iFHP NEWS

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Compulsory Financial Ratings for New Zealand Health Insurers

Andrea Pettet, Executive Director of the Health Funds Association of New Zealand, outlines the arguments against the introduction of a compulsory financial ratings system proposed by the New Zealand Government.

New Zealand health insurers operate in a lightly regulated market, particularly in comparison with other OECD countries. Health insurers are not restricted by regulation in the development or pricing of their health plans, are not subjected to oversight or monitoring by any Government authority, and retain the freedom to fully underwrite. The market environment, however, looks set to change, with the New Zealand Government recently announcing changes to the Insurance Companies (Ratings and Inspections) Act 1994 which will require all insurers to obtain a financial strength rating. Currently, only fire and general insurers must have an external financial rating.

The Health Funds Association of New Zealand Inc (HFANZ) has significant concerns with the proposed legislative amendments, which we consider to be unnecessary, expensive and unfair. We believe they will penalize some consumers and result in reduced consumer choice. The HFANZ is not against health insurers seeking a financial rating; indeed many New Zealand health insurers do, as there are commercial benefits for the larger health insurers in having a financial rating. But there are compelling arguments against a compulsory financial ratings regime that deserve consideration.

The New Zealand health insurance industry is unlike the New Zealand fire and general and life insurance industries. The New Zealand health insurance industry is comprised of a diverse range of providers from corporates through to non-profit friendly societies and industrial and provident societies. Indeed, the majority of providers in the

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Top job for iFHP member

Cleve Killingsworth has been appointed as president and chief operating officer of Blue Cross Blue Shield of Massachusetts, the largest of the USA's not-for-profit health maintenance organisations. Cleve Killingsworth is currently CEO of the Health Alliance Plan (HAP) of Detroit and a long-standing iFHP member. He will assume his new position at Blue Cross Blue Shield in February.

Cleve Killingsworth has served as president and CEO at 540,000-member HAP, a subsidiary of Henry Ford Health Systems, since 1998. He held previous jobs at the Kaiser Foundation and Blue Cross and Blue Shield of the Rochester, N.Y. area.

“Our challenges are different going forward, and adding Cleve to our team gives us additional strength,” said William van Faasen, Chairman and CEO of Blue Cross Blue Shield of Massachusetts, in a statement released by the company.

Boston-based Blue Cross Blue Shield of Massachusetts has 2.4 million members.

Editorial

from Tom Sackville

It is clearly not for me to judge, having had the responsibility of arranging it, whether the recent CEO Forum in Sydney was a success. Some of those who attended were kind enough to say they enjoyed it, as indeed did I. But what I can say without much fear of contradiction is that it is hard for anyone visiting Australia today not to be struck by a national personality of positive thinking and healthy no-nonsense attitudes, in refreshing contrast to the hypocrisy, pessimism and navel-gazing prevalent in much of the rest of the world.

Sydney itself is, of course, one of the great cities: it can match the weather (except during rugby finals) and rival the breathtaking natural contours or statuesque landmarks which attract millions to Rio, Istanbul, New York and Paris, without suffering from their background social or racial problems. To paraphrase Dr Johnson's famous statement in the 18th century about another city "A man who is tired of Sydney is tired of life".

One of the high spots of the Forum programme was a fascinating analysis of a century of Australian nation-building from Paul Kelly, editor at large of The Australian newspaper. In the space of an hour he traced the evolution of the establishment of the "democracy in the South" with its political system based on reward for effort, replacing the class-based inequities and injustices of the hierarchical societies which most new arrivals had left behind.

He went on to describe Australia's delicate diplomatic position, finely balanced between its traditional allies, the USA and Great Britain, on the one hand, and the new regional superpower, China (soon to become its major trading partner) on the other. Australia's national self-confidence would continue to grow and its foreign policy would continue to be a force for good in a region beset by "failed states" such as Indonesia, if it could stay on terms with, and remain independent of, each.

