BADRI

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The Vitals

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Medical Newsletter

TOPIC 1

HEALTH UPDATES IN MIDDLE EAST REGION

New mandatory health insurance system introduced in Qatar

Qatar has revised its mandatory health insurance scheme with a new law effective May 2022. The Ministry of Public Health ('MOPH') announced that the new mandatory health insurance system will replace the earlier scheme (SEHA) and must be implemented for all non-Qatari nationals living in and visitors to Qatar. Following significant changes to the current health insurance system in Qatar are as under:

- All non-Qatari nationals and visitors in Qatar must have private health insurance for the duration of their stay to receive basic medical services.
- Non-Qatari employees and their family members must be enrolled in the scheme.
- The same obligations apply to sponsors of expatriates in Qatar, such as the recruiter, to provide basic health insurance coverage.
- When issuing or renewing residence permits, employees must be approved by their employers that they are covered by the scheme.
- Fines will be issued to employers or recruiters who fail to provide basic health insurance to their employees and eligible family members.

The MOPH will play an important role as a regulator of the health insurance services. With this new scheme, one can expect that prescribed minimum levels of cover will be offered to private insurer. MOPH will require all participants including foreign insurers, brokers and TPA's to be authorized to offer public insurance services in the scheme.[1]

Mubadala Health announces expansion plans into Dubai

Mubadala Health in collaboration with Dubai Health Authority (DHA) and the UAE Ministry of Health and Prevention (MoHAP) announced its expansion into health-care services in Dubai, scheduled to open in Q3 in 2022. Mubadala Health's plan will aid to improve the efficiency and competitiveness of the UAE health sector and consolidating the country's position as a leading destination for innovative health care, something which will reflect positively on realising the reliable development goals. A range of specialties delivered by physicians and medical experts including gastroenterology, sleep medicine, ENT surgery for adults and paediatrics, rehabilitation, neurology, orthopaedics', and respiratory medicine services will be offered from Mubadala health assets.[2]

SAMA approves standard domestic worker insurance contract

The Saudi Central Bank (SAMA) has launched a model insurance policy for domestic workers. Under the new regulation, the rights, and benefits of both the employer and the worker will be guaranteed. This include compensating the risk of employer for expenses incurred to get a replacement in the event of the worker's death or his/her inability to work, affliction with chronic and critical diseases, compensation for expenses of repatriating the dead body, belongings, and personal properties in the event of the death of the domestic worker. The employer will also be compensated for losses due to risk of the worker's absence or run away from work. In case of loss due to a risk covered under the provisions of the policy, the maximum limit of the insurer's liability for all claims is SAR25,000. SAMA prohibits the insurance company and the employer from agreeing to reduce the limits of liability stated in the standard insurance policy but permits them to agree to add coverages not provided for in the standard policy. The move aims to increase the attractiveness of the Saudi labour market, facilitate bilateral negotiations with other countries, improve the contractual relationship, and reduce risks in the domestic labour recruitment market.[3]

Dhamani health Insurance Platform to adopt AMA System

The latter's Current Procedural Terminology (CPT) code for the Dhamani health insurance platform has been introduced by the Capital Market Authority (CMA) and the American Medical Association (AMA), line-up to support health data exchange, claims settlement and fund transfer between insurance companies, health organisations, and supervisory and regulatory institutions in the Sultanate of Oman. This will help serve the needs of the Sultanate of Oman's data-driven healthcare system by allowing clinicians, hospitals, health insurers, regulators, and researchers to electronically exchange standardised information on the medical services and procedures provided to patients within the Dhamani platform. This information across Omani health care system will enable reimbursements, reporting, predictive analysis, and benchmarking of medical services. With uniform language, AMA provides modern medicine, streamlines reporting and increases efficiency in the management of the insurance claims process. Moreover, the CPT standards will increase the accuracy and efficiency of medical services in Sultanate of Oman and magnify the Dhamani platform performance.[4]

TOPIC 2

CHRONIC DISEASE MANAGEMENT

Over the past half-century, GCC countries have experienced rapid economic growth and dramatic lifestyle changes. Low levels of physical activity and calorie-dense diets have led to an increase in the prevalence of chronic disease, most prominently diabetes. After having successfully controlled communicable diseases and advanced acute care, the GCC countries now face the challenge of orienting their health care systems toward prevention and treatment of chronic diseases.

