ITIC GLOBAL 2016 REVIEW

International Travel & Health Insurance Conference

Berlin 2016

The Ritz-Carlton
31 October – 3 November 2016
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It is always a pleasure to see so many familiar faces at ITIC, and to make so many new acquaintances. ITIC Global in Berlin was our biggest event to date and as the ITIC community continues to grow, so the conference evolves and provides more opportunities for networking, debate and education. Over the following pages, you’ll find panel session synopses, photo galleries, and a full round-up of all the social activities that took place throughout the conference – from the Welcome Reception at the stunning AXICA building to the Finale Dinner and ITIJ Awards ceremony in the ballroom of The Ritz-Carlton. Berlin was a fascinating location for this year’s ITIC Global, and it was exciting to host the conference in this great city for the first time. The event was, as always, concluded with the 2016 ITIJ Awards, and a full overview of this year’s winners can be found in this publication. If you weren’t in Berlin, or if you want to watch the Awards presentations again, you can do this online via the ITIJ website – www.itij.com/awards. May I take this opportunity to once again say congratulations to all of this year’s finalists and huge congratulations to all the 2016 winners. Also, thank you, of course, to all our valued ITIC and ITIJ Awards sponsors. On behalf of the ITIC and ITIJ teams, we look forward to seeing you next year at one of our ITIC events!

Ian Cameron

Chairman’s message
The first day of sessions at ITIC Global Berlin could not have ended on a higher note, with the official Welcome Reception – sponsored by New Frontier Group – being held at the AXICA building, adjacent to the historic Brandenburg Gate.

It may have been a cold and wet start to the evening, but the incredible architecture by Frank O. Gehry, the endless canapés, and bountiful drinks made for a wonderful evening, where attendees reconnected with old acquaintances and made new connections in the fantastic atmosphere of this stunning location.
Networking in Berlin

Networking at ITIC Global is one of its biggest attractions, and this year did not disappoint! Attendees were able to network from the moment they registered using the ITIC Berlin App, and the week in Berlin also saw endless possibilities for attendees to interact and create new connections.

The Networking Lounge – sponsored by REVA and Commercial Medical Escorts – provided a seated area for attendees to conduct those important meetings, the coffee and lunch breaks allowed everyone to refuel, and the many competitions and draws by exhibitors sparked quite a bit of interest – particularly UnitedHealthcare Global’s cycle challenge, which really got people’s blood pumping!
ITIC GLOBAL 2016 | REVIEW

- Business Cards: 308,750
- Exhibitors: 36
- Countries: 70+
- Speakers: 86
- Spreads: 253
- Sponsors: 26
- Networking Hours: 16
- First Timers: 217
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Medical transports: global case studies

Peru – Best-laid plans diverted during transport of four-storey balcony fall survivor

Denise Waye
President – AirCARE1 International

This medically challenging and logistically difficult case saw a 23-year-old woman transported from Peru to California when she sustained life-threatening injuries after falling 43 metres through a skylight in the roof of a hostel. She was taken to a local hospital in Trujillo on the back of a pick-up truck and given initial surgery on her back. When AirCARE1 received the call to ask it to transport the patient, there was still little medical information about her, except that she was badly hurt and was going to need further extensive surgery.

The air ambulance company had an aircraft in Mexico at that time, so the plan was to fly it down to Peru, via Costa Rica for a fuel stop, and collect the patient after an overnight crew rest at the destination. The aircraft set off as planned, but after leaving Costa Rica, it got turned around; no one knew why and the company had to wait for an hour and a half for more information. It turned out that the aircraft was diverted as it did not have the correct overflight permissions for Columbia. The pilot was told to head west, but would have run out of fuel before reaching Peru, so turned back to Costa Rica.

Crew duty times were now also an issue, meaning they could not now go on to Peru.

Various options for how to complete the transport were considered, some of which would mean a significant delay in collecting the patient, which AirCARE1 felt was not an option. So, the pilots were duties off in Costa Rica and subsequently flew to Peru.

There were various issues at the patient pick-up – mainly that the hospital had taken the patient to the airport, in the heat, with no pain medication. Once the patient was made comfortable, she was transported to Houston, Texas, US, via Costa Rica for a fuel stop. In Houston, a second set of pilots met the aircraft to complete the onward journey to San Diego, California, where the patient was admitted to Sharp HealthCare. She remained there for several weeks before her final repatriation via commercial stretcher home to Australia.

Denise said that the lessons learnt from this mission were to make sure you have a checklist, and to check it. The company responsible for obtaining overflight permits had failed to get the correct permissions for Columbia, so AirCARE1 had to pay for over two hours’ worth of extra fuel and work on pilot and crew repositioning. Denise said her company also has satellite communications on order for their aircraft.

China – Logistical issues using commercial and private business jets

Steven Holt
Chief medical officer – Deer Jet Medical

Steven began by citing a case in which a wealthy family had used their G550 business jet and a hired medical crew to transport a family member from China to the Mayo Clinic in Minnesota, US for cancer treatment, to highlight some of the issues that can be faced in China when it comes to the use of oxygen onboard aircraft. The family and local medical team in China had not consulted with the Civil Aviation Administration of China (CAAC) or a local aeromedical provider about what type of oxygen tanks and concentrators were allowed onboard, and this equipment was not allowed on the flight. The flight proceeded with a different type of supplemental oxygen (pillows), but unfortunately, the patient decompensated in flight above Japan, leading to a diversion to Tokyo for medical treatment. The aeromedical team was unable to procure oxygen bottles or concentrators while in Japan for the rest of the journey, so at this point Deer Jet was called in to assist. The company flew the patient on a Falcon 7X with an expanded medical team, oxygen tanks, an O₂ concentrator and intensive care unit (ICU) equipment in an uneventful onward journey. The emergency diversion, however, cost the family RMB1 million.

Steven went on to highlight issues that foreigners to China often experience when dealing with the local healthcare system.
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Despite the challenges of trying to communicate effectively with the treating hospital in Libya, the risks associated with flying into a ‘war zone’, and the poor medical condition of the patient in this case, an impressive team effort led to a successful repatriation. The patient, a 63-year-old male from Greece, was a sailor who became ill while onboard a commercial ship in February this year. He was transferred to the Libyan Red Crescent Hospital in Misrata in a serious condition, with generalised edema, and taken to the high dependency unit. Despite making initial progress in his recovery, after a few days, his condition showed sudden deterioration – hypotension, tachypnea, decrement of oxygen blood saturation and swift representation of the generalised edema. He also had a medical history of insulin-dependent diabetes mellitus, pulmonary edema, obesity and anemia. He was transferred to the intensive care unit (ICU), where he was intubated under sedation with morphine.

At this point, the patient’s family asked for him to be repatriated to Athens to be transferred to a more advanced ICU. Gamma Air Medical prepared to move this critically ill, intubated patient in an ICU configured air ambulance. There were a number of medical and logistical challenges in this case. These included very little direct communication with the treating doctor in Libya, and different names had been put on some of the medical forms, so Gamma didn’t even know if it had information about the correct patient. There were also: overflight permission issues as at the time of the mission, Italy wasn’t accepting overflights from Libya; the challenges of obtaining landing permission for Libya; a delay in receiving information from the insurance company; and issues regarding immigration procedures. Nevertheless, the Learjet 35 landed safely in Libya and received the patient at the airport. His condition was not good, however – he was intubated but not sedated, and was restless. The receiving medical team sedated the patient and hooked him up to the ventilator. He was also a very large patient, so a larger aircraft would have been suggested if this information about the patient had been conveyed, said Dr Kyriacou.

The transfer flight took place without incident and an ICU road ambulance was waiting for the patient at the airport in Athens. The patient was hospitalised for 40 days before making a recovery and being discharged.
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Kate Newhouse

CEO – Doctor Care Anywhere

Kate started by stating that, despite the blank face of the public when presented with the word ‘telemedicine’, around 70 per cent of consultations could be handled through a telehealth system. Although emergency situations may not directly benefit from the growth of telemedicine, she said, primary care situations will. Kate predicts that telemedicine will grow from 19.7 million users in 2014 to 158.4 million in 2020.

Globalisation has meant that travellers now expect a certain level of healthcare, even when abroad. A traveller in need of medical treatment for a simple illness may avoid going to see a doctor abroad because they feel uncomfortable in a foreign environment, and this, said Kate, is bad not just for the customer, but also for the insurer; the use of tech can assist an insurer with its continuity of care and its ability to ‘control’ onward care.