Health economists are not always the most scintillating people; they might even be said to err on the dry side of wet. Moreover, as academics they generally feel obliged to pander to the myth that governments are the natural providers, as well as funders of the nation's healthcare. Most are happy to receive fees for consultancy work from the private sector, but can rarely be relied on to support the principle of a mixed economy of healthcare, except through gritted teeth.

So imagine the surprise, when as part of our recent Sydney programme, one Professor Ian Harper of the University of Melbourne pops up and makes the most emotive and powerful defence of tax credits for private medical insurance I for one had ever heard. In the belief that such a message is highly relevant to all of us who know exactly what governments should be doing, but are sometimes a little coy about saying so in the teeth of the prevailing PC wind, we have invited Professor Harper to widen his talk to an international context, and address us in San Diego next September.

Compulsory Financial Ratings

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market are mutual type organisations and many are small niche players.

The average health insurance claim paid by a New Zealand health insurer is under $2,000, as the private health sector in New Zealand does not provide high level acute services, which are covered by the public health system. The most expensive claim paid by a New Zealand health insurer is less than $60,000. The health insurance market therefore faces considerably lower fiscal risks than the fire and general and life insurance industries, which can in a catastrophic event or natural disaster face very high claims.

Compulsory financial ratings are unnecessary, and discriminate on the basis of organizational structure, size and market share. Insurers with a small market share, and non-corporates (who are the majority in the market) who may well have strong financial reserves built up over many years, will receive a weaker rating. For the small insurer the costs are considered prohibitive for the perceived value, with non-corporate insurers understandably reluctant to be unfairly compared with their competitors.

Financial ratings must be disclosed directly to an insurer's customers, unlike other providers of commercial goods and services. Small insurers, who will likely receive a poor financial rating, will have to communicate the rating and the explanation of the rating directly to their customers.

Consumer protection and choice afforded by the ratings regime are of a limited nature. If all health insurers are forced to obtain a financial rating, then several of the smaller insurers may consider exiting the market. Consumers who have developed medical conditions will be unlikely to obtain coverage for pre-existing conditions from other insurers.

The New Zealand government is not interested in regulating the industry, but is desirous of some external measurement of the financial strength of the health insurance industry. The HFANZ has met with the Minister of Commerce and Standard and Poor's to discuss how a ratings regime could meet both the Government's objectives and the HFANZ concerns. We are exploring the possibility of an industry ratings model, possibly based on a solvency standard, with a simplified industry ratings scale. An industry ratings model would fulfil the Government's objective to provide meaningful consumer information on the financial strength of the health insurer. Provided the rating does not unduly discriminate against small and not for profit insurers, it is not likely to reduce competition, substantially increase premiums or disadvantage consumers.

As there have been no notable health insurer failures in New Zealand, we are hopeful that the Government will be persuaded to review its proposals.

President Bush signs Medicare Bill into Law

Diana Dennett, Executive Vice President AAHP–HIAA, summarises the key elements relating to the recent Medicare agreement from the USA

On December 8, President George W. Bush signed legislation authorizing sweeping changes in the government program – known as "Medicare" – that is the primary source of health coverage for 41 million seniors and disabled Americans.

This new law will devote $400 billion over the next ten years to improvements in the Medicare program. The core provisions of this law will from 2006 provide Medicare beneficiaries with coverage for a significant portion of their prescription drug costs and a broader range of private health plans offering comprehensive health coverage.

Other provisions of the new Medicare law will go into effect beginning in 2004. Approximately $1.3 billion in additional funding will be provided over the next two years to support the health benefits of seniors who are covered under the existing private sector Medicare program, known as "Medicare+Choice" and renamed "Medicare Advantage" by the new law. These funds will enable some health plans to restore benefits that have been cut in recent years due to the longstanding Medicare+Choice funding crisis. In other cases, these funds will be used to reduce premiums for Medicare health plan enrollees or to help restore choices for beneficiaries whose health plans were forced to withdraw from the Medicare+Choice program.