Chronic Disease Models

The five chronic disease models managing Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and cardiovascular diseases (CVD) includes:

- **Chronic Care Model (CCM):** This model applies to a broad range of chronic illnesses and serves as a roadmap for physicians to organize their practices and to meet the complex needs of chronically ill people. It provides a proactive, patient-centered and evidence-based approach.
- **Improving Chronic Illness Care (ICIC):** This model is to integrate medical science with redesigned health care delivery systems so chronic patients in any setting can receive prompt diagnoses and care.
- **Innovative Care for Chronic Conditions (ICCC):** This model recognizes the broader policy environment that involves patients, their families, health care organizations, and communities.
- **Stanford Model (SM):** The widely used Chronic Disease Self-Management Program (CDSMP) aims to provide participants with the skills required to optimally manage their chronic conditions regardless of specific diagnosis.
- **Community based Transition Model (CBTM):** This model addresses gaps in all care transitions, including hospital to home, home to hospital, physician office to home, chronic care to palliative care, and palliative care to hospice care.[5]

Chronic Disease Management – Comparison between regions

Saudi Arabia

NCDs account for 73% of the deaths in the country. In a country with 40% of the population older than 40, the risks of the onset of major chronic diseases are very high. It is estimated that new cases of common cancers are likely to increase to 150,000 by 2025 with 30,000 annual deaths by 2025. Breast, colorectal, and thyroid cancers account for 40% of all new cases. The average age of diagnosis ranges from 52 to 56 years, increasing the risks of co-morbidities. Late diagnosis increases associated risks and decreases survival rates. The weak primary care system has impacted regular screening trends amongst patients. Hence, the MoH has taken initiatives to conduct screening programs to support early diagnosis. People diagnosed with diabetes spent about 10 times more than non-diabetics on their healthcare needs. At the current rate, the diabetes burden is likely to increase from $21.3 billion in 2019 to $35.5 billion in 2040. Mhealth with a robust primary care centre-driven disease management program can improve glycaemic control and reduce expenditure for the country.

United Arab Emirates

NCDs are responsible for 77% of deaths in the country. At least 3% of the UAE's population is older than 60 years, and at least 70%-80% of the elderly have more than one chronic disease. The country has developed the chronic care model (CCM) as an integral part of UAE Vision 2021. CCM aims for population-based daily care for all patients with chronic diseases with structured and planned care interventions.

Chronic Care Model, UAE

Model Elements	Strategies
Self-management support	Emphasize patient central role to manage their health, usage of effective self-management support and organize resources.
Community	To advance community programs to support and develop interventions that fills gaps.
Health system	Improve organization, encourage handling of errors and quality problems to improve care.
Delivery system design	To improve system working, to support evidence-based care, provide clinical case management services and ensure regular follow-up.
Decision support	To provide guidelines, use provider education methods and integrate specialist expertise and primary care.
Clinical information system	Provide timely reminders to patients, facilitate individual patient care planning, and monitor performance of practice team and care system.

The Chronic Care Model increases access to patients, providing a structured approach to manage conditions. An estimated 17.3% of the population has diabetes, while 12.7 patients per 1,000 population suffers from some form of cardiac disease and about 35 per 1,000 population suffers from some form cancer. There are huge gaps in the system, impacting early diagnosis. Hence, the top priority is to increase the number of health educators to teach patients how to better manage their conditions.

Oman

Oman has witnessed an epidemiological transition to NCDs because of several factors, including lifestyle changes and an aging population. Nearly 68% of deaths are attributed to NCDs. Almost 12.3% of the population has some form of diabetes and 40.3% has hypertension. Recent government surveys determined that 20% of the elderly population needed 24/7 care, primarily because at least 68% had some form of hypertension and was at risk of having cardiac conditions. At least 80% of the elderly population leverage some form of inpatient and outpatient support annually, and nearly 13% have been admitted to hospitals. The projected quadrupling of the elderly population by 2050, paralleled by the lack of intervention to manage chronic disease patients, will place a high burden on the healthcare system.

