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Well, what a fantastic week it was in Athens! Heated debates, never-ending networking opportunities and more meetings than you can count! With more attendees than ever before at an ITIC Global, Athens 2015 perfectly showcased the increasing importance of our global travel and health insurance industry. From sessions on cost containment in the US, to mental health coverage in travel policies around the world, and industry insights dedicated to sharing information between experts, the educational aspect of the conference really was a great success.

The Welcome Reception at the Aegli Zappiou, complete with great food and some local dancers providing the entertainment, was appreciated by the hundreds of people who attended. Rounding off the conference with the Finale Dinner and ITIJ Industry Awards was a spectacular way to end the week in Athens. The Megaron Concert Hall provided a perfect venue for the ceremony, which was a grand affair enjoyed by everyone there – and with our live broadcast being watched by thousands of people around the world, it’s safe to say that this year was our best ever!

Thanks to all who sponsored the event and the Awards, and on behalf of the ITIJ and ITIC teams, we look forward to seeing you all next year in Berlin!

Ian Cameron
The Official ITIC Welcome Reception was held in the Olympia Hall of the Aegli Zappiou, in the beautiful national gardens of Athens. On offer was plenty of wonderful food and drinks, along with music and entertainment from some local Greek dancers, who were joined by some enthusiastic ITIC attendees! The packed venue was testament to the growing success of ITIC Global, showing just how many industry professionals consider the conference to be an unmissable part of their annual event calendar.
Networking at ITIC Athens

Team ITIC would like to thank all the exhibitors and sponsors that contributed to making the week in Athens such a success. The ITIC Exhibition Area gave attendees a chance to meet with top industry providers from all sectors of the business, including air ambulance companies, assistance firms and software developers. Elsewhere, the Networking Lounge provided a central meeting point for attendees, and the lunchtime drinks offered some much-needed refreshment!
Lunchtime drinks sponsored by ACE Air & Ambulance Ltd on Tuesday and TMH Medical Services on Wednesday.

Networking Lounge sponsored by Commercial Medical Escorts & REVA, Inc.
How well do you know your air ambulance suppliers?

Andy Lee
International Business Executive,
ER24 Global

Andy brought to this presentation his signature engaging style and a serious message to buyers of fixed-wing air ambulance services – caveat emptor. Standards, which should be the same across the market, said Andy, still vary widely. Assistance companies, therefore, need to know how to assess which are quality providers, making use of independent, knowledgeable auditors to assess potential partners.

Andy noted that there are various accrediting bodies around, such as the Joint Commission International, ISO, EURAMI, CAMTS and NAAMTA. ER24 recently went through the accreditation process with NAAMTA, as the company felt it was the best fit for its fixed-wing division, but Andy recognised that what suits one provider may not suit another. He added that NAAMTA, EURAMI and CAMTS are ‘vital’ for the air ambulance industry, as they help providers to show that they are attempting to raise the level of standards they provide to clients.

The existence of unscrupulous brokers remains an issue, said Andy, referring to those who have little more than a website and a phone line, offering no transparency to the purchaser. He recently performed an Internet search for ‘air ambulance in Cameroon’, and found what was clearly a broker website – it claimed to have services in 225 countries and a fleet of aircraft from a helicopter to a large jet, all in air ambulance configuration, with highly trained medical teams. However, there were no licences, credential documents or accreditation certificates. He tried calling the ‘international communications centre’, but after many rings only got through to an answerphone. The sad thing, said Andy, is that websites like this exist because they get business.

When assessing a new air ambulance provider, there are some initial questions an assistance company can ask to gauge, not least, whether it is a real provider or just a broker with a phone. Ask to see documents including the air operator certificate, pilot and maintenance records, and insurance papers. Ask whether the medical team has critical care experience, and what medical equipment and drugs are carried onboard the aircraft. Ask whether there is a call centre staffed round the clock, or if someone takes a phone home or switches on an answerphone. Regarding the aircraft fleet, ask for tail numbers and registration documents. Ask what medical records are kept (this is a good one, said Andy, as brokers are unlikely to keep records). All these questions will put a broker under pressure, whereas a genuine operator should have no problem answering them. Andy suggested they can be written up as a standard sheet that is sent to providers to help sort the wheat from the chaff.

In conclusion, the payers – insurers and assistance companies – need to buy into the need to raise standards.
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Evacuate or treat? When is an air ambulance transfer acceptable?

This session began with a look at traveller and expatriate needs regarding evacuation and medical treatment cover by Grégoire Ezanno of APRIL International, and an introduction by moderator Julie Remmington to the different factors that need to be considered by assistance companies when making the important decision of when to evacuate a patient to their home country or whether to treat them locally. Each entity— including the insurer, the assistance provider, the air ambulance company and the patient—involved in such decisions usually has different priorities, but the patient’s safety is always the overriding decision driver.

Dr Thomas Buchsein

Medical Director, FAI rent-a-jet AG

As a commercial provider of air ambulance services, FAI generally deals with around 40 to 50 different payers/clients— or up to 60 to 70 including the companies that put just one or two cases through the company. Each one has its own set of priorities and insurance covers it’s working around, so it’s hard for FAI to get too involved in the decision-making process surrounding whether to evacuate or treat locally. There are, however, instances when Dr Buchsein, as an air ambulance medical director, has to intervene to tell the assistance company that he can’t repatriate a patient because they are too unstable. As he has worked as a medical director for an assistance company, however, he understands the complexities of this role too. Dr Buchsein used a case study as the basis of his presentation to give an informative and entertaining perspective of the different approaches to the evacuate or treat question. The case in point involved a repatriation from Mauritius to Naples in Florida—a long-distance repatriation: although sometimes, said Dr Buchsein, assistance call centre staff seem to think you can fly direct between such places. The entities involved in the repatriation were the insurer (payer), assistance company, FAI (based in Germany), a US air ambulance operator, hospitals in Mauritius and Florida, the patient, and the pilots and medical crews. The patient was an 87-year-old man from Florida who was healthy except for a previous coronary artery bypass graft and a pacemaker. He’d been on a three-month round-the-world cruise and had contracted dysphagia and subsequent aspiration pneumonia in the Indian Ocean, being offloaded to a hospital at Port Louis. He was mobile, alert and responding well to intravenous antibiotics and oxygen. The assistance company in this case put out a tender for an air ambulance company, and FAI offered its availability and quoted a price. When the FAI requested further medical details, the assistance company sent screen grabs of multiple pages of information, at the same time inadvertently including notes on their decision to repatriate (Mauritius was far away and difficult to get back to Florida from; plus the patient had good insurance cover, so an air ambulance repatriation was deemed appropriate). The wife of the patient accompanied him on his repatriation journey, keeping a diary of her observations and experience, explained Dr Buchsein. Among her notes were comments on the small size of the plane, the amount of medical equipment taking up space in the cabin, the lack of a toilet on the aircraft, and the delays (and cold weather) at various airports where stops were made for refuelling and hand-over. There are various lessons to be learned from this case, said Dr Buchsein. Was the assistance company fully aware of the patient’s medical condition? Did they ask the right person in Mauritius? Why didn’t they leave the patient in the local hospital for another week then fly them back on a commercial aircraft? A commercial repatriation flight—with oxygen if necessary—would have had fewer legs, presented no need to leave the aircraft, had a toilet onboard, more space for the patient and his companion, and so forth. Many people believe that an air ambulance transfer is the luxurious option, said Dr Buchsein, but it’s not—it provides good intensive care medicine, though. So, even though Dr Buchsein anticipated that the patient and his wife would not be overly impressed with some of the harsher realities of flying by air ambulance, he did not attempt to stop the air ambulance transport—something that is not his place to do.

One of the key questions the industry can take from this case is whether it should consider opening a more sincere and honest relationship and dialogue between the insurer, the assistance company and the air ambulance provider. Dr Buchsein said that, in the case above, he would have liked to have been able to call the assistance company and tell them that he thought what they were doing was probably not the best decision—either for the patient or from a financial viewpoint on behalf of the payer—but he can’t. And this is something he’d like to see change.

One of the key questions the industry can take from this case is whether it should consider opening a more sincere and honest relationship and dialogue between the insurer, the assistance company and the air ambulance provider.
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Changing the image of insurance.
Cruise update

Steve Williams

Director Fleet Medical Ops, Royal Caribbean Cruises Ltd

Steve’s wide-ranging presentation aimed to give an overview of cruise ship medicine, the attendant issues, and the relationship between cruise lines and assistance companies. The last 30 years, he said, have been very successful for the cruise industry, with annualised growth of over eight per cent, and industry projections suggest that nearly 23 million people will have taken a cruise by the end of this year. In fact, according to Steve, the only thing constraining passenger numbers, is the number of ships.

After giving some general information about cruise ship medicine, personnel and regulatory requirements – for example the recent industry-wide agreement that onboard physicians must have paediatric and advanced life support/trauma training – Steve talked about some of the challenges of practising medicine at sea. The primary objective, he said, is stabilisation, as ‘we can only do so much onboard’. The highest quality of available care will be provided, and patients are then prepared for helicopter, boat or ground transport, with helicopter transfers being the most hazardous; Steve said that as much as possible, cruise lines attempt to minimise sea to air movement. He then spoke briefly about some advancements made in recent years, including electronic cruise ship medical record programs – as keeping track of all necessary data on paper was becoming next to impossible – and fleet-wide satellite synchronisation.

One major challenge cited by Steve was the time taken by insurers to accept responsibility during a crisis, as companies have criteria that must be met, so things can become difficult when time is of the essence. Ships must be re-directed and then put back on course as soon as possible, as delays can cause huge problems, not least financially. Setting up air ambulance transfers was also a bugbear, as was the fact that assistance companies want all information up front. Steve also noted that information-sharing is not as reciprocal as it could be between different parties, as onboard medical staff may give all the necessary information to a hospital on shore, but later, when the patient is at the facility, a hospital’s medical department can be much less forthcoming. He then talked briefly about some case studies ‘to make you weep’, including his company’s ‘SNAFU of the year’, with a serious lack of communication, and delays, being the most common themes.

Dr Robert Wheeler

Chief Medical Officer, On Call International

“Our industry,” said Dr Wheeler, “has gone from medical and travel assistance to travel risk management.” This can involve security solutions, political and natural disaster response and many other challenging variables, and it is important to have all the necessary information at your fingertips. He used Samoa as an example of a tricky location to have a critical patient, presenting myriad challenges – the patient’s condition, inadequate local medical facilities, and limited aircraft assets can all complicate matters, necessitating significant lead time.