Another reform with an immediate impact will provide low-income Medicare beneficiaries with $600 in assistance, in both 2004 and 2005, to help cover their prescription drug costs. As many as eight million beneficiaries are expected to qualify for this assistance even before the new prescription drug benefit becomes effective in 2006.

From June 2004, beneficiaries will be eligible to purchase prescription drug discount cards, endorsed by Medicare, which will allow them to pay lower prices for pharmaceuticals. The Bush Administration estimates that these cards will enable seniors to save in the range of 10 to 25 percent on most prescription drugs.

The 2003 Medicare law also includes provisions authorizing tax-free Health Savings Accounts (HSAs) as a new health care financing vehicle for working-age Americans. This option will allow consumers to cover their routine health care expenses with funds that they (or their employers) deposit in a tax-free account, while covering major health care expenses through a high-deductible health plan.

Although this legislation is helpful to seniors in many different ways, some Democrats have expressed concern that the 2003 Medicare law goes too far in "privatizing" Medicare. In Congress, leading Democrats have already introduced several bills proposing to repeal or modify provisions of the law that are aimed at strengthening the public-private partnership in Medicare.

Despite these objections, the Medicare bill was approved with bipartisan support in both chambers.

AAHP-HIAA member companies enthusiastically supported this bipartisan Medicare legislation and were actively involved in urging Members of Congress to vote "yes". In the months leading up to the final votes, members provided significant input to the team of lawmakers which negotiated the final bill.

When President Bush signed this bill into law on December 8, leaders from many AAHP-HIAA member companies were present at the bill-signing ceremony. This event was also attended by a group of seniors who have been working for many years, as members of the Coalition for Medicare Choices, to urge Congress to enact legislation to improve their health care choices and benefits.

News USA

AAHP and HIAA to merge

Directors of the Health Insurance Association of America (HIAA) and the American Association of Health Plans (AAHP) voted at their respective board meetings to merge the two leading trade groups. Together, HIAA and AAHP members provide coverage for more than 200 million Americans.

The directors of HIAA and AAHP have asked AAHP President Karen M. Ignagni to lead the new, unified association.

"Together, the members of AAHP and HIAA have the opportunity to speak convincingly and with one voice about the role of our private sector community in addressing today's pressing challenges," said HIAA's Chairman of the Board Ben Cutler, Chairman of Fortis Health.

"In unison, we can make a greater contribution to the nation's efforts to improve quality, moderate costs, promote access, and offer choice in health care", said AAHP Chairman of the Board William T. McCallum, President and CEO of Great-West Life.

The merged organization will use the name AAHP/HIAA until such time as a new name is approved by the combined boards, and will continue to maintain corporate offices in Washington, D.C.

News

UK

Patient passports proposed

The British Conservative Party announced proposals to introduce a Patient Passport to enable patients to be treated wherever they choose. Dr Liam Fox, Shadow Health Secretary, said that British patients were entitled to similar treatment to those in France and Germany who had control over the treatment they received. A standard NHS price would be set for each treatment or investigation, with patients free to choose where they are treated and with 60 percent of the cost paid by the NHS. Patient choice would be extended to 17.5 million patients with chronic conditions. Dr Fox said there would be compulsory health screening for those coming to stay in Britain, together with "health entitlement" cards to prevent tourists who have contributed nothing from using the NHS. "We are perfectly willing to give care to those who need it and are genuinely entitled to come to this country, That is our moral duty. But we also have a duty to ensure our own citizens, who have paid for these services, get the priority they deserve."

NHS introduces world first e-booking system

A £64.5 million contract has been awarded to Schlumberger Sema to provide a National Electronic Booking System in the UK.

Patients will be able to book hospital appointments online from their GP surgery. The first bookings will commence next summer and will be rolled out across the country by 2005.

It is hoped that the new system will reduce the number of missed appointments, estimated at 1.5million per annum.

Dr John Reid, Health Secretary, said: "We are the first country in the world to be introducing an electronic booking system".