Bahrain

NCDs account for 78% of the deaths in the country, the highest percentage in the GCC region and much above the global average of 70%. Morbidity and mortality statistics indicate that major diseases include cardiovascular disease, cancer, respiratory infections, diabetes, and genetic diseases like sickle cell and thalassemia. Key considerations impacting the disease burden in Bahrain are that more than 60% of the population is classified as overweight, with 40% of adults and 24% of youth considered to be obese. About 20% of the population is diabetic, and more than 20% of the population smokes regularly.

Qatar

NCDs are responsible for 69% of all deaths in Qatar. Cardiovascular diseases, diabetes, and cancer account for 24%, 17%, and 9% of deaths, respectively. Based on data from HMC, almost 16% of patients with more than one chronic disease were readmitted at the emergency department within 28 days of discharge, 6% of emergency patients had more than one chronic condition, and patients over 65 years of age with more than one chronic condition were seven times more likely to have emergency admissions than 45–65-year-olds. In effort to reduce chronic conditions, improving the health of people with multiple chronic conditions has been set as one of the seven priority areas in the National Plan Strategy. To measure progress, the National Health Strategy set targets to be achieved by 2022, including:

- **25% decrease in the 30-day readmission rates for chronic conditions**
- **5% decrease in obesity rates nationally**
- **30% reduction in smoking prevalence**
- **15% reduction in mortality from chronic diseases**