The first priority, said Dr Wheeler, always has to be the health and safety of the patient, and it is essential that ‘clear, concise and transparent communication’ be maintained throughout the process, between all parties. It can be difficult to communicate with a ship, so as much information as possible needs to be collected on first contact – electronic health records are key, he said, and every possible method of communication at one’s disposal should be employed if necessary, including email and even texting. As ever, more people are travelling to more remote and exotic locations, often with serious pre-existing conditions, and this makes provision of assistance more complicated – however, Dr Wheeler did say that the majority of patients can be treated onboard ship, with assistance companies actually only getting involved with a very small percentage of cases.

He then went on to talk a little about the process of managing a case. Contact is made, and the provider needs to ascertain whether it is emergent, urgent or non-urgent, as well as what local medical resources, if any, are
available, and whether the assistance provider has prior utilisation in the area. It is sensible, he said, to use the same services wherever possible. The ultimate aim, obviously, is to get the patient back to their home city.

Other questions that must be asked, said Dr Wheeler, include whether the patient is actually stable enough to be taken off-ship and flown home. If they are fit to fly, what sort of flight is required? A non-medical escort might be appropriate, but medical monitoring might be necessary, or even a stretcher flight or air ambulance, and in these more serious cases, timing is absolutely critical in order to sync up with the cruise ship’s schedule.

Luis Berraondo

Senior Travel Underwriting Manager, UK Accident & Health | AIG Property Casualty

Luis began his presentation by talking about the media’s general view of cruises, which is all disasters and pirates – the Titanic, the Costa Concordia and films like Captain Phillips. However, he said, that’s ‘not what we’re concerned with as underwriters’ – the reality is more mundane in many ways, but equally challenging in others, as cruise schemes are the most technically complex to underwrite, and there are a lot of problems that can present themselves. The main risk drivers, said Luis, are age and the time between booking and departure, and both of these are then magnified by cruise-specific factors. Traditionally, cruise passengers are older and more affluent, but there is a growing number of younger passengers, with each demographic posing very different challenges. Luis then showed a graph illustrating what he called the ‘age effect’. It used figures from the Association of British Insurers, aggregating claims paid by age across the UK market; but these vary, said Luis, to most places in the world. Claims were relatively flat between the ages of 30 and 50, rising significantly beyond that, and Luis said that between the age of 30 and 70 risks ‘double’. Older people, he said, will need to be in hospital for longer, and require more expensive, extensive treatment. They will also often book cruises far in advance – the period between booking and departure can be anything up to 18 months, and lots can go wrong in a period that long. Other risks and cost drivers cited were the location of the cruise and the number of passengers. The average UK premium, said Luis, is around £50, so if a company has to shell out thousands to transport a sick passenger home, lots of policies need to have been sold in order to cover these costs, so take-up needs to be improved.

From an underwriting perspective, long exposures, compounded by various risk factors, plus higher burn costs and greater volatility, make costs very difficult to predict, and while charging higher premiums is one method of dealing with this volatility, cruise insurance is a very competitive market that makes high pricing problematic. Younger travellers, he said, tend to go for cheaper options, leaving other insurers stuck with older policyholders, making it difficult to maintain cost-effectiveness, so underwriters need to ensure that they have plenty of excellent data. They need to understand customer profiles, booking patterns and risk exposure over time, in order to mitigate said risks.

In terms of strategies, said Luis, maintaining a loyal customer base that doesn’t feel the need to shop around for deals is very important. Extensive medical screening should be standard, and it might be sensible to exclude cruises from cheaper policies in a company’s product range.

In the discussion that followed, Steve Williams said that in his view, before long, the cruise industry would begin to handle insurance itself, as it knows what the data is and what the risks are. “I believe,” he said, “that the cruise industry should come together with its own product and offer a much more competitive proposition.” One of the biggest risks is cancellation, but if cruise companies were selling the product directly, if someone cancels, then the company can quickly re-sell the cabin, negating that risk – occupancy rates tend to be around 100, even 110 per cent, so re-selling would not be an issue, and there is room for a competitive product. Steve also said that relations between the cruise industry and insurers are improving, which can only be good news.

Then, as the session closed, Steve said – after first apologising for any offence caused – that, “When we go on holiday, we lose all common sense when we go on holiday...”
Variations in extreme sports coverage

Dan Richards

CEO, Global Rescue

Dan started by describing his company, Global Rescue, which ‘specialises in services for people in extreme situations, not just extreme sports’. He then discussed the growth in the extreme sports market, which is estimated to have been around 15 per cent per year over the last decade, and cited a 2013 study that suggested that 53 million people worldwide participate in extreme sports. While participation in other team sports has remained constant, said Dan, people are gravitating more and more towards the extreme end.

A common theme in this session was the challenge of defining exactly what an ‘extreme’ activity is. Dan gave a few examples of clients that his company has represented, and the dangers they face, such as participants in the ‘Spartan race’, an obstacle race whose risks include barbed wire, fire pits, spear chucking and the ever-present threat of gravity. Other examples included the events organised by Red Bull, which can involve risks like political unrest and hostile tribes. The formal definition, Dan said, was ‘a sport that is physically hazardous, such as bungee jumping or snowboarding’.

He then cited data from the National Center for Health Statistics, some of which was quite surprising. Skiing, for example, was statistically more dangerous than snowboarding in terms of how many participants die (one in 1.4 million skiers will die, compared with one in 2.2 million snowboarders), while jogging and swimming were about equal (both about one in one million), bicycling was more dangerous than bungee jumping (one in approximately 140,000 vs one in around 500,000), and Himalayan climbing (above 6,000 metres) was more dangerous than base jumping – one in 10 Himalayan climbers will die, versus one in 60 base jumpers. Dan then talked about the kinds of people who participate in extreme activities, citing a 2009 study by Active Marketing Group. Extreme sports generated over $12.1 billion in revenue in the US that year, and 80 per cent of participants were under the age of 54. Over 65 per cent were male.

The kinds of cases that Global Rescue encounters often involve fractures, joint injuries, traumatic brain injuries and, in some cases, fatalities. Approximately one in five of those requiring assistance are under the age of 18. Luckily, said Dan, the human body’s resistance to trauma is very strong, particularly when young, and fatalities are comparatively rare. Most cases can even be triaged and stabilised locally.

The general perception, Dan went on to say, is that both the frequency and severity of incidents requiring assistance are high, but evidence suggests that this is not always the case. People’s perceptions – and Dan very much included insurers in this – are that outcomes are binary, but non-binary outcomes can be influenced: medical, security and logistics expertise, for example, mean that early intervention can make a big difference.

After detailing a few case studies, including that of a climatologist who fell down a crevasse – nobody could really suggest that he was engaging in an extreme sport, as he was just carrying out his work and happened to be unlucky – Dan summed up with a list of essentials. The severity and cost of incidents related to extreme sports, he said, can be mitigated by expert case management and crisis response, and variations in coverage due to what insurers may perceive as high frequency/severity may not always match up with reality. A discussion followed in which it was asked whether skiing could really be classed as extreme – Dan said that on-piste versus off-piste was the generally accepted definition, although nuances had to be taken into account (helicopter skiing, for example, probably wouldn’t be covered).

The possibility of on-site triage, Dan said, was often determined by the youth of those involved, as younger skiers tend to be in good shape – an older enthusiast might have multiple morbidities, making their case harder to deal with, and repatriation more likely.
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One of the main challenges, said Todd, is how you class extreme sports and activities. He then showed a short video of a skier in South America who cracked his skull open, fractured his spine and damaged an artery to his brain, spending 12 days in hospital. Todd described this example as seeming ‘extreme in every possible way’, but it was covered by a regular travel insurance policy.

IMG, said Todd, compared and contrasted around 12 different policies, and found that there was not one single accepted definition of extreme sports and activities. Part of the reason for this is that the extreme sports industry is always evolving – people are constantly inventing new ways of doing ever crazier things, and the insurance industry is always on the back foot, having to react to these changes. It’s a problem, said Todd, because policyholders need to be made to understand what is extreme and what isn’t. Contracts need to be black and white, making this sort of uncertainty problematic. “Define the perils,” Todd urged attendees. “If it’s not there, it’s not covered.” It’s all about assessing risk and pricing accordingly, he said.

IMG also looked at 200,000 members who purchased policies for extreme activities, and analysed the take-up rates. Students, somewhat surprisingly, came second in terms of take-up, while 30 per cent of outbound British travellers accepted cover. Somewhat less surprisingly, perhaps, only five per cent of outbound US citizens were covered.

Todd then went on to talk about how risks can be assessed, and how insurers can set a baseline for coverage. He said that they should review trade periodicals, keep abreast of what specialised activities are popular, undertake an annual analysis of the market and also closely analyse prior incidents – for which, Todd added, conferences like ITIC are very useful! Overall, he said, lack of clarity is a major problem, as there are no universal definitions, and those on which the industry does agree are constantly evolving. Unfortunately, said Todd, ‘we have to let the market define the industry’s appetite for coverage’. “If someone gets injured,” he said, “someone has to pay.” He also said that more take-up is needed so that providers can properly cover their costs, and ended by apologising for posing more questions than answers!

The subsequent discussion, similarly, contained more questions than answers, as those present found it difficult to agree on a concrete definition of extreme sports. There are also lots of variables in terms of the demographics who will take out coverage in the first place, and at what point an extreme activity becomes too extreme to cover – which is ultimately up to the judgment of the individual provider. Dan Richards also cited the modern trend of ‘bucket lists’, and the accompanying habit of bragging about these achievements on social media, as a major factor in pushing people towards ever more extreme activities. This culture seems unlikely to change for the time being. “We have to continue to adapt,” said Todd. “And if we can make a nickel on it, fine.”

policyholders need to be made to understand what is extreme and what isn’t
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Cost containment – the true price of US healthcare

Jacquie Schwoerke
Director – Global Patient Services, Sharp HealthCare

Sharp HealthCare, based in San Diego in the US, consists of a range of acute and specialty care hospitals, as well as community medical centres, began Jacquie, but the majority of its patients are from outside the city. It is, therefore, used to dealing with a complex mix of payers – an integral factor in the wider complexities related to healthcare in the US, which are compounded by the number of businesses it takes to actually provide healthcare in the country. Payers include government (federal, state and country), as well as private (managed care and PPO contracts) payers, while the different types of hospital models (integrated systems, academic, not-for-profit, for-profit, government controlled) make the business of healthcare even more complex. In California, physicians are generally in private practice, while technology and pharmaceutical costs are also pushing up the price of healthcare.