Despite the positives, Kate pointed out a number of issues that telemedicine must overcome to be successful, such as the logistical and legal implications of such a service. Dr Cai Glushak delved deeper into these issues within his presentation from a medical view, but Kate was keen to emphasise the logistical and legal elements, pointing out that there will always be another party helping the customer, so the end user must map out care pathways clearly. A new telemedicine service should also be easy for a consumer to use. Services like Airbnb and Uber have taken off with customers because of their well-designed apps. A telemedicine app, Kate asserted, should aspire to be as simple as these apps, and she ended her talk with a call to arms: “Telemedicine has been around for 10 to 15 years, or longer in the oil and gas industries, but it hasn’t really been integrated in an international sense. There isn’t a blueprint for international telemedicine, or a framework that exists. So, we need organisations to work together to make that happen.”

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Dr Cai Glushak

International medical director – AXA Assistance USA

Dr Glushak spoke from a different perspective, focusing on the US rather than the global view, and explaining the differences telemedicine could make to rural areas in large countries. He pointed out straight away, however, that telemedicine internationally and in a domestic setting do share some similarities: both provide urgent and specialty care consultation, and can assist with the case management of chronic diseases – and, in some cases, mental health issues. However, domestic services do not have to be as bespoke as international care and can also deal well with stroke cases, said Dr Glushak.

Putting a label on telemedicine is an issue with the quickly mushrooming practice. With the rise of technologies such as Fitbits and other affordable personal health monitoring devices, telemedicine should instead narrow its focus to connected health, Dr Glushak asserted, but first he asked the audience a very important question that needed to be answered when defining telemedicine: ‘What is medicine?’ Dr Glushak’s defined a person practising medicine as someone who ‘offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition’. This definition, he said, serves to highlight a further issue with telemedicine: how do providers make sure the service is professional and medical, rather than simply advice? Where a normal medical consultation takes place in an overtly medical environment, he argued, the informality of telemedicine means that there would need to be certain safeguards in place to make sure the experience for both customer and consultant is consistent. However, keeping this experience consistent across both international, and even domestic, borders is difficult.

The biggest issue, especially within the US, is the legal issues that surround where doctors can practise and prescribe. Though doctors in the EU can practise in any EU member state, within the US and Canada, doctors are only legally able to practise in states they are licensed for, hence why Dr Glushak calls the states and provinces the ‘nations of the US and Canada’. He said that it would cost a doctor between $1,200 and $1,500 to practise in every US state, meaning that it would be difficult for a practitioner to assist a patient. To make matters harder, he added, some states require a doctor to have a previous relationship with a patient before performing telemedicine, and one state insists that all telemedicine must be conducted via video. Prescriptions would have to be restricted if telemedicine was to function ethically. Dr Glushak pointed out that most primary care situations do not need a prescription, but he suggested that doctors not be allowed to prescribe narcotics remotely and that antibiotics be given sparingly.

Despite the obvious barriers to telemedicine, Glushak agreed with Kate’s estimated growth figure, even saying that he could see the figure rising higher when questioned by the audience. He finished his presentation by saying to the audience that they cannot ignore telemedicine, but that it is key to find a successful niche in this quickly expanding market.
Security responses to terror

Assistant industry response to terror-related incidents; and how such events are impacting travel

Geoffrey Breeze
Marketing director – World Travel and Tourism Council (WTTC)

Geoffrey quickly set the scene, playing a video montage of terror events that occurred during the last 12 months. He then stated that tourism brings in around 10 per cent of the world’s GDP and accounts for one in 11 jobs worldwide. Recent events, Geoffrey asserted, have however had only a minor effect on worldwide tourism, usually denting only specific areas’ receipts. Only three events in the last 25 years have caused the worldwide tourism industry to decline, and only one has been terror related (the 2001 attack on the Twin Towers in the US). Geoffrey stated that terror events have increased 20-fold since 2000, but only one per cent of attacks have targeted tourists. Although the number of deaths has steadily risen, the number of people travelling has not declined.

The WTTC conducted a study, said Geoffrey, studying 38 crisis events in 34 countries, and tried to measure how a terror event impacted a country’s tourism, and how quickly the country recovered. When compared to political turmoil, environmental disaster or disease, terrorism events had less impact, lost the least new arrivals and took less time to recover from. The WTTC also wanted to see whether a government’s response can assist a country’s tourism recovery. For this it compared the 2012 terrorist attacks in Kenya with the 2003 bombings in the Philippines, and found that the Philippines recovered far quicker, with an upturn in bookings after only 11 months due to the perceived control the Philippine authorities had over the events. On the other hand, the negative reaction to the Kenya authorities’ response has meant a large downturn in bookings to the country after 36 months, still with no sign of recovery. However, Geoffrey was keen to assert that no two terror events are the same, and so recovery is always different. The net bookings were down in Brussels by 136 per cent after the attack there in March, but much of this was down to the fact that the airport and other infrastructure were damaged. The Paris attack saw a downturn of only 22 per cent as the venue hit was not in a tourist district and did not affect how travellers got to the city. Though the projected travel sector growth in both these cities is now less than it was prior to the event, the travel sector is still expected to grow globally by 3.1 per cent. Despite the turmoil, Geoffrey was keen for the audience to take away the sentiment that humans will always show resilience, and therefore still travel. "Terrorists aim to spread terror," he said, "so fear is an understandable

Rezwan Ali
Head of security – Falck Global Assistance

Rezwan approached the topic from a far more ‘hands-on’ perspective. From his Copenhagen, Denmark-based situations room, Rezwan has overseen Falck Assistance’s ground response to the year’s major terrorism events. From the first slide of his presentation, Rezwan was keen to assert that in any crisis event, situational awareness and planning are key to successfully protecting and extracting clients, whether they are business or leisure. The difference, according to Rezwan, is that with a leisure traveller, you are simply expected to give an emergency response to a situation, but for your own employee, a company should be ‘owning the situation’. Information is key to this: companies need to make sure the information they receive is screened and filtered before being accepted. Local sources need to be vetted and trusted sources need to be close to the event to relay information. Only after a full picture of a scene is obtained should a plan of action be implemented.
Rezwan then gave examples of his experiences with both the Paris and Brussels attacks. He said that gathering information as the event was happening, it shows you have to be creative, you have to quickly find a new way to work.

Rezwan then explained his company’s specific framework. After the incident itself, the first step was to assess the situation before initiating action plans. Only when all systems were ready to go were teams sent in to recover employees. Rezwan stated that taking all necessary steps properly will mean that ‘you are put back in control of the situation’. Planning and assessment are not only key during the event, but constantly. Rezwan stated that his company undertakes regular situation exercises to constantly check that the systems put in place work for numerous places, even those not in the western world. The systems are also audited regularly to make sure that they are as cost effective as they can be.

Rezwan then gave examples of his experiences with both the Paris and Brussels attacks. He said that gathering information on where people were situated in Paris was easier, as because the attack was in a residential area, teams were simply able to check an address to find out if clients were safe. Brussels was far more difficult, as those at the airport were taken away to safe places by local authorities. It was therefore harder to find clients, but good local intelligence helped to locate them. Smart phone apps, a topic that came up numerous times during the terrorism session, also helped in the location of those on the ground in Paris. “Once we knew where they were, we could start creating frameworks and infrastructure meeting points,” added Rezwan. “But that was not something we had in place already, that was something we had to find out on our own.”

Smart phone apps, a topic that came up numerous times during the terrorism session, also helped in the location of those on the ground in Paris. “Once we knew where they were, we could start creating frameworks and infrastructure meeting points,” added Rezwan. “But that was not something we had in place already, that was something we had to find out on our own.”

Rowland Brothers International are proud to be the winners of the first ever Ancillary Assistance Service Provider of the Year award at the ITIJ Industry Awards 2016. This global industry event took place at The Ritz-Carlton in Berlin on the 3rd November 2016 and was the 14th annual International Travel and Health Insurance Journal awards.

The ITIJ awards recognise excellence in the diverse companies providing services worldwide to insurers and their clients. The new Ancillary Assistance Service Provider of the Year award, sponsored by Jet Rescue, the worldwide critical care air ambulance, acknowledges the high-quality global repatriation service that Rowland Brothers International provide all over the world.
Ted Jones
CEO – Northcott Global Solutions

Ted started with the bold assertion that ‘the assistance industry has not kept up with changing travel patterns’ and is still based on an old model of working, one that only works for travellers in the developed world. These issues, he said, have been brought into focus due to recent terror attacks.

Ted pointed out the new dangers of travel, with subjects like natural disasters and kidnap and ransom being far more prevalent than 30 years ago. These new issues should not be shied away from, he said, or treated differently by insurers than more well-known medical situations.

These new dangers have caused an ‘assistance problem’ due to the outdated system. The exponential growth in global travel has seen travellers go to areas with little infrastructure, which has left significant gaps in assistance cover, both geographically and in terms of liability. He also pointed out that most assistance companies do not have point-of-incident cover. Customers therefore rely on ‘good Samaritans’ in countries with no proper service, something that Ted called a ‘not very grown up way of doing it’.