Kuwait

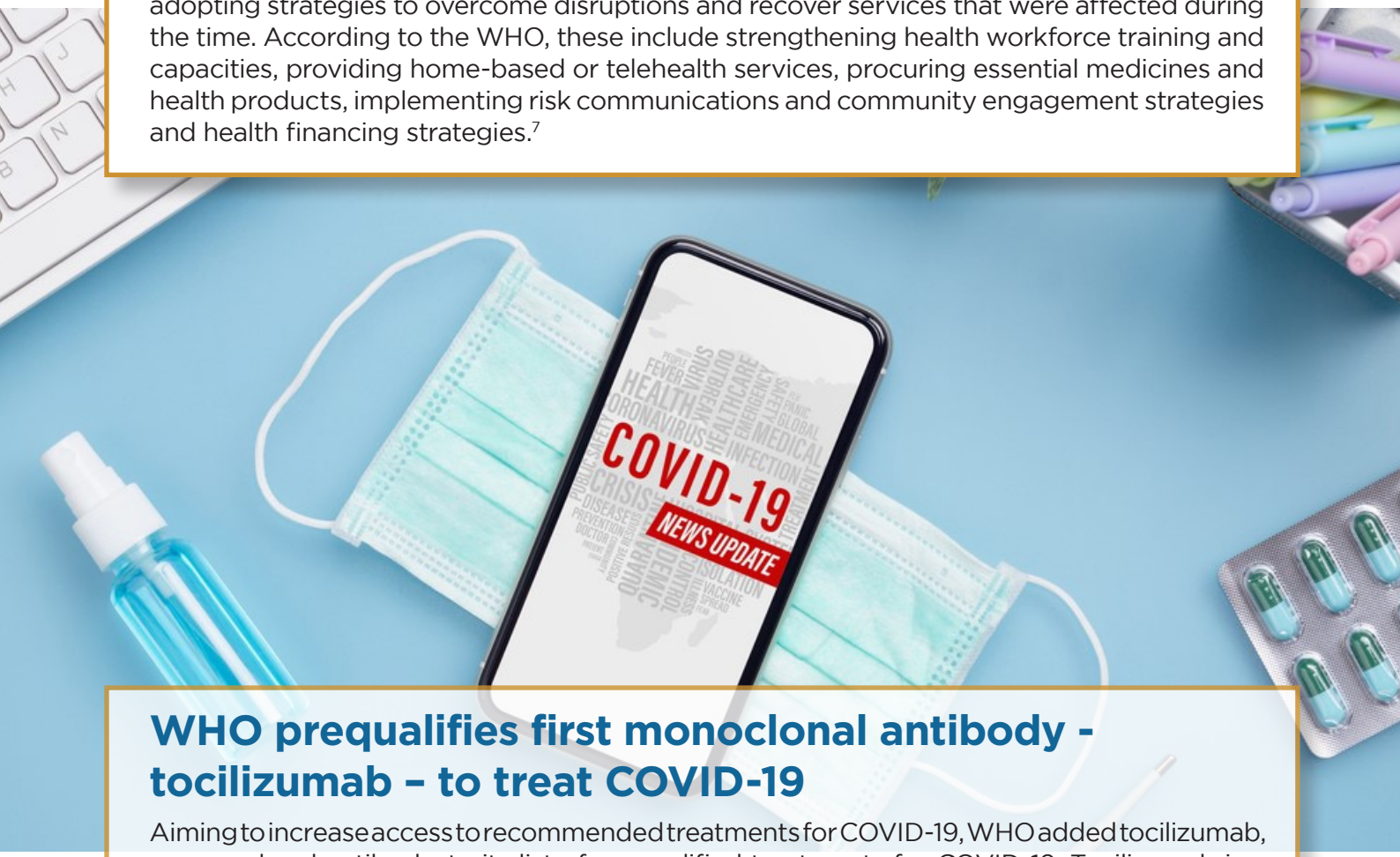
Around 73% of deaths in Kuwait are caused by NCDs like heart disease, cancer, diabetes, and upper respiratory diseases. Cardiovascular diseases account for 40.8% of all deaths, cancer for 13.7%, respiratory diseases for 1.9%, and diabetes for 3.9%. About 12% of adults between the ages of 30 and 70 years are expected to die from one of the four main NCDs in the country. Around 15% of Kuwait's population suffers from some form of diabetes. The Supreme Council for Planning and Development has listed fighting NCDs as a priority for Vision 2035. Around 0.5% of the country's GDP is spent on diabetes management; this is expected to double by 2030. Interestingly, diabetic patients are hospitalized 2 to 3 times more frequently than people without a history of diabetes. Moreover, studies conducted by government bodies found that 77% of Kuwaitis are overweight and 40% suffer from obesity. In addition, at least 25% of the population has high blood pressure and 50% have raised levels of cholesterol. Taken together, a staggering 50% of young adults have three of the five major risk factors: smoking, inadequate fruit and vegetable intake, physical inactivity, excessive weight, and high blood pressure. Cancer imposes a huge burden on the country. Kuwaitis accounted for around 40% of diagnosed cases annually, while expatriates accounted for the remaining 60%. The most common types are breast, colon, and lymph node cancers.[6]

TOPIC 3

LATEST UPDATES ON COVID-19

Essential healthcare services face significant disruption amid pandemic

Two years into the COVID-19 pandemic, healthcare systems are still facing challenges in providing people with essential services. Some of the major barriers to the health sector's recovery include pre-existing issues in health systems which have been worsened by the pandemic and the decreased demand for care. Countries are in the process of devising and adopting strategies to overcome disruptions and recover services that were affected during the time. According to the WHO, these include strengthening health workforce training and capacities, providing home-based or telehealth services, procuring essential medicines and health products, implementing risk communications and community engagement strategies and health financing strategies.[7]



WHO prequalifies first monoclonal antibody - tocilizumab – to treat COVID-19

Aiming to increase access to recommended treatments for COVID-19, WHO added tocilizumab, a monoclonal antibody, to its list of prequalified treatments for COVID-19. Tocilizumab is a monoclonal antibody that inhibits the Interleukin-6 (IL-6) receptor. Interleukin-6 induces an inflammatory response and is found in high levels in patients critically ill with COVID-19. So far, the product has been authorized mostly for the treatment of arthritis in about 120 countries worldwide. Tocilizumab given intravenously has been shown in clinical studies to reduce death in certain patients with COVID-19 who are severely ill, are rapidly deteriorating and have increasing oxygen needs, and who have a significant inflammatory response. In the largest clinical trial (RECOVERY), tocilizumab also reduced patients' time in hospital. WHO recommends tocilizumab only for patients diagnosed with severe or critical COVID-19. It should be administered by a healthcare worker in a monitored clinical setting along with the current standard of care for COVID-19, which includes oxygen, corticosteroids, and other medications. The prices reported is around USD 500-600 per single dose. With demand surging, and more manufacturers entering the market, prices could come down.[8]