Looking at charges versus cost, Jacquie said that charges really don’t mean anything – nobody pays the real retail price any more – but you do have to have a charge out there. Charges are, thus, fairly arbitrary and they do not bear much relationship to the actual cost of the business of providing healthcare. Jacquie then gave an example explaining the charges for an episode of care in a Los Angeles hospital, which showed that the direct and indirect costs to the hospital for a hip replacement was around $15,000, but the charge to the insurer was almost $90,000, and the average hospitalisation cost (what the hospital actually got paid) was around $26,000. Medicare barely makes up Sharp’s costs, so some of Sharp’s hospitals subsidise others that are in areas of high Medicaid uptake; while commercial insurer payments also balance out the shortfall from CMS. A great deal of wasteful spending in healthcare is also an issue affecting costs in the US – this comes in the form of excessive physicians orders; a lack of communication with primary care doctors; ever new technology and treatments; and patients heading into the Emergency Room (ER) for care when this is not necessary. Around 70 per cent of the patients coming through Sharp’s ERs do not need to come through that route, said Jacquie; instead, they should have gone to an urgent care centre or similar where costs are a fraction of those resulting from the ER, so travellers need better education around this issue.

Medicare already has tough reporting, auditing and cost justification requirements, and with no reasonable alternative, it is likely the best current benchmark available

Jason C. Davis
Healthcare Cost Containment Expert, Jason C. Davis Consulting

Jason talked about transparency and Medicare, saying that chargemaster transparency has not helped to reduce costs, and that costs vary widely between hospitals even within the same state. There is also no standard for how bill charges are grouped by hospitals; but at least Medicare bundles costs. Jason also showed, using a case study, how there is great variation between charged prices and average reimbursements, and how charges on a rate card are simply a starting point rather than having real meaning. A quote he used to illustrate this point was one from Jan Emerson-Shea, vice president for external affairs for the California Hospital Association, who said: “Charges are meaningless data – virtually no one pays charges.” Even providers would like their pricing to be more transparent, however said Jason; although transparency means many
better partnerships in healthcare – such as between medical providers and insurers – with transparency and loyalty at their core will become significant
PR crisis communications

Gug Kyriacou and Elliot Lane

Directors at FWD PR

The presenters began by pointing out that every organisation will experience a crisis at some point, and that how the company chooses to respond will have a huge impact on its reputation. “Having a crisis manual,” they warned, “is no substitute for your moral compass.” The different ways in which a crisis will be handled depend on the nature of the problem – whether it is known (such as the VW emissions scandal) or unknown (the German Wings aircraft crash), external (Tunisia beach shooting), or internal (HSBC’s setting of exchange rates or Starbucks’ tax payments).

The presenters went on to say that there are 14 different news values that journalists write about. These include death and harm, crime, money, success, failure, sex, conflict, and

Branding a crisis can become essential if a crisis has enough momentum, and this will be done by the media if the company doesn’t act first. The more values the story contains, the more prominent the story will be in the media, said Gug.

When it comes to the first response of a company to a crisis, it is of primary importance that the firm gathers as much information as possible, so as to eliminate any surprises, and if the first point of contact informing you of the problem is a journalist – do not make any comment! Assessment of whether a holding statement is required is the next consideration, followed by alerting staff in the firing line, to whom it must be made clear that all media enquiries must be channelled through the PR team. A crisis management team can then be formed, which should consist of a decision maker, a PR adviser, a legal adviser, an operations expert, human resources personnel and internal communications representative.

The key stages in any company’s management of a crisis should be as follows:

- Discovery → information gathering → response formulation → response implementation → reaction monitoring → modification (if necessary) → conclusion drawn → learn lessons

The time span between these key points are different for different crises, but they will always be touched upon at some stage.

What companies must understand about a crisis, continued Gug and Elliot, is that humans will always seek to connect one event to the next to form a coherent narrative, as storytelling is central to people’s understanding of the world. Therefore, inevitably, a company’s crisis will become a story. Stories demand a beginning, middle and end, as well as a hero and a villain. Branding a crisis can become essential if a crisis has enough momentum, and this will be done by the media if the company doesn’t act first.

The presenters also said that firms should consider if there is a way to rebrand the crisis, describing it in such a way that does not include the company’s name – Elliot pointed out the popularity, particularly in the British press, of adding the suffix ‘-gate’ onto the name of a crisis, such as the recent VW scandal, which has been labelled by some media outlets as ‘emissions-gate’.

Social media, continued Gug and Elliot, can work for you or against you, and it can be the cause of your problem, or it can amplify it. If used correctly, though, it can be a strong conduit for a company to communicate directly with consumers and gives the opportunity to highlight action being taken. When it comes to apologising, lawyers often say that an apology is an admission of liability, which was disputed by the presenters, who said that David versus Goliath situations in particular are emotional, and therefore need an apology for a resolution.

Examples of CEO interviews were then given – one showing an overly-polished, autocued presentation in a formal setting. The other was the CEO in a different setting that showed that he cared more about the crisis that had occurred and that he was addressing the problem in an appropriate manner.

David versus Goliath. The more values the story contains, the more prominent the story will be in the media, said Gug.

Social media is central to people’s understanding of the world. Therefore, inevitably, a company’s crisis will become a story. Stories demand a beginning, middle and end, as well as a hero and a villain. Branding a crisis can become essential if a crisis has enough momentum, and this will be done by the media if the company doesn’t act first. The more values the story contains, the more prominent the story will be in the media, said Gug.

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- Discovery → information gathering → response formulation → response implementation → reaction monitoring → modification (if necessary) → conclusion drawn → learn lessons

The time span between these key points are different for different crises, but they will always be touched upon at some stage.

What companies must understand about a crisis, continued Gug and Elliot, is that humans will always seek to connect one event to the next to form a coherent narrative, as storytelling is central to people’s understanding of the world. Therefore, inevitably, a company’s crisis will become a story. Stories demand a beginning, middle and end, as well as a hero and a villain. Branding a crisis can become essential if a crisis has enough momentum, and this will be done by the media if the company doesn’t act first.

The presenters also said that firms should consider if there is a way to rebrand the crisis, describing it in such a way that does not include the company’s name – Elliot pointed out the popularity, particularly in the British press, of adding the suffix ‘-gate’ onto the name of a crisis, such as the recent VW scandal, which has been labelled by some media outlets as ‘emissions-gate’.

Social media, continued Gug and Elliot, can work for you or against you, and it can be the cause of your problem, or it can amplify it. If used correctly, though, it can be a strong conduit for a company to communicate directly with consumers and gives the opportunity to highlight action being taken. When it comes to apologising, lawyers often say that an apology is an admission of liability, which was disputed by the presenters, who said that David versus Goliath situations in particular are emotional, and therefore need an apology for a resolution.

Examples of CEO interviews were then given – one showing an overly-polished, autocued presentation in a formal setting. The other was the CEO in a different setting that showed that he cared more about the crisis that had occurred and that he was addressing the problem in an appropriate manner.

Gug Kyriacou

Elliot Lane

Brand new content: 

Gug Kyriacou
Thank you!
Infectious diseases – the risks

Professor
Vicki Hertzberg

Associate Professor of Biostatistics,
Emory University

Vicki’s presentation centred on the risk of infectious disease (ID) transmission on aircraft. There have been many documented cases of disease transmission on aircraft, she began, including measles, SARS and norovirus. The long-standing guidance by public health agencies is that the major risk of infection being passed on is for people seated within two rows of an infectious passenger, irrespective of how close to the wall of the aircraft they are.

The FlyHealthy study undertaken by Emory University, in conjunction with Boeing, aimed to quantify the rates and routes of transmission in an aircraft. Methodology included tray table and toilet swabbing, as well as chronicling movement of passengers and crew in flight. Using this data, the team constructed and analysed the temporal network of close proximity interactions between and among passengers and crew during flight time. The air samples taken were immediately sent for metagenomics lab sample analysis for common infections. For the movement data analysis, it was assumed that the risk distance for large droplet transmission was one metre or less; the average number of contacts for each passenger while seated varied from eight to 11, depending on whether they were in a window, middle or aisle seat. For moving passengers, the number of contacts was four per row. Given movement and transmission patterns, it is possible to create dynamic contact networks, and from environmental data, post and pre-flight levels of viruses and bacteria were measurable. The results of the study will be available shortly.

The discussion that followed Vicki’s presentation centred on enveloped and non-enveloped viruses, and the differences in behaviour between the two types of virus. The issue of what kind of disinfectant was being used by the airlines was also a topic of interest.

The FlyHealthy study undertaken by Emory University, in conjunction with Boeing, aimed to quantify the rates and routes of transmission in an aircraft

Dr Vanya Gant
Division Clinical Director for Infection,
UCLH NHS Foundation Trust

Dr Gant offered an update on the Middle East Respiratory Syndrome Coronavirus (MERS CoV), which the World Health Organisation reports has infected over 1,600 people, with at least 579 deaths. Globally, the virus has a 36-per-cent fatality rate. In the last month alone, he said, there had been 34 new cases, with the recent outbreak at the Samsung hospital in Korea being of particular concern.

Coronaviruses, Dr Gant explained, are relatively widespread – it is a type of virus that includes the common cold, but part of the problem with the serious viruses such as MERS is that symptoms are the same as less serious ones, including a fever, sore throat and chills. With MERS, however, the patient also suffers from respiratory symptoms and diarrhoea, and it is the respiratory element that tends to be fatal.

The Samsung Medical Center outbreak in 2015 was the result of just one infected individual, who travelled to South Korea from the Arabian Gulf and sought treatment at the hospital; 186 cases of infection followed. There were several instances of failed infection control measures, such as the fact that the index patient failed to tell anyone of his recent travel history, and that the patient was not isolated soon enough – nor were the secondary infected patients. What then happened is that infected people travelled, which resulted in secondary cases of spread. The density and frequency of air travel is the primary problem when it comes to the spread of infectious diseases: “Global travel,” said Dr Gant, “equals a global spread.” The Hajj pilgrimage could potentially be a big problem when it comes to infection spread, as there are more than 2.5 million people travelling to Mecca in Saudi Arabia each year. Despite the crowds attending the Hajj this year, however, the Saudi authorities have put in place such strict procedures for infection control that not one known new case of MERS infection has resulted from the pilgrimage because Saudi Arabia wants to remain as ‘the keeper of the faith’.

Camels have been identified as the source of MERS, and the animals are used in every part of life in Saudi Arabia, as part of a cultural symbiosis. Up to 18 per cent of new infections are from people who have been in contact with a sick camel, but the idea of killing sick camels in order to protect public health is simply not feasible to a Saudi Arabian.