“In contracts you’ll see lines like these: ‘Evacuation services will be provided from the international port of departure’. Well that’s fine if you’re going to have your heart attack or car crash at the airport, but it’s very limited if you’re not.”

One of the key ways to transform an assistance system, said Ted, is to have a lot more ‘tools’ at your disposal. Different departments building up relationships with local medical services, ambulance services, diplomatic services and accommodation means that help can be brought to a customer at their point of incident in hours, instead of evacuating them from an international port of departure, which can take days. Realising that not all incidents will be medical related was key to this, said Ted.

He said NGS helped evacuate numerous clients during the Arab Spring in 2011, but not one was health related.

A strong due diligence model will mean that local companies can be trusted in all areas of customer evacuation and will also add more to the ‘toolbox’ of an assistance company, and the more tools, said Ted, the lower the risk involved in a situation. He said that it is key for companies to start offering customers a tracking app: ‘If you can combine technology with a response capability, then you’re looking at a 45-minute reaction time, when really the traditional model is not close to that. That’s when you start saving lives, and indeed money.”

Ted’s final piece of criticism was that many assistance companies’ operations rooms do not operate 24 hours a day, 365 days a year. This is not good enough, he said. Having your customer’s confidence that you will always have staff, especially medical staff, on call is the best way to build customer relations and therefore expand your company.

the assistance industry has not kept up with changing travel patterns
Jeff Rutledge
CEO – AIG Travel

Jeff rounded off the presentations by shedding light on how a large insurance company like AIG is writing products to help cover customers abroad in relation to terror events. He started by saying that the products on the market need to be ‘fit for purpose’ whilst also being understood by consumers, and focused his presentation on four statements: things that are small, not only big; care, not only compensation; public, not only private; and booking, not only cancellations.

“AIG relies heavily on data,” said Jeff, when explaining how AIG arrived at the conclusion that big does not necessarily mean good. He said that his company now thinks about the way small things influence the large insurance industry: “We have tried to make sure we are not missing the fundamentals.”

He called for the industry to work together to help revolutionise the way that terrorism coverage is put together, saying that insurers need to ‘pivot’ from a sole focus on money to the ‘underlying good we are trying to achieve’. By focusing on sorting out smaller issues within the industry, it means that customers will be more trusting and the ‘compensation will flow’. Education plays a large part in this, Jeff said, before challenging the travel industry to ‘sell the dream, but also enough of the reality’ to make sure customers know how to protect themselves more appropriately.

Part of this education, according to Jeff, is making sure that customers, especially the general public, realise that travel insurance involves security as well as health: “I looked at the list of attendees and all the companies [at ITIC 2016] and started counting. There were at least 246 companies, where the company name includes medical, healthcare, ambulance, or something in the medical space, so it is clearly identified … correct me if I’m wrong and I didn’t see it, but I don’t think I saw any at all that included security in their brand.”

Another part of education, and also part of Jeff’s fourth statement, was to think about how packages are put together, and how they are launched to the public. The best way to do this is not to focus on packages that cover global events, Jeff asserted, but to instead focus on events such as muggings. By focusing on the small, he concluded, the industry will have the appropriate infrastructure already laid for a larger event.

** insurers need to ‘pivot’ from a sole focus on money to the ‘underlying good we are trying to achieve’
How can the insurance and assistance industries better work with cruise lines when handling medical problems on board?

Dr Ben McFarlane
Medical consultant & author of Cruise SOS

Dr McFarlane gave an interesting account of life as an onboard doctor and provided fascinating insights into the realities of what injuries and illnesses usually befall guests and crew and why. Alcohol, he began, can be a big factor in cruise ship consultations – especially when it comes to treating crew members. These often low-paid workers, who are away from their families and lonely, are not unused to letting off steam at night by getting drunk. Bullying and depression are also not uncommon amongst crew members, while for female staff unwanted pregnancies are a recurring issue. Plus there are the physical hazards of some onboard jobs, such as sharp knives, power tools, bottles of bleach and steam irons.

So, the make-up of a ship doctor’s patient base is not just wealthy passengers who trip on their way to dinner or forget their blood pressure meds, said Dr McFarlane. Other common ailments include hot flushes from excessive hot tub use, injuries from using the gym for the first time in years, gastric issues thanks to over-indulgence at the ‘all you can eat’ buffets or the after-effects of street food, and jellyfish stings. Ship doctors are also treating more children thanks to the growing popularity of family cruises.

Larger cruise ships also contain a diverse population of 7,500 people – more than the old city of London. On land, such a community size would have a large medical support network of doctors, including osteopaths (back problems onboard are fairly common) and dentists (tooth problems are also a fairly common occurrence), and replicating this on a ship is a challenge. Very large ships can have up to three doctors onboard, but the standard large ships usually have two. Onboard medical equipment is very good, however.

Cruise ship doctors have little knowledge of what happens to passengers once they leave a ship, though, mainly because they’re so busy dealing with all the other patients passing through the medical centre. In any case, said Dr McFarlane, it’s important to remain in clear and constant communication with patients who need to be disembarked for treatment, especially if the cruise line wants to avoid bad press. This said, allowing patients to rejoin cruises at different ports after receiving treatment on land is happening much more frequently.

Ending the session on a lighter (if morbid) note, Dr McFarlane said the most common question cruise ship doctors get asked is ‘is there really a morgue onboard?’ and the other most common question is ‘is there anyone in it?’

Lee Thomassen
Senior director, health administration health services – Holland America Group

When it comes to helping passengers who become seriously unwell onboard cruise ships, cruise lines can’t function without the assistance industry, said Lee, and they want to work better with this industry. Holland America, he told attendees, is a collective cruise brand that operates four cruise lines that together employ over 400 doctors, nurses and paramedics across their 40 ships. The brand takes great pride in the quality of its medical standards onboard, and the health department of one of its cruise lines – Princess Cruises – is certified to ISO standards.

The cruise industry, continued Lee, has grown by 33 per cent since 2009, and more ships are set to be added to the cruising sector as demand continues to grow. Different types of cruise, such as river cruises, throw up different health and safety issues, but there will be more of these types of cruises in the future.

When a passenger has a medical issue onboard, explained Lee, they immediately have to deal with a range of logistical issues, and it can be an emotional and confusing time. They need to make financial and healthcare decisions they probably hadn’t planned for, they may not be aware of their insurance coverage details, and they have to deal with a range of loosely co-ordinated fee-based service providers. At the same time, the cruise line immediately faces the challenge of handling the patient carefully, especially in cases where they don’t have insurance cover or means to pay. This loss of control over the guest service experience also comes with related public relations, legal and ethical concerns.

It is furthermore a time that highlights the convergence of conflicting forces in all areas of the cruise experience – from booking to emergency medical evacuation – the burden of which sits ultimately on the shoulders of the guest. For instance, said Lee, you have the social media image the cruise line wants to promote; and the health department wants to avoid bad press. This said, allowing patients to rejoin cruises at different ports after receiving treatment on land is happening much more frequently.

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Cruise SOS
Cruise ship passenger assistance
Dr David Farcy

**Medical director – REVA, Inc.**

There are many aspects to mobilising a medical team to pick up a cruise ship patient, and a number of challenges that need to be overcome in order to successfully achieve such air ambulance missions. Obtaining a medical report is probably the most difficult thing, said Dr Farcy – whether from a cruise ship doctor or treating hospital on land. But medical reports are vital when determining what medical personnel to send with the air ambulance. When there is a delay in receiving medical reports, there is a chance that the patient’s condition may have changed since the report was made, so it is vital to get frequent updates from the treating physician – such as if IABP or ECMO is to be used – and all the necessary travel documents for both the patient and any accompanying family need to be obtained. All the while, time is of the essence – especially in the case of diseases such as myocardial infarction or sepsis that require urgent care. Other potential barriers and limitations to cruise ship repatriations highlighted by Dr Farcy were weather-related issues; equipment failure, meaning regular maintenance checks are required and equipment needs to be tested by the crew prior to flight; delays in getting insurance company approval; and conflict between the cruise line and the insurance company. Ultimately, communication needs to be better between cruise lines, insurers, and assistance companies.

Dr Farcy then looked at onboard medical centre equipment and services on cruise ships, which he said were good and include such facilities as ICU, pharmacy, lab and X-ray. However, these medical centres only stabilise patients, who need to be prepped for disembarkation and transfer by helicopter, boat or ground transfer. Where air ambulance transfers are requested, flight timing is critical, as there are often very tight deadlines to meet to co-ordinate the mission successfully. The cruise line and air ambulance provider also have to work closely together to ensure the patient arrives away with as positive a guest experience as possible despite their illness or accident.

