killingsworth was named President and COO in December 2003, and began his tenure at BCBSMA in February 2004. Cleve came to BCBSMA from Health Alliance Plan (HAP) in Detroit where he served as President and Chief Executive Officer.

New Zealand

Steve Boomert has taken up the job of CEO of Tower Health in New Zealand. He was formerly Corporate Development Manager for Medibank Private in Australia.

UK

PruHealth, the UK joint venture between Discovery Holdings of South Africa and Prudential UK in the private medical insurance market, announced the appointment of **Shaun Matisonn** as its new Chief Executive.

Matisonn is already a member of the PruHealth Board and a member of the Discovery executive, where he has been for over 10 years.

PruHealth was successfully launched in the UK market late last year. Catherine McGrath, the outgoing Chief Executive, leaves the business with the best wishes and thanks of the PruHealth Board for the immense effort that she and her team invested in the set-up phase of the business.

Biennial Conference

**Barcelona
14-16 May 2006**

Conference update

Stuart Altman will be a keynote speaker at the 2006 conference in Barcelona.

Professor Altman is an economist whose research interest is primarily in the area of federal and state health policy.

He has been awarded the Academy Health Distinguished Investigator Award and in 2003 was named by Modern Healthcare among the 100 most powerful people in Healthcare. He is a member of the Institute of Medicine at the National Academy of Sciences and the Committee on the Future of Emergency Care in the USA. Professor Altman has an MA and PhD in Economics from UCLA and taught at Brown University and the Graduate School of Public Policy at University of California at Berkeley.

Professor Altman is also a Board member of IDX, the leading US health software supplier who are partnering with BT for the £1 billion London Region NHS national programme for IT (NPfIT).



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New members

ORGANIZACIÓN SANITAS INTERNACIONAL (Colombia) SA

Colsanitas was founded in 1980 and is the market leader in Colombia.

It has over 40 offices located in 25 cities throughout the country. Sanitas Venezuela: provides services to more than 95,000 users throughout the country.

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Roberto Cochetoux Tierno
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RESOLUTION HEALTH, South Africa

Following the merger of Metropolitan and Commercial Union Life Assurance, Resolution Health took over the fiduciary responsibilities and was re-launched in 2000. It has grown from a tiny membership base to over 35,000 principle members.

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ACIBADEM LIFE AND HEALTH INSURANCE, Istanbul, Turkey

Operating in health and life insurance sectors since 1994, Bayindir Life Insurance was taken over by the Acibadem Healthcare Group in February 2004 and renamed as Acibadem Health and Life Insurance Inc. Acibadem Healthcare Group plays an important role in making health insurance an integral part of

the health system. Acibadem Health and Life Insurance currently operates with 287 agencies, 143 sales personnel, 28 brokers and 114 administrative personnel.

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