Dr Gant then went on to talk about a hospital he visited in Saudi Arabia that had been...
having problems with MERS infections. The team identified inadequate recognition of illness at the entrances to the hospital, and a lack of systems assurance when it comes to issues such as infection control. With 9,000 staff, issues were identified involving training, education, lack of empowerment, and a disconnection with hierarchies. There has since been a commitment to quality improvement, however, and a very visible commitment to avoid making the same mistakes that occurred at Samsung.

The Samsung Medical Center outbreak in 2015 was the result of just one infected individual, who travelled to South Korea from the Arabian Gulf and sought treatment at the hospital.
Infectious diseases – the reality

Professor
Robert Steffen
Epidemiology Biostatistics & Prevention Institute, WHO Collaborating Centre at the University of Zurich

Professor Steffen’s presentation focused first on the mortality and morbidity rates of several communicable diseases, including travellers’ diarrhoea (TD), malaria and other vaccine-preventable diseases. Statistics of French tourist fatalities between 2000 and 2004 show that infections accounted for 1.4 per cent of deaths, although it is important to note, he said, that occasionally infections can cause deaths after returning home.

TD statistics showed that incidence of this infection is falling around the world, with fewer countries presenting a high risk of infection to travellers, particularly in the Far East, and that overall, far fewer travellers are contracting the problem during a two-week holiday. Certain countries in Central America, Africa and Asia continue to present the highest risk of infection to travellers. The most common long-term impact of TD is irritable bowel syndrome, which can affect up to 17 per cent of travellers.

An emerging problem for today’s travellers, continued Professor Steffen, is that of antibiotic resistance. Drug-resistant bacteria can remain in the gut for many months, and a study is ongoing to examine the impact of those who take drugs to combat TD. Tourists with TD can be given obsolete antibiotics, as well as injections and infusions, and there is an ongoing issue with hospitals admitting patients unnecessarily.

Other diseases causing concern amongst the travel health medical community include dengue fever, which is often misdiagnosed as flu. The potential helpfulness of dengue vaccines is important, especially because the new vaccines aim to protect against all the different strains of the virus. There are serious limitations to the vaccines, though, which include the age of the person to which the injection must be administered. Malaria also continues to be a worry for travellers heading to sub-Saharan Africa and certain areas of Indonesia, as well as southeast Asia.

Typhoid is more common in South Central Asia, particularly for those travellers visiting friends and relatives in Pakistan and India. There are clouds on the horizon with the potential to worsen disease transmission rates, warned Professor Steffen, one of which is medical tourism. The lack of compliance with immunisation requirements for diseases such as measles is also of concern, with the potential risk of quarantines for individuals and/or affected groups. Another cloud on the horizon is our changing world – there are more Asian travellers who are less used to visiting far-flung destinations, and there needs to be increased travel medicine awareness in those populations of growing travellers.

With increased global mobility comes an increased risk of infection, concluded Professor Steffen, and travellers and their insurers could use epidemiologic data to help prevent outbreaks, as well as minimising exposure by, for example, using drug prophylaxis where appropriate, and immunisation where possible. Professor Steffen is an advocate of travel health kits that can be taken with the traveller to keep them well and so stop them going to hospital unnecessarily. He also proposed that travel insurers and travel health professionals should work more closely together to identify problems and work on alerts and advice for travellers.
SOMETHING BIG IS HERE!

LifeSupportTransport.com
Dr Albie de Frey
CEO, International Health Management Consultants

Dr de Frey introduced his company, which often works in West African nations with mining companies and was very busy during the Ebola crisis. Dr de Frey began by describing the various travel health risks prevalent in West Africa – from the ones that travellers ‘bite into’, such as TD, hepatitis A and cholera, to those that ‘bite into travellers’, such as malaria, yellow fever and rabies. Other risks include road accidents and tribal violence.

Talking about the impact of Ebola, Dr de Frey pointed out that in real terms, other diseases cause a great deal more harm on a day-to-day basis; HIV/AIDS caused 685 deaths per day in Africa, and malaria 552, while at its height Ebola caused 13 deaths per day. Still today, 14 people die every day from Lassa fever. The problems that were in the region before, such as malaria, are still there, and are in fact getting worse due to everyone’s attention being focused on Ebola. Part of the challenge with managing malaria, noted Dr de Frey, is that it is down to education of the traveller or expat when it comes to bite prevention.

The current situation of public healthcare in West Africa remains unchanged from pre-Ebola times, he continued, and worryingly, it is set to further deteriorate as mining companies pull out of the area, with governments losing money as a result. This loss of government income, and a lack of political will and leadership, mean that childhood vaccination campaigns are faltering, and malaria controls, diagnosis and treatment are being neglected.

Looking specifically at expatriate health risks in a working mining community in Senegal, Dr de Frey explained that a high proportion of expats employed there ranged in age from 41 to 60, many of whom will be at high risk of having a chronic disease – indeed, he then showed statistics which indicated that 48% of expats have a relative contraindication to travel (e.g. diabetic, hypertensive), although technically they are fit to travel. Details showed that while in July this year there were over 1,800 medical assistance cases from that mining community, only one resulted in a medical evacuation. The most common infectious diseases noted in projects in Guinea, meanwhile, were gastrointestinal or respiratory illnesses.

To mitigate health risks in expatriate populations, concluded Dr de Frey, pre-deployment medical screening is essential. Candidates with high-risk pre-existing conditions should be excluded from assignments, a comprehensive vaccination campaign should be carried out, and malaria prophylaxis should be distributed. On-site medical services need to be of a standard with those in the industrialised world, and finally, medical insurance and evacuation cover need to be in place. Health risk mitigation, he concluded, results in reduced incidence of medical evacuations. And by looking after the local population’s illnesses, a company can protect its expatriate workforce as it can be proactive in improving the general health and wellbeing of the overall population.

Part of the problem with managing malaria ... is that it is down to education of the traveller or expat when it comes to bite prevention.
Bastian Nagelschmidt
Deputy Managing Director,
DRK Assistance Nordrhein GmbH

Having introduced German Red Cross Assistance, Bastian went on to describe the system in place in Germany for handling highly contagious patients. In terms of treatment facilities, Bastian explained that there is a network of seven hospitals with isolation units, each prepared to treat five such patients. Every specialist centre is on 24/7 standby and has a ‘lead-in’ time of four hours. Five civil airports can handle contagious patients – Hamburg, Berlin, Dusseldorf, Frankfurt and Munich. There are several task forces trained for rescue, nursing and medical escort duties all over Germany. Five hundred aid workers went to West Africa during the Ebola crisis, and for those people the German government had to guarantee medical evacuation back to Germany in the event of an infection occurring. In order to keep these promises, evacuation options had to be in place, which resulted in the development of the Robert Koch Medevac A340 aircraft that was specially modified to handle patients during the Ebola crisis in 2014. The target of the aircraft’s development was to guarantee the evacuation of an Ebola patient to Europe as soon as possible so that they are able to start high quality medical treatment, offering the best therapeutic options in the air during the transport. The special isolation unit, with complete critical care capabilities, developed by Lufthansa-Technik and RKI, comprised three airlock chambers that were pressurised independently of the aircraft with an integrated hydrogen peroxide nebulisation system. Seventeen crew members were required to evacuate one patient – the team consisted of two chiefs of operation, six technical crew members, six nurses, two physicians and one leading physician, along with specialists for final disinfection and waste management, who were needed on the ground after landing.

When the aircraft was ready for service, there were over 40 highly qualified personnel ready to deploy who had undertaken over 200 training days together, during which time over 380 pages of standard operating procedures were developed and evaluated. The aircraft, and the special isolation unit, passed all the necessary tests for flight safety and security, and the system fulfilled nearly all the same requirements as the ground hospitals. In conclusion, Bastian said that it is possible to carry out the medical evacuation of highly contagious patients. In the future, it should be possible to decrease the size of the system required, with the size of the isolation unit matching the dimensions of the aircraft. Bastian noted that continuing the availability of the required competencies is quite expensive and therefore a challenge, as is the ability to match air safety regulations and gain approval for operations. The DRK system is not currently available as the government has shelved the project, because it considers the Ebola crisis to be over. However, the hope for the future is that the government will put the system in place in such a way that it would be able to be activated at a few weeks’ notice.

Seventeen crew members were required to evacuate one patient – the team consisted of two chiefs of operation, six technical crew members, six nurses, two physicians and one leading physician
Coverage of mental health conditions

Dr Suzanne Black

Former Clinical Assistant Professor of Psychiatry, University of California San Francisco Medical School

Travellers, began Dr Black, have higher rates of mental health issues than the general, ‘settled’ population, for a number of reasons. Travel is a stressful experience, involving separation from familiar support systems and exposure to myriad challenges including language and cultural barriers, and constantly needing to adapt and modify one’s own behaviour can be ‘chronically disabling’. Geography is also a factor – for example, higher rates of depression have been observed in areas far away from the equator, where there is very little daylight, and a traveller’s own nationality can be an issue – how safe is it to be an American, for example, in certain countries? asked Dr Black. These challenges are amplified for expatriates, as travellers only have to deal with them on a temporary basis, but travellers of all sorts head off with unrealistic expectations, and these challenges can all exacerbate pre-existing mental conditions, or even bring on hitherto unknown issues.

Students were a group that Dr Black cited as being particularly vulnerable and high risk, and one that may turn to reckless behaviours such as substance abuse in order to deal with mental health issues. Travellers, she said, generally have low help-seeking rates, and depression is the most common psychiatric condition and a major contributor to the overall global disease burden. Anxiety, post-traumatic stress disorder and psychosis can also be exacerbated by travelling.

Ideally, said Dr Black, those with psychiatric conditions should not travel without seeking help first. Unfortunately, travel can be mistaken for ‘a panacea for all that ails us’, with people often travelling in response to de-stabilising life stresses. Dr Black then listed some of the problems that travellers with mental health issues can face in foreign countries, such as the difficulty of obtaining standard psychotropic medications, and different cultural reactions to such issues, which can vary hugely from country to country. Forced hospitalisations could result, consent may not be requested, and patients may be denied adequate explanations for their treatment, which could be questionable or even unacceptable – 24/7 incarceration and solitary confinement were two extreme examples cited.

In terms of preparation and precautions, Dr Black said that insurers need to know whether there are appropriate clinicians and translators present locally, as even major psychiatric facilities may not have English-speaking professionals present. If a patient is hospitalised, can their care be managed at the destination, or do they require repatriation? These are ‘significant questions’, said Dr Black, and the consequences can be serious, so psychiatric evaluations should be a standard pre-travel step. Travellers should know what to do if problems present themselves, they should register with a local consulate, and if they have a personal history of mental health issues, they should have an action plan. The best course of action in the event of a crisis, said Dr Black, is usually to repatriate.