Questions from the floor following this session looked at how cruise patients pay out of pocket then seek reimbursement from their insurer, and discussed where responsibility lies in terms of who should inform the insurer that a patient is being disembarked (this can ultimately rest with the patient but more often it is the cruise line that does it) and the importance of notifying the insurer in the first instance, as they may refuse cover if they do not arrange the disembarkation themselves. It was also suggested that passenger lists could include information about whether the passenger is carrying travel medical insurance, who the insurer is, and whether they have pre-existing medical conditions.

**more open and robust discussions around the insurance products serving cruise guests are ... vital**

Dr David Farcy

roles in a medical emergency and ensure there is no overlap, so time and resources are not wasted, and knowledge is shared and utilised to the ultimate benefit of the patient. More open and robust discussions around the insurance products serving cruise guests are vital, and Lee talked about the idea of developing a product that can be purchased by a guest at the time of an incident. Guest awareness of the risks of travelling on cruise holidays, and around related insurance product features, is also a must.
InsurTech Showcase
The importance of digital innovation

Manjit Rana
CEO – Ingenin Ltd

This session lived up to its name and showcased some of the breathtaking technology that is currently changing the face of the global insurance industry, and is set to enable further rapid development in the future. Looking at the changing demands that consumers are putting on insurers – from what they buy to how, where and when they buy it – and analysing how these trends are shaping the evolution of insurtech, Manjit gave a fascinating glimpse into the swiftly evolving dynamics of the insurance sector. “This world is changing dramatically,” said Manjit. “Insurance has just got very exciting.”

“In this world is changing dramatically ... insurance has just got very exciting”

industry to come up with innovative tech-based solutions. In the last two years, insurtech has become the biggest concept in the global insurance marketplace and the only companies that have been slow to embrace it have been the larger insurers. That said, almost every tier-one insurance company is now creating accelerator funds to invest in tech start-ups. AXA, for example, launched a €400-million accelerator fund, and companies such as Allianz and Aviva have something similar. This year alone, over $2 billion will be invested in insurtech start-ups. Such investment has aided the phenomenal growth in start-ups, where we’re seeing young millennials disrupting the marketplace with some very interesting thinking.

The driving force behind these developments is that consumer behaviour has changed hand-in-hand with technological advancements. Smartphone usage has grown exponentially in all areas of the world, and consumers feel constantly connected. The sharing and gig economies highlight this connectivity, and insurers need to create products to protect people in these new situations, with smartphone operability a necessity. Speed is of the essence, though, with consumers demanding almost immediate access to products and services, and the insurance industry is going to have to react far more quickly, said Manjit.

Software is already allowing proactive and automatic communication from the insurer via smartphones, such as passing on helpful information to the policyholder, offering short-term cover based on the current location and situation of the smartphone user, or triggering the claims process. Insurers are also creating chatbots and messaging services, as this is the preferred method of communication for many of today’s insurance purchasers. New software such as Hound (similar to Siri) allows consumer queries to be answered electronically in near real-time. This is the kind of technology insurers need to embrace to stay competitive with the start-ups that are coming through.
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Ronald Pritchard
Head of network – Globality Health

Ronald began his presentation by talking about what insurers expect from their service partners and medical providers, from market knowledge (such as understanding the specific cultural requirements of a patient and the region in which they are being treated, as the needs of a German national requiring care in Singapore, for instance, will be different to those of a Chinese national) to excellent customer service and precise financial reporting. Poor service, he said, is often the result of a breakdown in communication at some level, so it is essential that insurers are on the same page as all their service providers, in every possible way.

Another key point to remember, said Ronald, is that while ‘somebody is always willing to do it cheaper’, a lower price isn’t the be-all and end-all, and you may not be getting the same quality of care at a lower price. Everybody has their own model for pricing, and while everybody obviously has to make money, it is incumbent upon insurers to ensure that the customer is getting the best possible level of service.

Ronald then went on to discuss some case studies illustrating examples of when things go well – and when they don’t. The more positive example involved a third party administrator (TPA) and preferred provider organisation (PPO) successfully navigating a complicated case involving a company whose employee required an organ transplant, with constant communication between family, insurer and employer a hallmark of the process. The less successful example involved a pair of TPAs, one local and one not, in which conflicting information was given, with the information from the local TPA being more accurate in the end than that provided by the other TPA. These examples, said Ronald, showed the absolutely essential role that good communication plays when managing cases – one of the issues in the second case, for example, was differing opinions and standards from different centres in different countries, with the insurer stuck in the middle, unsure of whose advice to follow. “At the end of the day,” said Ronald, “who suffers? The customer.”
Dr Arthur Zulficarov  
**General manager – Global Voyager Assistance**

The subtitle of Dr Zulficarov’s presentation was ‘the mission of a TPA’. These, he said, ‘are often underestimated’: “I’m going to tell you why they shouldn’t be.”

He illustrated the essential participants of a medical case with what he called the ‘case management triangle’, with the TPA at the centre and the patient, insurance company and medical facility at each point. The triangle is equilateral, he said, because the first principle of the TPA is equality of needs of all parties involved – although the relationships between the individual parties within the triangle are obviously complex. The baseline for a successful medical case, said Dr Zulficarov, is that all parties come away satisfied. The patient must be treated. The medical facility must be paid. The insurer must be sure that expenses are reasonable. While it may seem obvious, it is essential to keep this dynamic in mind.

He then spoke briefly about the two classic policy types – international private medical insurance and traditional travel insurance – and how they differ, before highlighting exactly how a TPA is useful for each other party represented on the ‘case management triangle’. For the insurance company, the TPA is a value proposition. For a patient, their expectations – that they get back to their normal life as soon as possible with no financial worry – must be met. And for a medical facility, payment must be given as quickly as possible for the job that has been done. He then framed the triangle in terms of the TPA’s three-pronged mission, including transparency, worldwide coverage and claims management for the insurer, understanding, information and care for the patient, and honesty and reliability for the medical facility. There is an ‘endless chain of challenges’ that must be addressed, Dr Zulficarov went on to say. Insurers must always carry out due diligence, as they are trusting TPAs with ‘their most valuable commodity – their patients’. Claims must be properly assessed, and over-treatment should be paid special attention, as much as over-pricing. Continuous contact with the patient is also necessary, as they may be in an unfamiliar environment and in need of explanation and reassurance (delivered in their native language by a friendly party). Sick people, said Dr Zulficarov, are ‘like kids’, and must be looked after at all times. The more information they and their family have, the easier it is for all parties. Once again, communication is key.

Using the analogy of a plane, Dr Zulficarov asked the audience to imagine that one wing is represented by the client, the other by the provider. “You can fly a plane with one engine missing,” he said, “but not one wing.”

In the Q&A that followed, it was agreed that it is key for TPAs to have a strong clinical presence, and that trust and understanding are paramount. A strong clinical presence means that those involved can brainstorm, and discuss how clinical issues could impact costs. Middle men are to be treated with suspicion – what is their role, and what is their relationship with the parties involved?

**[TPAs] are often underestimated**
Dr Wayne Lee

Medical director – GMMI

Dr Lee, whose expertise lies in emergency medicine and pre-hospital care, discussed cultural considerations and their impact on global cost containment, which he referred to as ‘a significant challenge’. Different patients from different states and of different nationalities naturally have different needs, and dealing with this is never simple. “You need to be adaptable,” said Dr Lee, as well as having the necessary skills and technology. Preparation is key: “Without preparation and good communication you can run aground.”

He went on to briefly discuss a few case studies in which cultural challenges had played a major role. One involved a woman from the Middle East, who had refused a biopsy because of the risk that it might result in a mastectomy – from her perspective, the scarring and disfigurement that would result might have made it more difficult to get a husband. She would only accept chemotherapy, which had an effect on the prognosis. A second case study involved a woman with a forehead laceration, but the peculiarities of the US system meant that she was sent to a plastic surgeon’s office rather than to the emergency room, where treatment could have been done. The outcome was successful – for the patient – but did result in both a high cost for the surgeon and a high facilities charge, the necessity of which Dr Lee questioned. The nuances in the US, he said, can often lead to much higher costs if not caught early: “In this case, we had no opportunity to catch early.”

Dr Lee also discussed a case in which a 16-month-old was referred for treatment in the US, but was accompanied by two male guardians who were unable to take care of her alone overnight in a hotel room, requiring extra – costly – hospitalisation while they waited for a female relative from the child’s country of origin. Cultural understanding, in this case, was key, said Dr Lee, and ‘we’ve adapted so hopefully this wouldn’t happen again’.