Source The Times

Kaiser Chairman on US

George Halvorson, Chairman and CEO of Kaiser Foundation Health Plan and iFHP Deputy President, was recently interviewed for the San Francisco Chronicle. The following excerpts outline his thinking on the uninsured, computerisation of medical records, the fashion for high deductibles and other issues currently affecting US health care

Q: *Year after year, we see health care costs rising faster than the rate of inflation. Why?*

A: Health care costs are exploding and there are about a dozen cost drivers. Everyone's looking for a simple solution, trying to find one culprit. There's a whole series of causes. Some of them are obvious — prescription drug costs are going up. They're about 14 percent of the health care dollar, and they're going up 10 to 20 points a year.

Hospital consolidation is another significant cost driver. During the 1990s, hospitals were in a highly competitive market. Hospital administrators are bright people, and they figured out it was an economic war that needed to be won with economic weapons. The most devastating economic weapons are consolidation, merger, oligopoly, monopoly. So in most communities, we're down to one or two hospital systems.

Q: *Do you see any pressures on costs changing in a way that would provide relief?*

A: Technology will continue to improve. Drug companies are working hard trying to figure out the next drug. The population is going to continue to age. None of the cost drivers is going to mitigate anytime soon. If you look at other issues, there's a shortage of health care workers. The average nurse is about 50 years old. It takes several years to train a nurse, and we don't have enough training programs in place. One of the ways you deal with the (staffing) shortages is pay more. That's a cost driver. Ways to reduce costs are to build care around medical best practices and best science, create more consistency and reduce some of the complications.

Q: *Do you agree with universal coverage that is not a single-payer, nationalized, government-run system?*

A: It's a crime we don't have universal coverage in this country. We spend too much money on health care not to have every citizen and, frankly, every non-citizen, with coverage. If you are an undocumented non-citizen living in Los Angeles, trying to get universal coverage by giving tax rebates is not going to be relevant. We need to break down the population into each category of uninsured and then deal with each category of uninsured separately.

Q: *Which model can you point to that does that well?*

A: Brazil has a good model because it has universal coverage and everyone has a choice among thousands of providers. The system is so underfunded it's staggering, but the model's good. Germany has a model where people can make a choice of their care-giving system. You get to pick your "sickness fund", which provides your care. The British do a good job because every person picks a primary care doctor. In terms of a system in this country, we need some form of voucher system that lets people make choices. To have a system where two-thirds of American diabetics receive inadequate care is terrible. No other industry would accept that level (of failure).

Q: *The potential for information technology in medicine is indisputable. But the track record, including Kaiser's, has been kind of abysmal. Didn't Kaiser have to junk a multimillion-dollar system only a few years ago? Why have these technologies continued to fall flat on their face? What makes you think it's not going to happen again?*

A: The answer is that computers are better today. I was experimenting with automated medical records 17 years ago. There's a different level of sophistication now, a different level of interaction with the computer.

Q: *How much is Kaiser going to be investing in this system, and what sort of savings do you expect to see?*

A: We will spend over $2 billion in the system and, depending on how you count them, as high as $3 billion in operating costs. Within three years, we will turn it into a positive. It's a quick return.

Q: *It seems that in the public's mind, you either love Kaiser or hate Kaiser. There seems to be a very polarized view out there.*

A: Some research people told us that when they looked at Kaiser, they'd never seen such a wide gap in opinion between customers and non-customers. Customers gave it the highest satisfaction ratings around. But non-customers had a much lower expectation of what their satisfaction level would be if they joined us. One big thing we've done in the past 18 months is work on our brand. What does it mean to be Kaiser Permanente? What are we about? We spend a lot of time doing surveys. We've interviewed our patients, customers and employees. Starbucks has a consistent, customer-focused product and understands its brand really well. We brought in some of the people who worked on the Starbucks brand to help us think through some of this. We also used some of the consultants that Nike used. We view this (branding effort) as a serious strategic issue.