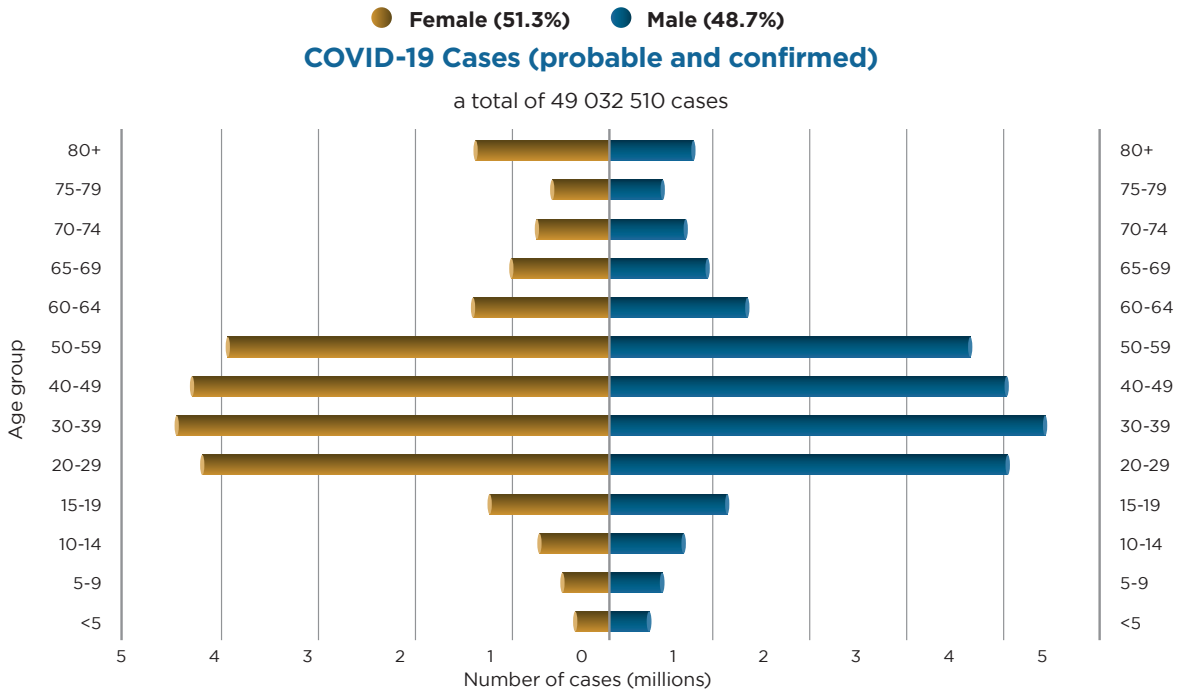
COVID-19 as a leading cause of death

To put deaths due to COVID-19 into perspective along with other leading causes of death, relative to causes described in the WHO Global Health Estimates 2019, the absolute number of reported deaths in 2020 would rank COVID-19 within the top 10 causes of death globally, with only ischaemic heart disease, stroke, chronic obstructive pulmonary disease (COPD), lower respiratory infections and neonatal conditions ranked higher.

Cause	2019	2020
Ischaemic heart disease	8,880,000	
Stroke	6,190,000	
COPD	3,220,000	
Lower respiratory infections	2,590,000	
Neonatal conditions	1,960,000	
COVID-19		**1,800,000**
Trachea, bronchus, lung cancers	1,760,000	
Alzheimer's disease and other dementias	1,590,000	
Diabetes mellitus	1,490,000	
Diarrhoeal diseases	1,450,000	

Note: Comparing total deaths estimated for leading causes in 2019 Global Health Estimates to the reported COVID-19 deaths for the year 2020. Comparing quantities from two different periods and so does not account for population growth or any epidemiological changes. However, gives an order of magnitude picture and expected relative ranking of causes for 2020 assuming mortality risks and levels for other causes have not changed significantly.