Following Dr Lee’s presentation, a member of the audience asked the question that subtitled the session, as they felt it hadn’t actually been answered yet – is case management the way to go, in order to contain costs around the world? Dr Lee said that while he would basically say yes, it’s a complicated issue, and individual situations need to be taken on their own terms. Dr Zulficarov agreed, saying that ‘case management is difficult, but if it’s necessary, you do it’, and Ronald said that cost management means different things to different people. It was generally agreed that it is often a question of definition, and that there is no one-size-fits-all rule.
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Insurer due diligence: air ambulance provider selection

What are the optimum tools for selecting air ambulance partners?

Dr Michael Weinlich

President, founder and chief medical officer
– Med Con Team

Dr Weinlich opened the session by highlighting the need to make the air ambulance provider market more transparent. He stated the importance of looking at accreditation and ‘choosing the right ambulance provider in a different way’. According to Dr Weinlich, there are different measures of quality, including structural, process, and output and performance quality; and these competences must be demonstrated to insurance companies. He reiterated the fact that the most important thing for a patient is the outcome, but stated that with official accreditation systems, which tend to look at equipment, aircraft, and processes, the output for the patient cannot be easily found out. He said that questions arising include: “How do I choose the preferred air ambulance provider?”, “Have they done it according to international standards?” and “Have they treated the patient well?”. Dr Weinlich moved on to discuss how customers can be attracted and retained, and covered the elements that ‘count’ in a preferred provider. Another important question raised was ‘what exactly are international standards?’. As he explained it, standards are being made up by the community. He said that people came together as a group and tried to define ‘international standards’, but he questioned the basis behind these standards and whether there is any proof behind certain elements within the standards. “What would be the minimum standards you would expect?” he asked. “The right equipment, basic standards such as the service. But there is nothing that is fixed.” Accreditation should not be overestimated, he went on to say, and it is important to look at the outcome of air ambulance cases from a medical perspective and to have direct contact with the air ambulance provider rather than using brokers.

When opened up to the floor, there were a number of questions and points of discussion. Input from NAAMTA executive director Roylen Griffin (or ‘Griff’) was that municipalities have all kinds of standards, and best practice procedures should be established as standard and also be based on outcomes, i.e. “this is the bar that we will accredit or audit you to”. “All of the companies they audit are within an acceptable, agreeable portion,” Griff added. “If you’re not using something that has acceptable processes you will not have the outcome you need.” Griff also questioned whether it is a problem for companies if their accreditation is pulled.

Europ Assistance Group’s medical director Dr Matt Kalina’s response was a resounding ‘yes’: “We do care because it’s an important part of our business.”

Dr Matt Kalina

Group medical director – Europ Assistance Global (EA)

Dr Kalina began his talk on air ambulance certification by highlighting the fact that due diligence is an important topic for major insurers, and said he believes the importance of the overall market is being underestimated. “The importance of standards is obvious,” he said. “We need optimal quality for our clients. Are all stakeholders involved as much as they should be?” Speaking from an assistance provider’s perspective, he said that providing international rules allow one to fly into an area, there should be a way for an air ambulance to access that area. He used Ebola as an example and stated that only those who agree to expose themselves to the risk should access a particular area. “We how can we move from an informal accreditation process to something much more structured
Roylen Griffin

Executive director – NAAMTA

After introducing himself with the request that everyone call him Griff – as only his mother calls him Roylen – Griff began his presentation by stating that a minimum standard needs to exist. “There is a human being involved in every flight that we do,” he said. “Standards are there for the protection and safety of the patient and the crew.”

He explained that rules, regulations and standards increase outcome performances, and that this is the reason for standardisation and why there is a need for those involved to meet to talk about these things. “We seem disjointed,” he added.

Griff said that the problem with some standardisation is communication, and explained that he devised tools to assist air ambulance providers with demonstrating their compliance. He listed the considerations for partnerships between patient and medical control, air ambulance and insurer as being: ethical, qualified medical team; appropriate medical supplies and equipment; appropriate aircraft and pilot; logistical operations and case management.

Next, Griff explained that there are important things to be taken into consideration when an assistance company vets an air ambulance provider, such as whether they are ethical, profit driven, honest and so on. He said that it’s important to make sure the team is qualified based on standards and rules and has appropriate medical supplies, that a minimum equipment list must be specified and that the team must have training in administering that particular treatment and be able to demonstrate this – an audit must be done where these performance standards are demonstrated. Furthermore, medical supplies should be documented and the aircraft and pilot must be appropriate; the pilot must be certified for that particular aircraft and the aircraft must be big enough to perform the mission, for example.

Griff highlighted that you can’t control anything you do not measure, and reiterated that this is a high-risk business. He said that although cost is a consideration, it is not the priority: “Remember, there’s a human being in there and cost does need to be evaluated, but not above other criteria,” he stated, also revealing that he thinks accreditation should be more thorough: “In my opinion, accreditation doesn’t go far enough. I read every incident and every complaint, which has established good rapport with my clients.”

To conclude, Griff said that the bottom line is that it’s important to standardise and follow the rules, and that there is liability, so insurance of accreditation companies needs to happen.

The session came to a close with the agreement that there needs to be uniform performance and uniform standards across the globe. However, the big question was: ‘How are we going to agree a uniform protocol between the air ambulance, insurance and assistance companies?’
Fraud in the digital age

Detection and deterrence: how best to combat fraud in the digital environment

Ray Collins
Head of international business development
- Performant Europe Ltd

Ray began by saying that the quest to find the optimum way to fight fraud and make the best use of data is ongoing, and that there is ‘no silver bullet’. Domain knowledge, i.e. understanding every aspect of the environment and the different types of fraud, is essential – once that is in place, you can then apply technology to solve it, in order to save money. “But human interaction,” said Ray, as well as technology, “is key.”

He then outlined the three main solutions that insurers can utilise to fight fraud. The first was industry intelligence sharing – the importance and difficulty of which were recurring themes of the conference – which is a long and complex process, with issues such as data protection and compliance coming into play. What is needed, said Ray, is the creation of a community, with as many competitive corporate barriers as possible removed; and he gave an example of a success story in which a company made a saving of £60,000 after paying only £600 for some information from a smaller company. The second solution Ray explored was data analytics, as ‘the amount of jobs that one person can do is not comparable to the amount that data analytics can do’. In terms of processing large volumes of data, tech is the way to go, but Ray did point out the potential weaknesses of this method – ongoing technical support is required, for example, and it’s a complex and costly option that can require a big leap of faith from those in control of a company’s budget. Finally, Ray listed management of cases, i.e. actually using the intelligence that has been gathered. The positives of these, he said, were myriad – among other benefits, it makes investigators accountable, measures their success, and can prevent a company from being hit twice by the same fraudster.

In closing, Ray said that the fraud landscape has changed with the advent of new technology. Fraudsters are more anonymous now, with the ability to mask their locations, and cross-border policing can be difficult. Fraud is a major challenge, and one that won’t be going away any time soon, but it can be tackled.
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Dr Nikki Grieve-Top

Head of health analytics, health & benefits – Bupa Global

Dr Grieve-Top, an investigative psychologist, gave a fascinating presentation about the psychological profiling of fraudsters and how it can be used “to support those on the frontline, improve decision making, use different tech tools and ensure a company is getting the best bang for their buck.” It’s important, she said, to look into fraudsters’ motivations and backgrounds: “The industry is reported to lose around £180 billion per annum to fraud, so management of tools is key. Make sure you’re putting them in the right place.”

Dr Grieve-Top then gave a few examples of models that psychologists have used to explain the thinking behind fraudulent behaviours, such as Wolf & Hermanson’s “fraud diamond” – which cites motivation, personal integrity, rationalisation, opportunity and capability as key elements. Social attitudes and acceptability within one’s peer group, she said, were also strong markers of whether an individual is likely to commit fraud. And younger fraudsters, for example, tend to see things in moral (right vs wrong) rather than legal (lawful vs unlawful) terms, so if they don’t perceive insurers as innocent they will not see fraud as wrong. Higher premiums may also mean that a potential fraudster sees fraud as more permissible, said Dr Grieve-Top, while a stronger relationship between consumer and insurer will make it seem less permissible. “Collectively,” she said, “this research reinforces that when there is a perceived lack of effective controls/guardianship over a product, business is seen as a fair target.”