Q: *Kaiser seems to be moving toward a broader range of products with higher co-payments in exchange for lower deductibles and broader types of PPOs, or preferred provider organizations, which is a different type of a managed care plan. Kaiser has had a standardized, comprehensive plan for everyone from the service-type employee to the high-level executive. This seems to be more focused on what the patient can afford. Is it a departure from Kaiser's philosophy?*

A: We're introducing plans that have more cost-sharing in them. We're doing that in part because the market has asked for more cost-sharing. We're used to having, as we still prefer, products that are comprehensive. With additional cost-sharing, we're going to be as comprehensive as we can be. We have no interest in going out and doing $1,500, $2,000 deductibles. We don't want to be in the big deductible (business). You've got to be able to intervene and have people get care, fill their prescriptions and do all those things. We don't want to create financial barriers to doing that.

We've done market research and found that people would like to have access to our system but can't afford full benefits, so they want something in the form of a deductible. We're putting in some additional co-payments and additional cost-sharing on group products as well.

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Ireland

New Policy Administration Software Package for Private Health Insurance Industry

Like many other private health insurance organisations Vhi Healthcare faces many challenges in the market place. The following article outlines an initiative by Vhi Healthcare to introduce a new software package to support its strategy.

As part of its strategic plan Vhi is committed to a major diversification programme in products and services while retaining its customer focus. To support this strategy going forward Vhi Healthcare needed to improve its systems support for its core policy administration processes such as Enrolment, Renewal & Billing, Alterations etc., as the legacy systems were not sufficiently flexible to support the business strategy in a cost efficient and speedy manner.

A major programme was initiated, consisting of a Business Process Review incorporating market best practice, solution selection and change management.

Our goal was to:

- Provide an integrated approach to our customers through one single customer view thus significantly improving customer service.
- Enable us to bring new products to market quicker than our previous legacy system allowed.
- Allow us to streamline our processes and automate the many customised solutions developed for our customers.

We required a system that supported changing business processes with a modern

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ifhp

News

Australia

Rising Health Costs Ease

The Australian Age newspaper reported that, although health insurance firms may have to continue to lift premiums, the need for large increases may have eased compared to previous years.

According to the ratings agency Standard and Poor's the health insurance industry earnings and profits had stabilised in 2003 after the losses experienced in 2002.

"Future premium increase will be needed to maintain current levels of benefits and service, given strong cost pressures as medical inflation generally runs at least twice as high as nominal consumer price index." The agency also said that there was room for consolidation among the 44 funds, with some of the smaller funds looking less viable.

Australian Hospital Group Sold

Mayne Group, the Australian hospital group, has sold its 53 hospitals to a private equity consortium of CVC Asia Pacific, the Government Investment Corp of Singapore and Ironbridge Capital for $813 million according to The Australian Financial Review.

According to the AFR the proceeds will provide managing director Stuart James with a $2 billion "war chest" for the expansion of Mayne's interests in generic injectible pharmaceuticals. The deal will be a disappointment for a Macquarie Bank-led syndicate that included the listed Ramsay Health Care and privately owned Benchmark Healthcare.

The private equity trio is believed to have outbid the Macquarie syndicate on price, as well as in its willingness to take on Mayne's three Indonesian hospitals.

Source Australian Financial Review 20th October 2003

For your diary

San Diego Conference

19th – 22nd September 2004

Middle East

The coming of regulation in Saudi Arabia

David Maltby, Managing Director BUPA Middle East, outlines the background to new regulations announced in Saudi Arabia, which will have a significant impact on the health insurance market.

All non-Saudi employees will be required to have health insurance cover under new health insurance regulations first announced in 2001.

With a three year phased implementation planned, the first stage was theoretically implemented in 2002. However, sanctions for non-compliance have not yet been applied due to the limited ability of employers to sign up with a licensed insurer in the Kingdom. To date, only the semi-government insurer NCCI has a licence to operate as an insurer in the country.