Peter Hayman

Director, PJ Hayman & Company

Peter’s presentation gave a UK perspective on travel insurance for travellers with mental health issues, specifically those going on short-term trips. He described his company as a ‘niche provider’, and talked about its Free Spirit scheme, which caters to those with pre-existing conditions, and the risk assessment method that it uses, which is a medical screening system provided by Healiq. Peter talked attendees through an example of the initial online screening process, which uses a Q&A system. Travellers are asked what condition they have, questions are generated and the answers then produce a risk score (which can be destination loaded), which determines acceptability and premiums.

The majority of travel insurance policies, said Peter, will not offer coverage beyond a risk score of around five, although sometimes more specialist policies will be offered. PJ Hayman, he said, will potentially cover up to a score of around 60.

The questions generated for bipolar disorder are essentially the same as those for anxiety, depression, and schizophrenia; Peter said that insurers need to be more enquiring. Forty per cent of single-trip policies sold in the UK are bought online. When people self-declare they tend to under-declare, and as a result they may not be sufficiently insured. For higher-risk cases, it is preferable for insurers to speak directly to customers, although this throws up similar problems, because people will often refuse to acknowledge any issues they may have. To illustrate this, Peter played an illuminating audio clip of a call made to PJ Hayman by a woman who significantly downplayed her previous issues. It turned out that she was bipolar and should not have travelled, leading to a potentially very large loss for the insurer. This illustrates the difficulty of insuring those with mental health issues, as more specialised personnel and treatment are needed – more than an insurer can reasonably provide.

Other problems that Peter highlighted included the disproportionate number of declined claims that they experience, usually due to non-disclosure, which then require a retrospective screening; the fact that standards of care vary wildly across the world; the fact that patients cannot be transported home against their will, even when that may be the best course of action; and the fact that repatriation costs are high because of the specialist doctor and nurse teams required. In terms of future developments, Peter said that more communication is needed
It’s all about right and wrong...

When you contract with an air ambulance provider to transport your patient home, they always do it themselves, right? **Wrong.**

When you contract with a provider who tells you they operate their own jets, that means they only ever use their own jets for your patients, right? **Wrong.**

When you contract with a provider with their own medical personnel, then those are the personnel that always move your patients, right? **Wrong.**

When brokers state that they will only use certain accredited companies to transport your patient, then that’s what they always do, right? **Wrong.**

Operators never act as brokers. Brokers never pretend to be operators, right? **Wrong.**

It’s either right or it’s wrong and most of the names in the air ambulance business don’t seem to know the difference. **We do.**

**How?**
Because we move patients on behalf of brokers and accredited air ambulance providers all the time.

**But wait....surely it’s better to know 100% that your patient is with the plane and medical crew that you actually hired, right?** **Right.**

And surely it would be cheaper to use us direct rather than pay a middle man, right? **Right.**

It’s not what you say, it’s what you do. **Right!**
between insurers and medical professionals to expand question sets. He also said that insurers should limit the availability of online self-screening and work to improve awareness of the need to declare mental health conditions. It is an important sector of the market, he said, and the industry should be able to help the huge number of sufferers they should be allowed to travel. "It’s about equality of mental health," he finished.

Laura Hilton

Director, Global Health at HTH Worldwide

Laura began by talking about new US legislation covering parity requirements for mental health coverage – the Affordable Care Act (ACA) requires compliant expatriate plans to have parity between medical and mental health benefits. She then spoke a little about the complications that arise in the US because while federal guidelines cover some areas, others depend on state legislation. Connecticut and Oregon, for example, require the same parity mandated by federal guidelines, and Kentucky requires that alcohol abuse coverage be the same level as for cardiac issues.

Laura then discussed mental health diagnoses, and the fact that more and more conditions are now being recognised as mental health issues. She cited gender identity – in California, transgender surgery would need to be covered by a policy, because it is related to mental health. Adjustment disorder – 'what I would have thought of as homesickness', said Laura – is also now included in some areas. Because of this, she said, an expat might for example relocate to Paris from the US, have trouble acclimating, call a psychiatrist back home and perhaps pressure them to come up with a diagnosis so that treatment will be covered, even if they might not have a serious mental health issue. This, said Laura, makes things much more complex for assistance and air ambulance providers, and repatriation may end up being essential because there is simply no way of progressing the case within the expatriate’s host country. She cited telehealth as one method that has been used to manage these issues – in the past, in the US at least, it would not have been covered, but now approximately 40 per cent of states will cover secure video consultations. Insurers are also now having to decide whether treatment in facilities such as spas and detox centres can be covered as medical treatment, and find out what sort of clinical oversight there might be – a spa day may be great for one’s mental health, but it doesn’t necessarily count as a treatment facility.

Now that there is so much more pressure for insurers, assistance providers and air ambulances to manage mental health issues, Laura said that there is potential for more complex benefit designs on all sides. “We should all be watching where this is going to go for short-term plans,” she added.

In the discussion that followed, Laura said that ‘we in the industry’ need to create better relationships with local mental health treatment providers, and expand networks on the ground, as one facility may be appropriate for one expat, but not for another. ‘Grey areas’ were also discussed, whereby some argue that certain conditions should be covered, and others are more resistant. Ultimately, said fellow panellist Peter, ‘it’s not for us to judge people’, and the industry needs to give the most support possible to those with mental health issues. Dr Suzanne Black, meanwhile, said that she makes herself available 24/7 to expat clients, a stabilising factor from which many would benefit. Laura said that the industry needs to focus on identifying appropriate resources wherever expats may be in the world. “Travel is a right,” said Peter. “People with serious issues need support, they need coverage. We shouldn’t be denying claims. We want to cover people.”

It’s about equality of mental health

More and more conditions are now being recognised as mental health issues
Nordic Insurance Software
For Insurers, Brokers, MGAs, Assistance Providers and TPAs - the de-facto software for the travel, expatriate, health and specialty insurance industry.

Our adaptable, modular system is available as a Software as a Service (SaaS) solution covering:

- Underwriting
- Sales
- Provider Networks
- Assistance Case Management
- Claims
- Reporting

We help you see the opportunities
Claims and subrogation

Dick Atkins
Owner, International Recoveries, LLC

Subrogation, began Dick, is the legal process by which an insurer can reclaim money from a third party that caused an insurance loss to the insured. However, subrogation is often ignored (by companies who don’t understand the concept), forgotten (by those who start the process) or mishandled (by those who do it).

Very few companies have put together the in-house expertise to handle the process of subrogation themselves, so it should mainly be outsourced to a subrogation specialist. The next question is whether to pay for such services through an hourly fee or via a contingency fee, and this is really an easy decision, as with contingency fees you only usually have a legal bill once a recovery is made.

Dick then talked about the importance of starting the subrogation process early, including providing early notice of liens (legal claims to secure payment) so the right to subrogation is not lost, and preserving evidence, both of which are especially important in cases where there are mass casualties and insurance claims are resuttantly high. In the US, the process of subrogation is made more complex by the fact that there are 56 jurisdictions, each with own rules and regulations affecting the legal process. There are also wider restrictions on subrogation, explained Dick, such as the Made Whole Doctrine (which stipulates that it is only after the insured has been fully compensated for all of their loss that the insurer acquires a right to subrogation); legal arguments to overcome; and various state prohibitions. Once negotiations with the insured’s lawyer begins, though, it is very important that your subrogation expert understands the value of claims; the impact of claims value being inflated; and the importance of avoiding court if possible.

Dick concluded by touching on the difference between reimbursement and subrogation, the importance of policy wording including strong subrogation language, and the benefits of including a legal hotline in the early part of the assistance process.

Robert Blackwood
VP General Counsel, Global Excel Management

Robert gave an insightful presentation about knowing and preserving an insurer’s right to subrogation. Good policy wording, he began, is not onerous, but he is still surprised at the number of policies that don’t give the ammunition needed to subrogate. Policy wording needs to be sufficient to allow you to claim against someone who’s competing with you to get that money back. So, good policy wording should have clauses that deal with the insurer’s right to subrogate; the insured’s duty to co-operate with recovery efforts (insureds also often don’t realise a pay-out can be beneficial to them); strong and clear second payer wording (so, you pay second – after anyone else has paid); and a good choice of law clause (stipulating under which jurisdiction the subrogation can be brought). Good examples of clauses are not difficult to include and save trouble later on.

Robert also showed a slide that covered dealing with hostile jurisdictions, and stated...
that ‘doggedness really makes a difference in subrogation’. He gave examples, including a skiing collision, where a decision had to be made over who was responsible and how resultanty to split the claim; and a case of a woman who cut her hand while in her condo, who wasn’t covered by her own insurance but was covered by the overall condo complex insurance.

**doggedness really makes a difference in subrogation**

During the subrogation process, concluded Robert, you have to be mindful that just because you are on the same side as your insured’s lawyer, it doesn’t mean you want the same thing – both the insurer and the lawyer want the at-fault party to pay, but they also want as much of that payment for themselves as possible. As such, it’s important to understand the Made Whole Rule versus pro-rata recovery, and to understand your insured’s actual losses. Robert reiterated the importance of sending the notice of liens early and ensuring an insurer’s legal counsel has the skill and finesse to follow a claim and policy wording in an adept and agile way to recover costs for the company effectively.

**Julie Remmington**

*Consultant, Travel Insurance Suppliers Network*

Julie explained that the third party in subrogation can be any party to an incident, case, quarrel, or such, who is incidentally involved. Key to successful subrogation is collecting evidence, continued Julie, and assistance companies are key to getting the right information. Don’t be afraid to spend money on investigating an incident, and involve your insured if necessary – this is perfectly acceptable. Julie’s advice was to pick up the phone and talk to your insureds: “You’ll be amazed at what they tell you”, she said. What is also important is using the services of someone who knows the local laws and requirements around subrogation as the rules vary between - and sometimes within - countries.

Essential, for insurers, is thinking outside the box. If you receive a claim for a broken leg, for example, ask how it was broken. If the insured says they fell over in a supermarket, you can start a recovery. Julie also gave the example of a case where a recovery was made following an accident when, during the running of the bulls event in Pamploma, the animals injured a number of people in an official viewing area and a successful claim was made against the local council. In any cases like these, though, it’s essential to get the right evidence to be able to successfully subrogate. Local knowledge is also vital, especially in cases where standards differ. So, broken pavements in Thailand are a fairly standard sight, but in the UK, broken pavements need to be clearly marked out – this kind of information is useful to know to aid a successful subrogation.

Acting quickly is key too. So, getting photographs and statements from hotels or tour operators as soon as possible is essential. This can help in cases that seem too bizarre to be true, but it can also help in cases that seem perfectly straightforward, said Julie.