One of the main issues, Dr Grieve-Top went on to say, is that while insurers invest lots of money in counter-fraud methodology and interventions, they do not have a good enough understanding of fraudsters to proceed effectively, and to make proper use of the data that they accumulate. “If you get your deterrent correct,” she said, “there is a ripple effect.” This will then be felt across your business. Ultimately, said Dr Grieve-Top, it’s essential to take a good look at all the measures that are available, and if those that are being used are not effective, insurers either need to change the point at which they are applied or abandon them altogether. She also re-iterated Ray Collins’ call for the industry to pool resources and information: “Fraud will always be here, and we will only see what we detect. If we accept that and work together [using data sharing protocols and so on] to deter as much as possible, we become less attractive as an industry.”
Andrew Whitney

Executive chairman – ALETHEIA

Andrew heads up a company called ALETHEIA, part of what he called ‘a new generation of technology companies’ seeking to provide ‘cost-effective, real-time solutions’. In his presentation, he talked about some of the new technology that ALETHEIA has been developing, and how it could be applied to tackling insurance fraud. “Big data,” said Andrew, “offers lots of promise, but it can struggle to be objective, accurate and timely.” Supposedly neutral data collection comes with its own biases, and sifting through it takes time. It is also, by its nature, backward-looking, and suffers from the same problem that often afflicts military organisations, i.e. ‘fighting the last war’ rather than the current one. The technology that ALETHEIA brings to the table, Andrew explained, makes use of proprietary algorithms and touch-screen technology, and provides a series of questions that a traveller, for example, would answer via a smartphone or tablet. Originally developed for Homeland Security-type applications, Andrew claimed that it can arrive at a ‘92-per-cent accurate’ assessment of the truthfulness of an individual’s answers. This makes it similar in terms of accuracy to a polygraph, but it significantly cuts down on the time that a polygraph would take, effectively providing the answers needed in real-time. “It’s not a solution to the whole problem,” said Andrew, but can perhaps help to point insurers in the right direction. He went on to talk about the ‘feedback loop’ of fraud, whereby people believe that higher premiums justify them in committing fraud, and insurers consequently have to raise premiums further because of the fraud that has been committed. And criminals, said Andrew, are ‘an innovative bunch – they will find opportunities’. His company’s technology could also help to catch people during the application process rather than after the fact, he claimed, because the level of detail that it can detect and analyse means that potential fraudsters could be identified early. Likewise, it could come in useful during the claims process, detecting anxiety perhaps, as a clue that fraud is on the claimant’s mind. An attendee in the ensuing Q&A asked how the technology can tell the difference between genuine anxiety on the part of someone who has suffered a loss abroad, and the anxiety of someone planning on committing a crime, and Andrew said that the questions involved have been compiled – and then analysed – by ‘very smart psychologists’. “You have to remember that people are customers,” he said. Normalising questions from the outset establishes a baseline, and it is obvious when someone’s responses diverge from the norm. This can then lead to further questions.
Medical site inspections and international patient care

Kevin Dodd
Head of medical networks – Allianz Global Assistance

Kevin’s presentation covered the hospital evaluation programme that Allianz Global Assistance (AGA) carries out around the world, discussing the whys and wherefores of inspecting medical facilities (including public and private hospitals, clinics and even air ambulance providers). Depending on where one is in the world, medical standards obviously differ wildly, so while quality is not an issue in some countries, in others – for example where infrastructure is generally poor – it can be a major sticking point, so it is essential for insurers and assistance companies to know all the facts.

The primary objectives, said Kevin, are ‘to assist our medical operations teams to make appropriate case management decisions, notably in critical care cases and in countries where our operations teams have limited exposure’, ‘to enable best quality or best equipped providers to be identified and included in our network’, and ‘to enable quality-approved providers to be shared with customers via digital solutions’.

“We must carefully choose which cities we target,” Kevin went on to say. Questions that affect these choices include whether the infrastructure is of poor or variable quality, whether that quality seems to be evolving or declining, and whether the city seems to be generally reflecting and anticipating the footprints of customers. Kevin then talked a little about the logistics of undertaking these hospital evaluations, and what needs to be taken into account.

An evaluation team that knows what it’s looking for is essential. A travel budget must be allocated. Local logistical support is helpful, as is provider buy-in and support, from the initial opening of doors to the explanation of structures. Analysis is undertaken by an expert panel of doctors and selected external doctors, supported by local network managers or correspondents, and Kevin was at pains to point out that what Allianz does is not accreditation – rather, it is a three-hour overview looking at different aspects of the facility in question, which is then fed into an algorithm that generates scores. These are circulated internally, and are not shared widely. Full-scale accreditation is not on the agenda, said Kevin, in response to a question from the audience, because it takes weeks, and for AGA’s purposes, the time and resources are unavailable – or at least better spent looking as widely as possible, with a focus on countries where there is less immediately available knowledge.
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Pascaline Wolfermann

Director, healthcare intelligence, clinical services – UnitedHealthcare Global

Pascaline’s presentation discussed the considerations of moving patients across borders, when it is and isn’t appropriate and what the challenges are. She said it is important for all providers to know what the biggest risks are, and what they should – and shouldn’t – be concerned about.

For example, she said, during the Olympics, despite a huge amount of hype from the media and even within the industry, there were very few cases connected to the Zika virus. There had been conferences and webinars discussing the potential problems, but no crisis had materialised. However, dengue fever and standard trauma cases were still very much present. "We need to focus on the actual problems," said Pascaline, although of course the industry should not be ignoring Zika and other infectious diseases.

If it is the case that local healthcare networks cannot provide the necessary care, Pascaline went on to say, it is essential to have a trusted international network in place. But, at the same time, the initial diagnosis, and the decision of whether to move or not to move, needs to be evidence-based. "Sometimes," said Pascaline, "patients are evacuated without needing it." And evacuations, she said, should be a ‘global healthcare red flag’, as they are always, at some level, a failure – at the very least, the local healthcare infrastructure has failed, or, if it turns out that the patient could have been treated there rather than moving them, it’s ‘our fault’ for not having sufficient information about what was available and what could be done. Medical evacuation should, said Pascaline, be carried out if care is not available locally, or if long-term care and support is required – even if care is available locally.

Pascaline also talked about the priorities and pitfalls of building an international healthcare network. Care quality, she said, comes first and foremost, and while cost-effectiveness should be a watchword, it is sometimes the case that higher upfront costs may end up reducing costs further down the line – for example, because extra long-term care is not required. Compliance is also essential, as if everyone in the network isn’t working to the same standards, it can create confusion, and spell trouble.
Brenda Durow
General manager – MSO International

Brenda’s portion of the session focused on unique situations specific to working within Africa. Provider assessment in the African context, she said, while similar to what had been previously discussed in the session, also presents its own challenges – ‘we can’t always be looking at standards, because the minimum entry level for a hospital in Johannesburg, for example, will be different from Burundi’. It’s not always possible to judge based on first-world criteria. Brenda then showed a chart of various medical facilities across the continent, with ratings ranging from ‘poor’ to ‘good’ (unfortunately they had to remove ‘excellent’ because no hospitals conformed to that standard). There are more poor hospitals than basic ones, and more intermediate facilities than good. “But you can’t just form an opinion based on one single source,” said Brenda, because what you see and hear isn’t always necessarily the whole picture. It’s important for those in the industry to share subsets of data; although unfortunately, in Brenda’s opinion, ‘the idea of sharing all data is a utopia, perhaps’. She then went on to talk a little about referral patterns in Africa – where people are going and why – and stressed that Africa is a continent, not a country, as is often lazily implied by commentators. Cultural differences, including language barriers, come into play just as much as they might between countries in other parts of the world, and many people prefer to fly out of Africa entirely for treatment, into Europe for example. However, sometimes the knee-jerk emotional reaction of a traveller that they wish to leave Africa – say if they contract malaria – should not be indulged. Local doctors are likely to see malaria every day, but a GP back in the UK or the US will not. They may never have seen it, in fact, and malaria is a serious disease. “This comes back to the point,” said Brenda, “that all cases must be taken individually, and should be based on medical necessity.”

The subject of communication and data sharing came up in the discussion that followed Brenda’s presentation. Mutualisation of information and pooling resources, the panellists said, are necessary and hopefully not utopian. Globalisation isn’t going away, and technology is there to support organisations’ needs and the requirements of patients. “Sharing,” said Brenda, “should be very possible.”

Will it prove to be so? Same time next year...
Finaccord latest industry research

Global expatriate and student health insurance trends

David Bowles
Consultant – Finaccord

The market research presented in this session looked at the global market for international private medical insurance (IPMI) for locals, expatriates and international students. The research took in different distribution channels, specifically bancassurance and affinity marketing, looking at the actual and potential market in seven origin and destination regions for 2011, 2015 and a forecast for 2019.

The total premium value of the global IPMI market is US$13 billion (2015), which is a 1.2-per-cent share of all health insurance, said David. This represents growth of 11 per cent from 2011, where the market value of other health insurance only increased by 4.8 per cent, and the global travel insurance market only grew by seven per cent.