The Saudi Government issued a royal decree in July 2003, which formed the basis for licensing and regulating insurance companies in the kingdom. This will effectively facilitate the growth of the health insurance industry in Saudi Arabia – enabling the health insurance regulations to be enforced.

In Saudi Arabia, the Ministry of Interior is responsible for issuing work visas (Iqama's) for all non Saudi workers. Refusing to issue or renew an Iqama unless the applicant has a valid health insurance contract through his employer will drive the anticipated market growth.

Over the past 15 years, Saudi Arabia has built its financial services infrastructure, ensuring compliance with the strict Islamic traditions governed under the Sahri'ah Law. Insurance is the latest industry to receive attention – and publication of the byelaws to support July's royal decree is imminent.

Clearly competition for both regulated status and access to the new market will be fierce. There are already over 30 insurance companies registered in Bahrain and other offshore countries operating through administration/distribution companies in Saudi. SAMA (The Saudi Arabian Monetary Agency – the Saudi central bank and nominated regulator) has made it clear that in the rush for registration, it will apply tight controls over the quality of application and company selected for initial regulated status.

Many of the other Gulf states are watching the development of Saudi regulation with keen interest. With burgeoning health costs in the public sector, they see Saudi's leadership in mandating health insurance as an option to reduce foreign workers' reliance on public services.

A special feature looking at the more detailed implications of these regulations will be published in the next edition of the iFHP newsletter.

iFHP UPDATE

The Urgent Need for a Web Strategy

An ad hoc group of iFHP senior executives with special interest in use of the Internet convened in London at the end of November for a two-day Web Strategy Workshop. The meeting resulted from an initiative by Mark Newson, head of Web Strategy and Marketing at BUPA, who played a major role in its planning.

From seven different countries, the group included chief executives, marketing directors and chief information officers, reflecting the diversity of the approaches being taken by member firms to the management of the Web as a separate channel of communication.

The workshop began with an account of the future shape of the web by Margaret Gardiner, a well-known UK based IT consultant and Web futurologist who has advised many large corporations. This led to a discussion of the growing cost and complexity of Internet security and the need for a global regulatory framework to protect the interests of users and consumers, based on a foundation of US and EU law.

The core of the workshop was a series of presentations by delegates about the history behind their companies Web strategy and their plans for future development. These revealed wide variations in the level of investment allocated to the Web and in levels of transparency, especially over availability of claims data to members. While some of those present were still using their sites for mainly for "brochureware", others were already transacting a substantial volume of e-business with members and providers, as well as providing diet or other health focused programmes.

Other sessions dealt with the question of how to find ways to generate revenue from Web operations in a health insurance context, and to what extent the Web can be treated as a separate channel, rather than as an adjunct to conventional marketing or other activities. Among several important conclusions reached there was strong general agreement that:

The individual with responsibility for the coordination of web operations needed ideally to occupy a senior board level position.

There needed to be a well established, adequately financed Web strategy in place, rather than use of the Web evolving from a series of uncoordinated initiatives.

A web presentation at the San Diego conference is planned to disseminate these findings to a wider audience.

Banknotes II

Mark Bassett has been an iFHP Fellow at The World Bank in Washington DC for six months and has produced an update for iFHP members on life in the USA.

Let me begin with the job. Over the past few months I have prepared what the Bank calls a "concept note" setting out a proposed plan of work on my topic (the role of voluntary health financing in developing countries) in the coming years. The note is presently being reviewed by senior management and I await the outcome.

In the meantime Roger Bowie, the immediate past president of the iFHP, has nearly completed an excellent paper on best practice in voluntary health insurance in the developed world, and my colleagues and I have drawn up terms of reference for a number of other papers and begun to set up several steering committees. Our "academic" steering committee had a very successful first meeting in August at University of California, Berkeley. We hope to convene an "industry" steering group (which George Halvorson has kindly agreed to chair) in 2004.