To conclude, the importance of policy wording to protect subrogation rights was reiterated. Successful subrogation can be the difference between profit and loss on a travel account, said Julie. So, ask questions, and don’t be afraid to ask difficult questions. Subrogation is fairly standard in the US, but we need to enhance its popularity in the UK and Europe, and travel insurers need to understand it better, Julie concluded.

**Successful subrogation can be the difference between profit and loss on a travel account**
World markets

Brazil: Rafael Vasconcellos
Senior Vice-President of Medical Affairs, UnitedHealth Group (UHG)

Beginning with an overview of the Latin American market, Rafael explained that in Brazil, there is a dual system of health provision – public, government-run facilities, and a private healthcare system. Public facilities take care of about 75 per cent of the population, although the private industry is growing year on year. One problem that Brazil faces is access in the public sector – logistics, protocols and delivery of medications are challenges that need to be overcome, not to mention the financing of the system itself. Around nine per cent of GDP is spent on healthcare overall; medical inflation, though, has consistently been in double digits for the past five years, and is forecast to reach almost 20 per cent in Brazil this year due to stress on the economy putting pressure on the value of the currency. Given that a lot of raw materials for medication production is imported, this cost is passed on to the medical system. Travellers are, by law, allowed to receive free healthcare in public hospitals, and Rafael warned that while the system is good in terms of vaccination and primary care, funding the system to maintain this high quality care is very challenging. Emergency care in Rio de Janeiro is most often accessed through public hospitals (which can suffer from seasonal infrastructure and funding issues), urgent care facilities (UPAs) and the SAMU ambulance service, which is operated by the Rio fire department. Rio has 13 public hospitals that can handle emergencies – they are mostly located in the city, and are able to receive clinical and trauma patients. Most staff, however, are not proficient in English, so for international assistance companies, getting reliable information can be difficult, although some hospitals have good relationships with the local consulates. Private UPAs are fairly new – most are actually modular structures made from containers. They offer a good solution, however, for lower to mid-level trauma patients or disease management, although many have a 24-hour treatment time limit. SAMU has 82 active ambulances, 80 ground vehicles and two helicopters. Amid, part of UHG, operates three ground ambulances, two helicopters and one fixed-wing air ambulance. During the upcoming Olympic Games, there will be an extra 100 state ambulances contracted to serve the Olympic venues. Private sector hospitals are numerous in Rio, and some have experience treating expats and travellers – these include Hospital Samaritano and Hospital Procardiaco. Such facilities, though, can be expensive, and assistance companies were warned by Rafael that physicians’ bills can be charged separately from the hospital bill. Private providers have benefitted from an increase in the number of people with private health insurance, which has resulted in a steady increase in demand for hospital beds. However, with no real change in hospital bed supply, the hospitals are in a powerful position to dictate prices.

Private sector hospitals are numerous in Rio, and some have experience treating expats and travellers

Myanmar: Dr Dhun Damrongsak
Deputy CEO and Hospital Director, Samitivej Sukhumvit Hospital

Having introduced the hospital group for which he works (Samitivej International Clinic in Myanmar was built recently and is part of a much bigger organisation based in Thailand), Dr Damrongsak began by giving an overview of the economy in Myanmar, looking in particular at recent investments made in the country’s tourism infrastructure. There has been much investment in telecommunications, transport and healthcare in the past few years, but this is mostly in Yangon. In terms of tourism, there are many World Heritage sites of interest. There are also a lot of natural resources such as oil and gas, which are prompting interest from international companies. The communication network in Myanmar is patchy – uploads can be slow for instance, so it can take a long time to send a medical report out of the country and it is often quicker to send a CD of radiology images overnight to Bangkok, rather than try and send them over email. In terms of logistics, communication problems can also cause delays for international assistance companies. Healthcare facilities are best in Yangon, but quality and resources are both sometimes difficult to guarantee. There are many private hospitals, but few of them have good emergency facilities, so most urgent cases end up in public hospitals, which can vary in quality. Moving on to air ambulances, Dr Damrongsak pointed out the limitations in the operation of airports in Myanmar. Some only operate between sunrise and sunset (Yangon is the exception to this rule), permissions for landing are complex to obtain (it can take anywhere between two hours and two days to obtain such permissions), there are language barriers to overcome, and logistical complications can mean that evacuations are delayed. In terms of medical assistance accessibility, Dr Damrongsak went on to say that the healthcare system works mainly on a cash payment basis, with only limited acceptance of international payment guarantees from insurance providers. Given that US$1 is worth around 1,200 Myanmar kyat, you almost need suitcases of cash to pay for large hospital bills, and an imminent new law means that hospital bills have to be paid in Myanmar’s local currency. Some credit cards are now accepted though, with VISA probably the most widely accepted card for hospital payments. When accidents or acute illness strike international visitors, they will most likely be taken to a local hospital, where an assistance company will have to deal with
When accidents or acute illnesses strike international visitors, they will most likely be taken to a local hospital, where an assistance company will have to deal with a lack of communication networks and language barriers.

West Africa: Christian Deloughery

VP International Business Development, Swan International Assistance

Christian began by saying that working in West Africa can be challenging for many different reasons, including corruption, security, medical infrastructure, cultural differences and unreliable communications; so having a local partner is almost essential. Close personal relationships with providers are very important to successful operations; and corruption is a particular issue for which international assistance companies should be prepared.

When it comes to security concerns, in some countries there are curfews in place that can complicate patient movements, and in practical terms, there can also be unexpected roadblocks and checkpoints – both official and unofficial – while natural disasters can also affect patient movements. Daily challenges to assistance provision in West Africa include low infrastructure development, especially when it comes to medical infrastructure, limited use of the English language, and uncertainty around legal protection due to an inefficient court system. Transport can be patchy – in towns it is usually sufficient, but outside of major cities, roads can be very dangerous. Ambulance services can range from sophisticated ground and air ambulances to rural ambulances that are really donkey-drawn carts. Challenges for assistance companies to overcome are a lack of proper medical infrastructure, the varying price of medical care, different competencies and skills of medical staff, communication problems, language barriers, and problems with guarantees of payment – if an assistance company is unable to set up a guarantee of payment, in some cases the patient simply will not be accepted. An important point made by Christian is that a personal relationship with the hospital often needs to exist in the first place in order to ensure patients are accepted.

Finally, traditional versus modern medicine practices can mean huge variations in care are provided across regions. Hospitals can have very poor sanitation with poor quality medicine, or they can be fairly advanced in the private medical sector, where there is state-of-the-art equipment. Meanwhile, air medical evacuation costs can spiral due to no-fly zones increasing distance and therefore expenses. Christian’s final word to attendees was to always have a plan B, otherwise you really shouldn’t work in Africa!
Security of travellers

Frances Nobes

Senior Intelligence and Security Analyst, red24

Frances explained first why expatriate security is so important, highlighting regulations such as the Corporate Manslaughter Act and Corporate Homicide Act, both of which place the duty of care firmly on the employer concerning what is reasonable for the employee to expect, and what risks are foreseeable by the employer. There are potentially huge sums of money at risk for breaking these pieces of legislation – all the way up to 10 per cent of a company’s value, said Frances.

She then went on to detail the most common risks that expats face, including residential security (which introduces different risks than for normal travellers, who stay in secure hotels, and could be helped by adding a security gate or a burglar alarm to a residence), family security (companies can have a duty of care to an employee’s family and provisions should ensure the family’s safety – children can be a kidnap and ransom target, so school choices need to be carefully considered), and expats who end up becoming complacent in their surroundings and take their safety for granted.

In order to ensure duty of care obligations are fulfilled, employers should, pre-deployment, carry out job and location-specific risk assessments, including physical and mental health risks, ensure the safety of transportation options of people and belongings (Frances noted that RTAs are a considerable risk abroad, so expats who drive themselves are at increased risk), and also provide education and training of personnel. In-country support can be offered through improving the security of a person’s home, and ensuring that transportation options are appropriate and safe (in countries where there might be a risk of kidnap, for example, expats could be urged to vary their routine, as it can be easily predicted and therefore make them an easier target), as well as offering employees information about potential or actual criminal activity, with advice should they become a victim of crime. Finally, regular situation updates about political or local incidents should be provided.

During a security incident, it is incumbent on the employer – or their third party security assistance provider – to offer immediate advice and support to overseas employees.

The implications for a business’s ability to continue functioning when evacuating an employee should also be considered. Furthermore, the way in which expat and local staff are treated should be an important consideration – companies should find a way to keep all their employees safe, but just evacuating expats, and leaving locals in place, can be controversial.

Andrew Kain

Security Consultant, Heathwick Solutions LLC

Andrew began by saying that traveller demographics vary widely, from students or academics on university assignments, to gap year/backpacker travellers, to expatriate workers (within this category there are variations in risk as some are in more dangerous countries) and older holidaymakers, who may feel more capable of dealing with security challenges than they actually are. This wide range of travellers inevitably results in a wide range of destinations – party locations, safaris, adventures; workers on the frontline – and therefore risks, said Andrew. However, what everyone has in common is that as individuals, we all have a duty of care for ourselves. The problem is that there is a growing expectation among individuals that their safety is someone else’s responsibility. For travelling workers, the employer has a legal duty of care over them, but nonetheless the individual still has to be responsible for their own wellbeing as well. Simplified, said Andrew, the legal duty of care can be boiled down to show that the employer has done what is reasonable to mitigate foreseeable risks. Understanding the risks involved in any particular trip requires intelligence information to identify the risks and therefore mitigate them in an effective manner.

Duty of care, he warned, must enable, not inhibit, a traveller.

Examining the most significant risks to today’s traveller, whether on vacation or business, we need to look at medical risks (disease, illness or accident); environmental risks (desert, urban, jungle); security problems (petty crime to full-blown terrorism); perception of the
Globalisation, began Ali, is changing the safety needs of travellers and global employees. He pointed out that when it comes to risk considerations regarding travellers, there are three different levels of approach taken – the first is by the employer, who considers issues such as plans and procedures for crisis management, how to train and educate employees, and how to keep employees updated. The second approach is that taken by the local management, who consider security mitigation, contingency and evacuation plans. Then, finally, there is the employee/traveller themselves, whose considerations usually centre around whether or not they (and their family) are personally well prepared for their trip, what they would do in an emergency, and how best to communicate with the right people in case of emergency, in terms of the equipment they need.

Factors likely to complicate a traveller’s ability to stay safe, according to Andrew, are really all based on the problem of being human: the certainty and invulnerability of youth; paranoia leading to an ineffective working ability; tourists ignoring the risks by pretending they aren’t there; and very experienced travellers believing they have ‘seen it all’ and therefore aren’t worried about risks.