Looking at regions of origin, almost half of all the 105 million eligible customers identified – those staying in a country other than their place of origin for between three months and 10 years – were from the Asia-Pacific area, where intra-regional travel is an important factor. However, Europe is most important in terms of actual policies sold. Although fewer than 10 per cent of all eligible customers globally took out policies, and although Europe ranked third in terms of the number of eligible customers, it accounted for 41 per cent of policies sold. This is because customers in this region are more likely to be corporate or student travellers, which are demographics more likely to take out cover. Europe also ranked top in terms of market value (with 49.5 per cent of the total), due to the fact that customers generally pay more for their cover in this region, as significant numbers travel to North America, and there are significant numbers of students seeking cover.

David also showed that the Middle East is the largest destination region for eligible customers, but its importance drops significantly when looking at the number of policies taken out, in which case North America holds the top spot, together with the top spot for market value. Students are also an important subsector, as although they represent just four per cent of eligible customers, they are much more likely to have cover than other groups, even though their policies tend to be much cheaper.

Looking forward to 2019, David said the global market value of IPMI will be around $20.2 billion [in 2019]

market value of IPMI will be around $20.2 billion from 11.4 million policies sold, of which 3.7 million will be newly bought in 2019 itself. Over 90 per cent of eligible customers will still not have international health insurance cover, though. The Middle East will represent the fastest growing region of origin; Latin America will be the fastest growing destination region; and the fastest growing customer type will be corporate and other transferees, closely followed by students.
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Dr Vanya Gant
Divisional clinical director – The Hospital for Tropical Diseases, UCL Hospitals NHS Foundation Trust

Dr Gant gave a fascinating overview of some of the most common mosquito and tick-borne viruses and how they have spread in recent times. Beginning with a look at flaviviruses, which include yellow fever, dengue, and West Nile virus, Dr Gant explained the origin and spread of the most high-profile virus currently in this genus – Zika. Zika inactivates very quickly, which is just as well, he said, as its spread has been swift and it has serious potential health risks associated with it. It was first identified in 1947 when it was isolated from Rhesus during a yellow fever study, but was not considered to be a big deal until 2007 when an outbreak occurred on the Pacific Ocean Island of Yap. For a ‘weedy’ virus it had a phenomenal attack rate – between one in five and one in seven of the population acquired Zika within a short space of time. That year, out of the blue, Zika was also found to be crossing the Wallace line – a virtual line separating Australia and New Guinea from the Far East, which very few biological agents crossed. In 2013, Zika exploded in French Polynesia, where it was first linked to a case of Guillain-Barré syndrome. An outbreak was also reported in Brazil, where infection rates had increased tenfold, and with the link to Guillain-Barré syndrome, authorities began to sit up and think about the potential medical and economic impact of this virus with regards to providing long-term care to sufferers. During the same period, between 2012 and 2014, concurrent outbreaks of dengue and chikungunya were occurring in an unprecedented epidemic wave of mosquito-borne viruses in the Pacific region. The mosquito responsible for carrying and transmitting these viruses is the Aedes aegypti, which bites in the day time when people are less likely to be covered up and are not expecting to be bitten. Dr Gant also looked at events that might have assisted the spread of Zika, focusing on a number of international festivals and sporting events; but ultimately, he said, you can’t stop global travel. The Zika spread is now truly explosive and it’s global. It’s also not just clearing up in patients, with one in five now reporting other health issues including neurological problems, and there is also its link to microcephaly to consider. Dr Gant concluded his presentation with an overview of the current spread of MERS, viruses currently affecting Niger and Haiti and the DRC, the issue of antimicrobial resistance, and where to find advice on travel health matters.

ultimately, you can’t stop global travel

Dr Vanya Gant
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John Rose

COO – iJET International

Opening the session, John posed the question: ‘How do we keep our flight crews safe?’. He said that he has seen medical crews refuse to go into certain areas because the safety is inadequate, and that there are many things to consider when evaluating scenarios. For example, he said, bringing in security raises the cost of the evacuation, adding that once the threat has been identified, the risk can be assessed and mitigated, and this should be a process that is laid out simply. Important questions to be asked, said John, are where are they flying and what conflict zones are they going through? He said that the crew may be going through an area where there are ‘bad actors’ or people on the opposition that may not want them there. He added that when it comes to such areas, the news is ‘100-per-cent useless’ as it states ‘false, crazy things’. Another important question, according to John, is what is the protective zone around the landing area? “You have to understand the threat in the area and assess the risk,” he said. “Is it worth attempting to land.” He then highlighted the fact that time is critical in picking up injured patients, and added that the best intelligence is required. He said that risk can be reduced by hiring security professionals, and reiterated the importance of assessing the situation, as ‘just because they are wearing a medical uniform, it doesn’t mean they are necessarily safe’. John went on to underline the essential pieces of knowledge, which he stated as being: the intelligence of the area, on the ground, i.e. tactical information coming in from people manning the routes; and who is being transported. “These people are hurt for a reason,” he said. “Perhaps they have been attacked and there are bad actors who still want to eliminate this individual.” John said that there is a need to get the individual to a safe location where the medical crew can work, and that real-time intelligence is required by the minute. Finally, John highlighted that real-time intelligence and alerts does not mean news. “It has been analysed and is meaningful and actionable to you,” he said.
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Martin Bauer
Regional security manager – MedAire

Martin began his presentation by asking whether the situation changes if we know we are going into a high-risk environment. “No,” he answered. “The assessment of all of those various risks should be consistent across the board. The risk assessment should not change.” He then went on to highlight some of the threats and hazards encountered in travel security and their risk rating. At the top of the list was crime, followed by social unrest and terrorism. The hazards with the lowest risk rating were cultural issues, internal travel and natural hazards. He said it is important to ascertain whether certain weapons are easily available on the ground and decipher how lethality will affect an aircraft.

Martin then showed the audience a list of the countries with the most over-flight concerns. Afghanistan was top of the list, followed by Algeria, Armenia and Azerbaijan, Colombia and the DRC. He also spoke of the incident in 2014 when Malaysia Airlines Flight MH17 was shot down over Ukraine.

Next, Martin highlighted the fact that threats to aviation vary by location and altitude, and that the MedAire team provides airspace assessments to help security departments to make informed decisions about their flight plans.

He explained that an airspace assessment involves the analysis of the airspace of a country or region to identify overall kinetic risk and individual threats to aviation assets throughout each phase of flight.

According to Martin, these assessments include analysis of airspace restrictions and warnings issued by governing aviation organisations, including the US Federal Aviation Administration, International Civil Aviation Organization and European Aviation Safety Agency.

Martin then went on to say that, at a minimum, each airspace assessment looks at specific weapon availability, portability, lethality, ease of use, documented use and intent (for example, government or military groups). He said that kinetic risks and non-kinetic risks must be assessed at altitude.

Following the presentation, an audience member asked: “What about the ‘normal’ places and how do we deal with the aircrews; particularly the ones who stay overnight?” Martin responded by highlighting the need for consistency in assessing each different site in the same way. “The assessment shouldn’t change just because we don’t think it’s a high-end conflict zone.” However, he added that the risk assessment may change according to how basic the resources are on the ground. For example, he said that some areas may be missing simple things such as radar and aerial communication.
Dr Bettina Vadera
CEO – AMREF Flying Doctors

Bringing an air ambulance provider’s perspective, Dr Vadera began by listing some of the conflict areas AMREF has been asked to visit, citing Somalia, a country in which AMREF performs hundreds of patient evacuations every year, South Sudan and the DRC, followed by Burundi, the Central African Republic and Mali. Dr Vadera explained that AMREF’s crew doesn’t leave the airport and added that there is a clear agreement that there is security all around them. Next, Dr Vadera moved on to talk about the steps AMREF goes through from a practical perspective. These are: pre-departure briefing and clearance; pre-landing preparation;

**pre-landing preparations involve scouting by boats on the ground, which must happen before landing**

...specific approach procedures; on-ground security protocols; emergency shelter for patient and crew; and finally, a debrief after landing back at their base in Nairobi. She described this example as AMREF’s ‘daily/weekly bread’.

Going into detail about each of the six steps, Dr Vadera explained that the pre-departure briefing involves an active security report from UNSOS Air Ops offices in Nairobi and Somalia, insurance briefing and clearances, and flight clearances from the Government of Kenya and the Swedish Committee for Afghanistan, and encompasses security information and a security brief from AMREF Health Africa’s corporate security manager. She highlighted the importance of flight planning, security updates between crews and a quick departure. Referring to air ambulance evacuations from Mogadishu, Dr Vadera then revealed that pre-landing preparations involve scouting by boots and/or boats on the ground, which must happen before landing, and that a pre-landing security clearance must be issued by UNSOS Air ops. She added that the ETD and ETA are classified information. She explained that the specific approach procedures involve a steep descent and a high-speed approach just above the water, with a sharp turn towards the airport before landing. When it comes to on-ground security protocols, an allocated secure parking bay for the aircraft, security on standby for both the crew and the aircraft, and an armoured vehicle for patient transport are required. Regarding emergency shelter, standard operating procedures (SOPs) and a pre-flight briefing on locations and use are crucial, Dr Vadera said. Finally, the debrief back at AMREF’s base comprises: a hazard or incident report, a review of the voyage report, a review of protocols and SOPs with the relevant stakeholders, formalisation of the recommended changes and confirmation that these changes have been implemented. She added that all of the changes must be implemented before another mission to that area is launched, and that this is always the guideline that AMREF works through. Dr Vadera also pointed out that some missions AMREF just cannot do, and this is because there are human lives at stake: not just the lives of the patients, but the lives of the crews.
The ITIJ Awards marked their 14th year in Berlin and, as is customary, they were hosted by ITIJ editor-in-chief Ian Cameron and ITIJ editor Sarah Watson. Held each year at the Finale Dinner of ITIC Global, the ITIJ Industry Awards recognise excellence in the various sectors that make up the international travel and health insurance marketplace.