I have established numerous points of contact in the Bank and with the Bank's sister organisation, the International Finance Corporation which specialises in loans to the private sector for use in the developing world. I have also taught on a number of World Bank Institute courses.

Last week I completed my first overseas mission. In Malaysia I worked informally with officials of the Malaysian Ministry of Health on their plans for hospital and financing reform. In Singapore I taught a course and visited many different health care organisations and institutions.

The last six months have been a time of change at senior levels in the Bank. Jacques Baudouy, our new Director of Health, Nutrition and Population, is reviewing the Bank's whole range of health related activities and considering how the Bank can best work with partner organisations, like the Gates Foundation and the World Health Organisation, towards the achievement of the Millennium Development Goals (which can be seen at www.developmentgoals.org/).

My family joined me in the USA in August and we have made our home in Alexandria, Virginia, not far from George Washington's old home at Mount Vernon. My wife Elena is enjoying the chance to spend time with our young daughter Phoebe. Our eight year old son Sacha is completely immersed in his new life at Washington International School, where he studies in Spanish and Russian as well as English. We recently watched our first baseball match in Baltimore and hope to see some ice hockey soon. Later this week we have Halloween.

My colleague Alex Preker and I hope to attend the iFHP Annual Conference in San Diego in September 2004 and introduce some of our work to iFHP members at that time. In the meantime members are always welcome to contact me by email at mbassett@worldbank.org

Administration Software Package

continued from front page

and flexible architecture and capable of evolving as business needs dictated. Following a market analysis Vhi Healthcare recognised early on that there was no 'off-the-shelf' package that could readily meet its requirements.

After an extensive solution evaluation process Vhi Healthcare identified GIOS (Global Insurance Open Solution) supplied by CGI as the best approach to its systems support requirements. The GIOS system is a flexible modular solution that comes with generic based insurance modules that can be customised to specific business requirements. Following a preliminary study and requirements phase there was a shared understanding of what was required, and it was agreed that both organisations would jointly develop a health care insurance administration solution that would meet Vhi Healthcare's needs. The partnership between Vhi Healthcare and CGI provided an opportunity for the coming together of two key competencies: Vhi Healthcare's health insurance and business knowledge and CGI's insurance technology and systems delivery capacity. As part of the agreement both parties recognised the potential for developing an industry solution that would be of interest to other health insurance companies.

The programme commenced in June 2002. Vhi Healthcare and CGI personnel have been working very closely together during the past year in developing the solution and we have completed the development of the health care insurance administration system. We are now focussing on the internal implementation which is scheduled for completion in June 2004.

In the meantime, market interest in the health care administration solution has been growing and a major UK health care insurer has recently purchased the Healthcare Template.

News

USA

Google to limit some Drug Ads

Google, the search engine, will stop accepting advertising from unlicensed pharmacies that have used the Internet to sell millions of doses of narcotics and prescription drugs without medical supervision, company officials said. Google's move follows decisions last month by Yahoo and by Microsoft's MSN site to stop accepting similar advertising.

The decision by Google comes as regulators and members of Congress shift their focus from the illicit pharmacies to the legitimate Web sites, credit card companies, shippers and banks that facilitate the sales.

"These legitimate businesses are an important but faceless part of the supply chain for these dangerous drugs", said Carmen Catizone, executive director of the National Association of Boards of Pharmacy, which has been lobbying Google and other search engines to stop accepting advertising from rogue Web sites. "If the government is serious, it has to look at these businesses."

Illegal Internet pharmacies have become a virtually unregulated pipeline for highly addictive painkillers, tranquilizers and anti-depressants that have resulted in overdoses and deaths.

Health care represented about five percent of total online advertising sales in October, according to the California research firm Nielsen/NetRatings. The search engines say the revenue is a small part of their overall advertising business.

David Krane, a spokesman for Google, said the search engine will start using a third-party company to weed out rogue pharmacies that advertise on its site.

America Online Inc. said it began restricting those sales approximately two years ago.

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