Total number of COVID-19 Cases (probable and confirmed)
by Age and Sex, January 2020 to April 2021



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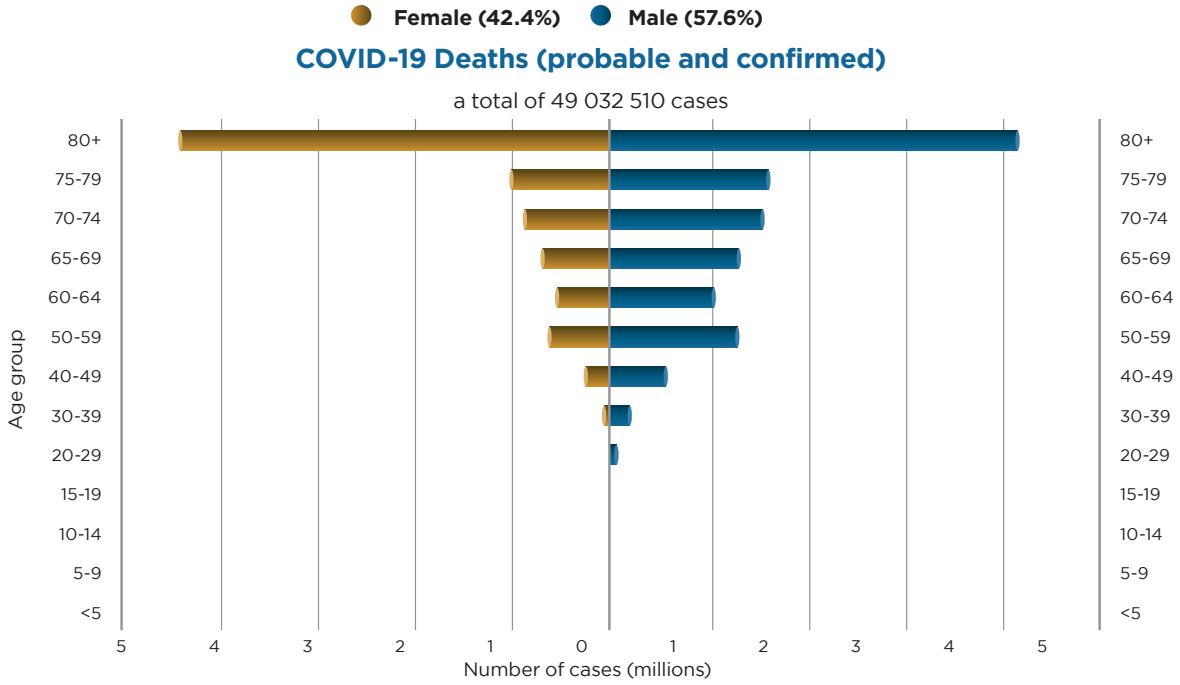
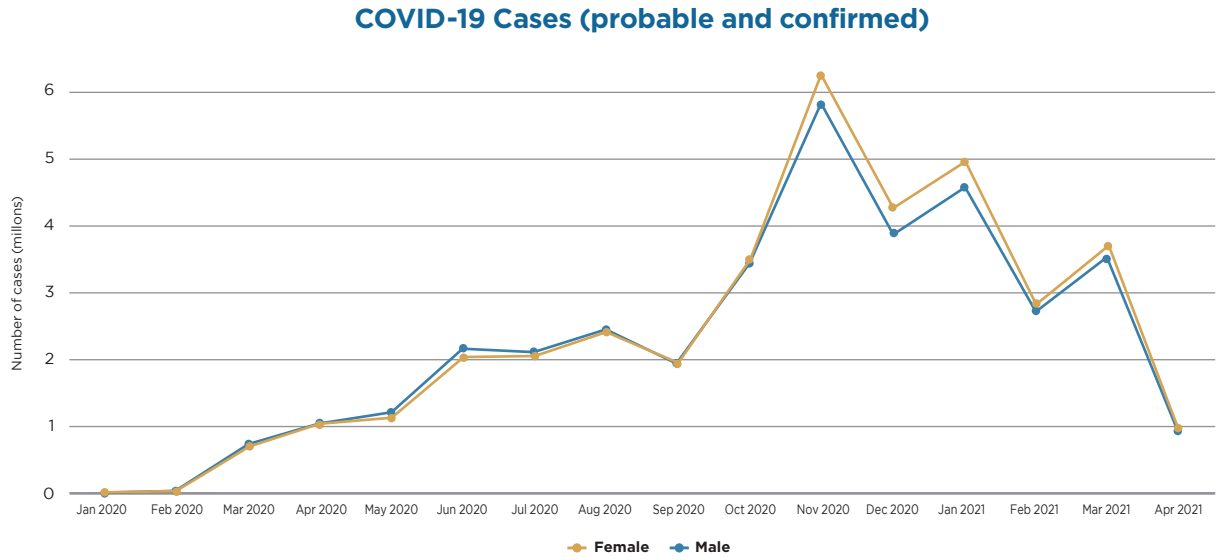
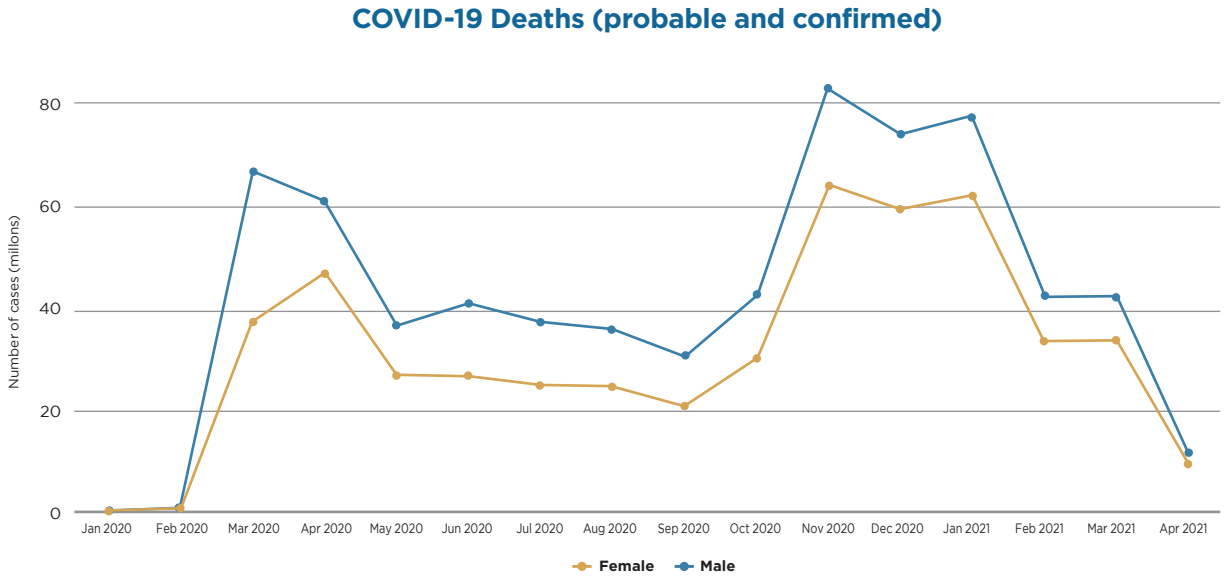