Keeping people safe can be simplified, concluded Andrew, by mitigating the risk, monitoring the risk and managing it effectively. Intelligence leads to risk analysis, threat assessment, planning and contingencies.

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**Ali Rezwan**

*Head of Security, Falck Global Assistance*

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**for the employer, travel risk management and crisis management response systems are essential to ensure plans and procedures are in place to manage situations as they arise**
Fraud focus

This joint presentation covered the key issues pertaining to travel insurance fraud from an international perspective, and looked at the impact of fraudulent activity, how insurers are enhancing their fraud detection systems, and how fraud can be prevented.

Gary Sommerford

Consultant, Larus Consulting

Different sources suggest that the cost of insurance fraud is between three and 10 per cent of claims volume, began Gary, highlighting the importance of reducing the risk of fraud for businesses. After providing a definition of fraud, Gary looked at the many different ways in which fraud is committed – from during the insurance application process (identity theft, backdating cover, mid-term additions to corporate policies) to the claims process (inflated claims, amended receipts, serial claiming), before explaining how technology has helped the fraudster in all areas of such activity, whether opportunistic, planned/pre-meditated, or part of an organised crime syndicate.

Gary also went through the stages of a fraud investigation – gathering information from as many sources as you can; analysing the information (is it reliable, valid, relevant, and so on?); reviewing and evaluating the information gathered, identifying any gaps; and decision making (do you have enough information to refuse the claim, or is a full investigation or even legal action needed?).

A key part of any fraud investigation is gathering information – not just via desktop or internal enquiries, but also in the field. By visiting the scene of an event, you can make local enquiries to help establish the facts of a case and verify any accounts already given. If you act quickly enough, you can even speak to people who witnessed or were at the place of the incident when it occurred. By making field enquiries, you can also make your own sketches of the scene or events, take measurements, or more easily obtain CCTV footage. You can also identify the current situation and make useful contacts with local police, other government agencies, courts, and attending medical facilities. This can help with obtaining consents and reports. Specialist services are also available to help with fraud investigations. These include handwriting experts, computer forensics (such as examining mobile devices), surveillance, and open source research. However, said Gary, there are certain expectations that need to be placed on external investigators – they need to be qualified, experienced, legally and regulatory compliant, professional, ethical, and meet any relevant industry standards. They should also provide you with an estimate of costs, provide regular updates on the investigation, give a personal statement if required and be willing to appear at court proceedings for you if needed, provide a factual report and evidence at the end of an investigation, and identify any subrogation opportunities.

Once an investigation is complete, you need to decide what action to take – whether business sanctions against the policyholder, civil or criminal proceedings, or an alternative. You can also consider your options around how to get your money back – forms of redress could be simply asking for the money back or, if financially viable, starting legal proceedings. Gary concluded his presentation by looking at how insurers can manage the risk of fraud. This includes developing an integrated strategy for the prevention and control of fraud, and instigating a coordinated approach to implementing fraud risk management policies and strategies.

Developing an anti-fraud culture within the company, together with an information and communications (internal and external) strategy, is also important. Any fraud response plan, though, needs to be constantly evaluated and monitored to ensure it remains optimum effectiveness.

the cost of insurance fraud is between three and 10 per cent of claims volume

Ann Adams

International Fraud Manager, Cigna Global Health Benefits

Ann gave a fascinating insight into a case currently under investigation by law enforcement involving group insurance and individual private medical insurance policies that has affected a number of insurers, and is a scheme that may still be ongoing. Cigna was alerted to the scam via the US’s National Health Care Anti-Fraud Association, which sent out a message to multiple international insurers giving an overview of the scheme and names of the subjects. After looking into this, Cigna found it had been affected and started working almost straight away with four other affected insurers to share information and act collectively to help combat this fraud scheme. What Cigna learned was that the perpetrators were a husband and wife who were employees of a legitimate client insured with Cigna for four years, but who had been...
Insurers have a realistic opportunity to deter and prevent fraud via the proactive identification and removal of enabling factors, began George, who said the key to this was knowing your business. By knowing your customer base, you can identify where your high risks are – your customer risk profiles will show you what sort of claims you’re paying, and the use of claims data is key to showing an insurer where it’s losing money (and not just through fraud). Global insurers have a slightly tougher challenge, as clients are spread all over the world, but it’s essential that these insurers know the risks in different parts of the world.

Stopping fraud at the front line is proving quite difficult for insurers, continued George, so insurers need to understand the types of fraud that pose the biggest threats to them. This, of course, is no mean feat, as there are so many different types of fraud. However, some quick wins can potentially be gained by validating people’s identities (while not creating too much of a hindrance during the purchasing process), cross-referencing existing customer data (depending on your system capabilities), and checking insurance fraud registers.

To prevent and control fraud, insurers need to be proactive in assessing their risks and looking at their data and claims trends. There need to be systems in place that flag up claims that need to be referred for closer inspection rather than simply paid. Some of this can come from system controls – where technology can cross-reference historic claims data to highlight similar claim types, claim amounts, invoice numbers and the like – but there also needs to be sufficient front-line knowledge and training so that claims handlers know when to refer a claim to the Special Investigations Unit (SIU). Building an anti-fraud culture into the business is an ideal extension of this, so that the right staff are always given the right information at the right time. Essentially, though, maintaining effective control over the identification and detection of fraud requires continuous assessment of emerging fraud trends and constant and rapid revision of your detection techniques; and the best way to approach this is through co-ordination and the sharing of fraud data with other insurers.
Nepal: problems and solutions

Phil Peart
Managing Director, Centricity Ci

In Phil’s presentation, he talked about the pricing and fee structure of evacuations carried out in Nepal, analysing insurer findings. His company, Centricity Ci, engaged in an extensive audit in an effort to understand why there was such a high mark-up on medical bills and rescue operations, and in doing so uncovered a plethora of anomalies. Much of the blame, it turned out, could be pinned on trekking companies.

Kathmandu, said Phil, is a ‘hive of activity’ where trekking companies are ‘a dime a dozen’. There are 1,184 registered trekking companies in Nepal, and 90 per cent of these are based in Kathmandu – in some areas, there might be up to six occupying a single building. Frequently, these operations are making extra money by charging inflated prices for guiding climbers.

Trekking, Phil explained, usually commences in Lukla, and a round trip from there back to Kathmandu should take approximately 2.5 hours, although both the time and the price will often be inflated significantly if there is a rescue operation. Critical questions must be asked, said Phil, such as what the weather was like on the day of the rescue, and how long a helicopter should have taken to carry it out, compared with how long it was claimed to take. There are of course often legitimate reasons for rescues, such as severe altitude sickness or other illnesses and injuries, but sometimes it’s simply a case of a free ride back to Kathmandu, the bill for which can then be sent to an insurer.

Phil then described the sort of plan that a more unscrupulous trekking company might put into action – the companies will be ‘delighted’ to find that a trekker has travel insurance, as that can mean an extra US$1,000 going straight into the company’s pocket. They will bill the insurer, having inflated the costs, and then after being paid, they will pay the helicopter that carries out the rescue; the insurer tends to have no contact with the operator, said Phil, who then went on to give examples of evacuations that ended up costing insurers significantly more than they should have. Tricks used include giving deliberately non-specific details of locations – such as ‘Everest region’, which covers a fair amount of ground. Insurers, said Phil, need to find ways of making sure they know exactly what is going on before the rescue operation is underway. In some cases, he said, there might be four trekkers onboard a helicopter, each with a different insurer, and each insurer is getting the same bill – a significant pay day for the trekking company and those in on the scam.

Of the 38 different claims reviewed by Centricity, 83 per cent involved evacuations off-mountain, and kickbacks were going to helicopter pilots, to trekking companies, and to the guides encouraging insureds to get on the helicopter in the first place. One solution, Phil said, was for insurers to speak directly to customers – if the guides are able to call down the mountain to the trekking company, then the trekker should be able to call their insurer. Pricing and contracts also need to be agreed beforehand, and insurers must demand to see flight logs and passenger manifests for billed flights, because according to the local Civil Aviation Authority, often these will not be shown. Phil also said that template medical claims are an issue, with the same forms being copied and pasted by local hospitals, just with names and certain details changed. He gave an example of a US$10,250 fraud case involving a fake health report and a fake company. When dealing with this case, Phil said, he spoke to an accountant, and the very next day found that that accountant had ‘done a runner back to India’.

Insurers need to find ways of making sure they know exactly what is going on before the rescue operation is underway.
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Ram Bahadur Nepal Chhetri
Executive Director, Alpine Rescue Service Pvt Ltd

Alpine Rescue Service, said Ram, has been working in Nepal for two decades, so he was able to give a broad view of how things have changed in the area. For example, due to the proliferation of cheap, online deals, there are many more treks being undertaken, and whereas itineraries used to be much longer, with experienced guides and trekkers taking their time, now treks are much shorter, which – perhaps paradoxically – means that things are more likely to go wrong.

One danger, said Ram, is that because trekkers now have less time to acclimatise to the altitude and conditions, altitude sickness is much more common. However, despite the fact that there are plenty of medical facilities on the mountain, many of them with Western doctors, trekkers are not taken to them, they are evacuated. This, said Ram, is deliberate – insurers and aviation companies need to make sure that these available facilities are being used. “We are still paying for these unnecessary evacuations,” he said.

Another reason for unnecessary trips cited by Ram was the fact that Lukla Airport is often closed due to bad weather. People need to catch connecting flights, and cannot trek to their next destination, so they will talk to locals, who will ask if they have insurance. When the trekkers say yes, they are told that if they make a big scene, they can be evacuated off the mountains. “Poor travellers don’t have a choice,” said Ram, explaining that insurers need to look closely at the reasons that people are being flown off the mountain, and to update their policies and insert warnings accordingly. He also warned about the fact that prices for flights in Nepal are often given in ‘block hours’, rather than exact flying time, which is another method of inflating costs and obscuring what’s actually happened.

In terms of solutions, said Ram, insurers need to look very closely at what is occurring on the ground. They need to look at accident records, undertake internal audits, and cannot rely on paper reporting – all the proposals that they will be given, according to Ram, look ‘beautiful’, but they can’t be trusted. Many air companies – not all, but many – have been blacklisted, and competition is fierce, which increases the possibility of fraudulent behaviour. It is hard, Ram admitted, for insurers that do not have a local presence to get a clear idea of what is happening, so local connections need to be fostered. Insurers must have representatives on the ground who are familiar with local customs, geography and habits, so that there is a better idea of what is legitimate and what isn’t. In the event of evacuations, additionally, insureds must be asked more questions, and more specific information is essential, such as where exactly they were evacuated from, what the altitude was, and how many people were on board. If there were five, for example, why were they all there? Then, finished Ram, “if evacuation is carried out without prior approval, insurers must claim back [the cost]”.