With a number of the Awards categories expanded and a new category added for 2016, this year saw even more industry sectors represented and being rewarded for their service to the industry over the previous 12 months. For a full overview of the category changes in 2016, please visit www.itij.com/awards.

If you were unable to be part of the ceremony in Berlin, you can still watch this year’s Awards presentations online at the web address above.

ITIJ extends its congratulations to all the finalists and all of the 2016 ITIJ Awards winners.

Look out for details of the all-new nomination process for the 2017 ITIJ Awards that will be revealed early in the New Year!
The finalists in each category were:

- **International Travel & Health Insurer of the Year**
  - Tokio Marine HCC
  - Allianz Global Assistance
  - Manulife Assistance Company of the Year

- Healix International
  - Falck Global Assistance
  - Global Response

- **Aggregator/Broker/Affinity Partner of the Year**
  - Columbus Direct
  - InsureMyTrip
  - Moneysupermarket.com

- **Air Ambulance Provider of the Year**
  - European Air Ambulance
  - AMREF
  - REVA Air Ambulance
  - Skyservice Air Ambulance

- **Cost Containment/Claims Management Company of the Year**
  - New Frontier Group
  - ChargeCare International
  - GMMI

- **Medical Provider of the Year**
  - Jackson International
  - Commercial Medical Escorts
  - Sharp HealthCare

- **Ancillary Assistance Service Provider of the Year**
  - Rowland Brothers International
  - Anubis
  - One Call Medical Transports

- **Specialist Service Provider of the Year**
  - Passport Card
  - Borden Ladner Gervais
  - Socrates Systems

- **ITIJ Marketing Campaign of the Year**
  - Passport Card
  - AMR
  - ER24 Global Assist
  - New Frontier Group
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Judges’ comment: There have been numerous standout advertising campaigns in ITIJ this year that have made judging this award a real challenge. The finalists have maintained a clear identity throughout their campaign, while at the same time offering new creatives.
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Judges’ comment: This company has come up with an exciting innovation that could have a considerable impact on the travel claims industry.
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ANCILLARY ASSISTANCE SERVICE PROVIDER OF THE YEAR

Presented by
Shai Gold, managing director – corporate strategy and business development

WINNER: ROWLAND BROTHERS INTERNATIONAL

“Rowland Brothers International is a global funeral repatriation specialist. Established in the 1870s as family funeral directors, Rowland Brothers International developed international repatriation strategies in the 1970s, and now benefits from more than 45 years’ experience. Based in Greater London, our multi-lingual team works with a global network of agents to bring loved ones home – to or from the UK, or any point of origin and destination worldwide.

We work every day with families who feel shocked and vulnerable, who are in unfamiliar surroundings, and confused by local regulations. Our ongoing commitment is to share information with travel insurance and assistance clients at our operational and bereavement education days, to follow a consistent protocol, and by working together, to deliver an excellent and reassuring service to bereaved families all over the world.”

Judges’ comment: This company offers considerable support to the industry in terms of both sponsorship and education, and its rapid growth in 2016 indicates it will continue to be a major force.
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MEDICAL PROVIDER OF THE YEAR

Presented by
Mark Somers, managing director

WINNER: JACKSON MEMORIAL

"Jackson Health System, one of the nation’s largest public hospitals, delivers world-class care to patients locally and across the globe through our collaboration with UHealth – the University of Miami Health System. We give patients more expertise, treatment options, and access to the newest therapies. Jackson is home to the Miami Transplant Institute – one of the world’s largest and most comprehensive transplant centres, performing all solid-organ transplants. Through our maternity services, Jackson offers the most complex level of care to mothers and their babies. Home to one of the largest neonatal intensive care units in the nation, Jackson is known world-wide for its cutting-edge research to improve neonatal care and its success in caring for critically ill babies. For decades, the UM/JM Burn Center, one of the leading burn treatment facilities in the nation, has treated adults and children. From Ryder Trauma Center, which trains US Army forward surgical teams and treats the most critically ill adult and paediatric patients, to Jackson Rehabilitation Hospital, where patients from all over the world work toward a second chance at an independent life, Jackson Health System makes miracles daily."

Judges’ comment: This company takes the top spot for its range of cutting-edge specialties and technologies – from neonatal ICU (research as well as treatment), trauma (civilian as well as medical), through to its transplant centre.
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New Frontier Group’s new Medical Emergency Assistance (MEA) Center is a state-of-the-art facility that provides accessibility to patients, clients and medical providers 24/7/365 allowing both early intervention and advice regarding immediate medical services. Experience, ingenuity, and leadership set the standard for our best-in-class client ratings for our customers worldwide.

Judges’ comment: 2016 has certainly been a special year for this company, which has seen remarkable growth. It has also achieved a growing reputation by focusing on the needs of its customers, irrespective of size.
As part of its 2016-17 Best Hospital analysis, U.S. News & World Report ranks the top hospitals across the country by metro area and nationally in 16 specialties. Only 3 percent of nearly 5,000 U.S. hospitals are ranked in at least one specialty.
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EAA provides its services 24/7/365 throughout the world and can also rely on a dense network of international co-operation agreements, which ensures speedy and smooth execution of intensive care transports with bed-to-bed service. EAA co-ordinates a fleet of five air ambulance aircraft – four LearJet 45XR and 1 LearJet 35A – all fitted with state-of-the-art medical equipment and supplies to ensure the best possible patient care in the air. All EAA missions are staffed by an experienced intensive care medical team consisting of at least one physician and one flight nurse.

Judges’ comment: The first air ambulance firm to have an infectious disease module and the only certified weight transportation stretchers on the market, this operator is at the forefront of the air ambulance industry.
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Presented by
Louis Kaszczak, partnerships director - global markets

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Judges' comment: This company deserves to be applauded for its recent imaginative project – the installation of travel kiosks at airports could have a major impact on the purchase of travel insurance and reduce the number of uninsured travellers.
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Presented by
Carmen Poehlmann-Wolfe, vice president of business development & client accounts

WINNER: HEALIX INTERNATIONAL

"Healix International is a global leader in international medical, security and travel assistance services. Working on behalf of multinational corporations, governments, NGOs and insurers, we are entrusted to look after the welfare of millions of expatriates, travellers and local nationals right across the globe, many residing in remote or challenging environments. Providing a comprehensive, integrated range of bespoke solutions, we help safeguard the health and security of our clients' employees or policyholders and provide a single point of contact for 24/7 access to the help and expertise they may need, wherever they are. Having built our reputation on medical and security expertise, our understanding of risk and our ability to move with the times, we boast a track record of service excellence and product innovation. Our core values are professionalism and reliability and our investment in staff and systems development ensures our clients always receive quality services and excellent value."

Judges' comment: This company continues to set the benchmark for the assistance market. Its growth in the last 12 months both in terms of turnover and case activity is very impressive and its client acquisition is testament to its reputation.
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Judges’ comment: This company has developed into a truly global insurer operating in many international territories. It has shown the ability to adapt to local conditions and its flexible approach has assisted its international development.
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For more photos from ITIC Global and the 2015 ITIJ Industry Awards visit www.flickr.com/photos/voyageurgroup and select the relevant album.
For the second year running, Sharp HealthCare sponsored the #LookingSharpITIC selfie campaign, and even more attendees got involved for their chance to win a free registration to ITIC Global Barcelona 2017!

From selfies taken in and around the conference venue, to attendees getting out and about and snapping pictures of themselves at famous landmarks with some very interesting props, it can safely be said that this year’s selfie challenge was a huge success.
After all of the submissions that were received, Team ITIC thought it best to narrow them down to six finalists and then leave it up to ITIC Berlin attendees to cast their votes for their favourite selfie.

We’re very pleased to announce that the winner of the ITIC Global 2016 Sharp HealthCare selfie campaign is Claudia Schmiedhuber from Tyrol Air Ambulance!
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