With the limited data available, the current analysis shows COVID-19 cases and deaths not only vary between countries, but also between population subgroups within countries, including between males and females and between different age groups. Available global data show that the number of COVID-19 cases does not differ significantly between males and females (48.7% vs 51.3% of all reported cases), however the number of deaths is markedly higher among males than females (57.6% vs 42.4% of all deaths).

Change over time in number of COVID-19 Cases (probable and confirmed)
by Age and Sex, January 2020 to April 2021



Change over time in number of COVID-19 Deaths (probable and confirmed)
by Age and Sex, January 2020 to April 2021



Among both males and females, the number of COVID-19 cases increases with age until age 30–39 years, then decreases until age 75–79 years, but is slightly elevated again for those aged 80 years or older. For both sexes, the highest numbers of COVID-19 cases are observed for ages 30–39 years, representing about 20% of all cases. About 60% of all cases occur among ages 20–60 years, for both males and females.

The number of COVID-19 deaths shows a very different pattern: overall, the number of COVID-19 deaths increases with age and is highest for those aged 80 years and older (representing one third of all deaths, among both males and females). Available time trend data shows that, temporally, the number of cases was about the same between males and females, while the number of deaths was continually higher among males than females.[9]

Health insurance policies see growing demand as Covid-19 cases surge

With the rise of the third wave of Covid-19 in the country, more people are rushing to buy health insurance to protect them and their families. Leads for health products have increased by 30%, and daily premiums have increased by 45%. The demand for health products is increasing faster than we have seen in the past. Customers are also looking for policies that cover consumables or selecting riders. Even health insurance renewal persistence has increased by nearly 3%.

While earlier people used to consume at least a week on an average to decide to buy health insurance but now people are willing to buy health insurance where they purchase a maximum a day or two as they are quite terrified with another wave of the infection. The pandemic has also increased awareness about the health insurance product as people have been more inquisitive than before about terms and conditions while buying the policy.[10]

Latest on the region's Covid-19 recovery

- The number of Covid-19 cases in the Middle East and North Africa (Mena) region reached 19,323,067 on 22 March, according to Worldometers data.
- Countries in the GCC account for 18.6 per cent (3,559,300) of all regional cases.[11]

Covid-19 in the Middle East and North Africa

Country	Total cases	Total deaths	Active cases	Cases/ 1m popn	Deaths/ 1m popn	Total tests	Tests/ 1m popn	Population
Mena	**19,323,067**	**296,321**	**446,784**	**41,945**	**643**	**343,176,866**	**744,945**	**460,674,405**
GCC	**3,559,300**	**20,277**	**49,748**	**59,287**	**338**	**232,515,374**	**3,872,994**	**60,035,039**
Iran	7,142,287	139,662	173,911	83,208	1,627	48,534,882	565,434	85,692,557
Iraq	2,316,306	25,131	16,810	55,454	602	18,242,985	436,754	41,648,357
Jordan	1,689,314	14,003	6,459	162,796	1,349	16,575,546	1,597,359	10,363,297
Morocco	1,162,539	16,052	532	30,869	426	11,237010	298,374	37,602,251
Lebanon	1,088,595	10,252	45,567	160,725	1,514	4,795,578	708,041	6,777,092
Tunisia	1,029,762	28,065	18,067	85,595	2,333	4,475,031	371,968	12,014,156
UAE	888,386	2,302	27,345	88,000	288	145,413,162	14,404,013	10,079,328
Saudi Arabia	749,730	9,030	8,416	20,975	253	41,387,358	1,157,900	35,670,839
Kuwait	627,584	2,553	2,403	143,321	583	7,763,313	1,772,906	4,370,404
Bahrain	545,761	1,465	8,664	302,716	813	9,550,968	5,297,611	1,794,919
Libya	501,135	6,377	6,996	71,270	907	2,464,710	350,523	7,019,001
Egypt	500,889	24,361	46,265	4,689	230	3,693,367	34,961	105,384,390
Oman	387,730	4,250	1,865	72,756	797	25,000,000	4,691,147	5,311,744
Qatar	360,109	677	1,055	128,253	241	3,400,573	1,211,114	2,807,805
Algeria	265,562	6,872	80492	5,874	152	230,361	5,107	45,102,387
Syria	55,577	3,127	1,209	3,049	172	146,269	8,024	18,172,155
Yemen	11,801	2,142	728	381	69	265,253	8,570	30,863,723

Source: MEED; Worldometers; as of 22 March 2022

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How we can help

- **Pricing and predictive analysis**
- **Fraud Waste and Abuse**
- **Cost Containment Alternatives**
- **Performance Monitoring and Analytics**
- **Profit Optimization**
- **Provide Network Structure**

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