Despite the fact that there are plenty of medical facilities on the mountain, many of them with Western doctors, trekkers are not taken to them, they are evacuated...
Louise Heywood
Marketing and Business Development Manager, CustomerCare Medical Assistance

Louise’s presentation looked at the issue from a slightly different angle, taking in an assistance company’s perspective, rather than focusing just on helicopter medevacs. She talked a little about her company, which manages over 40,000 cases a year, dealing with 500,000 incoming calls and over 400 evacuations and repatriations, and then brought the focus to the Nepal earthquake that occurred on 25 April this year.

Louise said that phone calls began on the evening of the first day, and within a week CustomerCare was ‘snowed under’ with calls, and dealing with a spreadsheet of around 200 people. They were matching up the names of missing travellers with information from people calling in, liaising with the Red Cross on the ground and myriad other tasks. Having previously dealt with ash clouds, tsunamis and other such events, Louise explained, they knew to immediately activate catastrophe response protocols, splitting up teams and assigning different duties, including notifying clients, changing phone lines (for example ‘press 1 for calls related to Nepal’), entering ‘cat’ codes on case management systems and managing business as usual, as there was still plenty of non-earthquake related business to attend to.

Louise's company offers a global SIM card to policyholders, which offers both a cheap method of communication but also a way of providing data to the assistance company - the SIM card can easily show how many insureds are on the ground in one place at one time, so when an incident such as the Nepal earthquake occurs, it was easy to see how many people needed assistance. Phones could also be topped up remotely, and insureds could be informed about what help was available.

The next step, said Louise, was working out how to take people home. Airports were blocked up, with relief planes flying in, and most of the available helicopters were being used by the local government. One issue was that the longer it took to get people out, the more fatigued the company’s staff were getting, as there were only so many hours that they could work, and only so many duties that temporary staff could handle. The emotional distress of the friends and family of those on the ground also, in turn, emotionally affected the staff.

A multi-disciplinary team was eventually dispatched to Nepal, including a physician, a nurse, a counsellor, an ex-military case manager and a security expert, and other staff members were flown in from Sydney, Brisbane and even China, meeting first a base in Kuala Lumpur, and then travelling on to Kathmandu. At the same time, chartered aircraft were being dispatched from Kuala Lumpur to Kathmandu to pick up insureds. Louise then showed a short video of the rescue operations, including interviews with those who had been evacuated, demonstrating the important role insurers and assistance companies play, not just as a facilitator of rescue, but as a connection between distressed people and their families back home.

In the Q&A session that followed, attendees and panellists discussed the importance of having psychological support staff present, something that is still relatively uncommon. Points were also raised about the scale of the fraud problem in Nepal, with parties at all levels involved in fraudulent behaviour – an example was given of 25 Japanese tourists being evacuated on a single day and the same report being copied 25 times, with all those involved apparently having identical blood sugar levels! The problem, said one attendee, is endemic.

Another point was raised by a helicopter operator, who said that while they weren’t trying to defend fraudulent behaviour, people needed to understand the economics of helicopter operators, and the challenges of a competitive environment. The insurance industry, they said, should set up country-specific standards, and make sure to stick with reliable companies in order to phase out more unscrupulous parties. It was also asked whether the global SIM cards used by CustomerCare could be made a requirement, rather than a suggestion, and Louise said that there was already high take-up, with cheap rates being a good incentive. However, she said, while the cards could be given to everybody, companies couldn’t really force them to insert them into their phones.
The ITIJ Industry Awards 2015 were held on 5 November in the Megaron Athens Concert Hall. With hundreds of professionals in attendance, and thousands more watching online, this year’s show was more spectacular than ever. The glittering awards ceremony – now in its 13th year – honours those companies that have made an outstanding contribution to the global travel and health insurance industry over the past year.

Ian Cameron, ITIJ’s editor in chief, said of the Awards: “It was a fantastic evening! I would like to say congratulations to all the winners on the night, but also to all those companies who were nominated as finalists as well. The competition was fierce this year, and goes to show how important these Awards are to everyone in the global travel and health insurance industries.”

ITIJ would like to congratulate all the finalists and winners of this year’s awards. The finalists are selected through an open voting process on the ITIJ website, and when the top three or four companies in each category are determined, a panel of industry veterans then judges submissions made by our finalists to decide the ultimate winner.

Watch a full recording of the warm-up show and the Awards at: www.itij.com/awards

Thanks must be given to South Africa-based air medical provider ER24, for sponsoring the amazing entertainment that served as the perfect warm-up to the awards ceremony itself.
The runners up in each category were:

**Travel Insurer/Underwriter of the Year**
- Ageas Insurance
- TuGo

**Assistance Company of the Year**
- Active Care Management
- Global Response
- Orion Assistance

**Intermediary/Broker of the Year** (includes own brand insurance retailers)
- Columbus Direct
- InsureMyTrip

**Air Ambulance Provider of the Year**
- ER24
- FAI
- Tyrol Air Ambulance

**Cost Containment/Claims Management Company of the Year**
- GMMI, Inc.
- marmassistance

**Medical Provider of the Year** (includes medical escorts and hospitals)
- Matilda International Hospital
- Vithas Xanit International Hospital

**Legal Services Provider of the Year**
- Blake Morgan LLP
- International Recoveries LLC

**ITIJ Marketing Campaign of the Year**
- marmassistance
- PassportCard
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WINNER: CIGNA INSURANCE SERVICES

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Judges’ comments: What a significant year this has been for Cigna! With such a remarkable growth rate it can now be regarded as one of the major players in the market. Much of this success can be attributed to its focus on customer care, which bodes well for the future.
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WINNER: FALCK GLOBAL ASSISTANCE

“For over 100 years, Falck has been keeping people safe. With operations in 47 countries on six continents, our global network of hospitals, clinics, response centres, and security offices means you’re always in safe hands. Falck Global Assistance is the biggest assistance company in Scandinavia and one of the largest global players in the world. We have consolidated our global position establishing our US, Indian, and Chinese Emergency Response Centre – a journey that goes across cultures, religions, colours and beliefs.”

Judges’ comments: Despite only entering the assistance market six years ago, Falck Global Assistance has achieved an impressive growth rate and is achieving high satisfaction levels from both customers and staff. With the support of its parent company, Falck is set to expand on a global basis.
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WINNER: HEALIX INSURANCE SERVICES

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Judges’ comments: Healix Insurance Services continues to set the benchmark for the travel insurance industry. Healix never rests on its laurels and its initiatives this year, notably in product and service expansion, are very impressive. Its future strategy suggests it will continue to be a significant force in the market.
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Judges’ comments: For their commitment to training, charitable work and community support along with a 100-per-cent accredited lifetime safety record, the judges were in agreement that REVA, Inc. deserves the ITIJ Award.
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WINNER: CHARGECARE INTERNATIONAL

“Celebrating 20 years in the business, ChargeCare International continues to be a market leader in the provision of cost containment and claims administration services throughout Europe. Combining the specialist skills of our multinational team of experts, along with advanced technology, ChargeCare is proud to provide independent and highly transparent cost saving solutions. We are proud to work in close partnership with a global list of blue-chip companies, to reduce claims costs, enhance their customer experience, streamline administration overheads, fight fraud and deliver valuable claims reporting.”

Judges’ comments: Despite lacking the structure of some of its major competitors, ChargeCare International has developed its global base and can now be regarded as a credible player on the international scene. An efficiently-run entity with a focus on both clients and staff – its future prospects look bright.
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www.Jet-Rescue.com | operations@jet-rescue.com
WINNER: SHARP HEALTHCARE

“Sharp HealthCare is an integrated healthcare delivery system based in San Diego, California. Sharp includes four acute-care hospitals, three specialty hospitals, two medical groups, outpatient and urgent care centres, home healthcare, hospice, occupational rehabilitation, and many more services. Sharp is not for profit, but for people, which means all of our resources are dedicated to providing the highest quality of care, the latest medical technology and superior service for our patients and their families.”

Judges’ comments: This cutting-edge medical facility impressed the judges by devoting thousands of hours to community service projects whilst being challenged with great pressures to keep up with unpredictable, and often uncompensated, service demands from Mexico.
WINNER: TROWERS & HAMLINS INCORPORATING STONES SOLICITORS

“From its offices across the UK, Middle East and Far East, Trowers & Hamlins provides commercial advice across a broad range of practices including corporate, real estate, housing and regeneration, construction, public sector/local government, dispute resolution, private wealth, banking and finance, employment, pensions and tax. It is ranked in over 90 categories across the UK and international editions of The Legal 500 and Chambers & Partners, the independent legal directories. Stones is a leading firm in the southwest of the UK.”

Judges’ comments: The judges were impressed that Stones Solicitors competed in terms of client base, expertise and marketing with their much larger competitors. Their presentation highlighted a ‘boutique’ approach to meeting their clients’ individual needs. Stones’ new partnership with Trowers & Hamlin looks set to build on their success.
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Presented by Mandy Langfield, Title Editor and Mike Forster, Group Sales

WINNER: UNITEDHEALTHCARE GLOBAL

“UnitedHealthcare Global safeguards the health, well-being and productivity of global workforces and populations, through its range of healthcare and mobilisation solutions; developed in-house, and delivered in an integrated package or as a single product. Working specifically in the areas of insurance, assistance, safety, medical delivery and traveller protection, its real-time, global capabilities enable a new age of human capital logistics, empowering organisations to mobilise their talent to wherever they feel it delivers the greatest return on investment.”

Judges’ comments: The judges appreciated the dynamic adverts from UnitedHealthcare, noting how the constantly changing artwork and clear messages throughout the year is a reflection of the innovative approach it takes to meeting its customers’ needs.
For more photos from ITIC Global and the 2015 ITIJ Industry Awards visit www.flickr.com/photos/voyageurgroup and select the relevant album.
2016 ITIC SCHEDULE

6th annual conference
San Diego
Westgate Hotel
28 Feb - 1 March 2016

17th annual conference
Oxford
Randolph Hotel
4 & 5th May 2016

8th annual conference
Singapore
The Park Royal on Pickering
13-15th June 2016

24th annual global conference
Berlin
31 Oct - 3 Nov 2016
Ritz Carlton Hotel
The #LookingSharpITIC selfie challenge went down a storm with attendees this year! Competition to win a free registration to next year’s ITIC Global in Berlin was fierce, and selecting the finalists was a tricky task!
The winner will be announced via email on 2 December.
New look - same passion for service and savings.

See it all at globalexcel.com.