Private Healthcare Australia
Better Cover. Better Access. Better Care.

House of Representatives Standing Committee on Health, Aged Care and Sport

Inquiry into Diabetes

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 24 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for 14.6 million Australians.

Supplementary submission

On 16 February 2024, Ben Harris and Julia Medew, of Private Healthcare Australia, committed to providing the following information to the committee.

Evidence of increasing burden of diabetes for health funds

Private health funds have noticed a trend of more members needing expensive, complex care for diabetes in private hospitals. Given 45% of Australians have hospital cover, diabetes is a growing concern for the sector.

Since 2015, there's been a 17% increase in the number of people with health insurance making 'high claims' in excess of $10,000 for hospital treatment where the principal diagnosis was diabetes. The average cost of these claims has increased from around $18,000 to $21,000 over that period. Since 2015, the total cost of these diabetes claims for insurers has soared 32% from $33.9 million to 44.9 million. See table below.

Reporting data period	Number of high claims directly related to diabetes	Total PHI Industry expenditure on hospital high claims directly related to diabetes ($)	Average cost per high claim ($)
2015	1,807	$33,948,687	$18,787
2016	2,013	$38,375,615	$19,064
2017	2,128	$42,981,170	$20,198
2018	2,265	$45,416,849	$20,052
2019	2,246	$46,848,385	$20,859
2020	2,237	$45,564,142	$20,368
2021	2,352	$47,725,168	$20,291
2022	2,119*	$44,926,214	$21,202

Source: Private Healthcare Australia

* Numbers have been impacted in 2022 due to the Omicron COVID-19 wave. Government-imposed restrictions in response to the COVID-19 pandemic continued to limit private health insurance policyholders' access to non-urgent elective surgery and non-urgent extras treatments. Significant restrictions on access to treatments were seen across Victoria, New South Wales, and to some extent Western Australia and South Australia during the Omicron wave.

Health fund programs to help members prevent diabetes, better manage diabetes, and prevent complications of diabetes

Australian Unity: Healthier Me program

HealthierMe is a telephone-based support service that provides eligible members with personalised health coaching aimed at preventing, or helping them cope with, long-term health conditions including diabetes. Members work with their personal health coach, a qualified health professional, over an extended period up to 2 years to meet personally identified health goals.

Australian Unity: Diabetes health care pilot for Aboriginal and Torres Strait Islander peoples

In November 2023, Australian Unity announced a partnership between its Aboriginal Home Health business, joint venture Ramsay Connect and University of Queensland to deliver a two-year pilot health care model for Aboriginal and Torres Strait Islander peoples living with type 2 diabetes in northern New South Wales, commencing in April 2024.

Funded by the Department of Health and Ageing's Targeted Translation Research Accelerator program, the $1 million pilot utilises the Diabetes Using Our Strengths Service (DUOSS) program co-designed by Indigenous Elders, Ramsay Connect and Australian Unity's Aboriginal Home Health.

Bupa

To trigger proactive health attitudes and behaviours, assist with early diagnosis and intervention, and promote preventative health behaviours, Bupa is testing propositions with customers who are potentially at risk of Type 2 diabetes.

In 2023, telehealth, in-person and digital health checks were developed. Customers potentially at risk of Type 2 diabetes were invited to participate with the health check through two specific tests. The purpose of the tests was to understand customer behaviour, validate customer cohort identification and channel preference for the health check.

Although participants within the pilot were small, around 300, more than 60% were referred on to a GP, dietitian, physio, counsellor or Bupa Health Program. Channel preference also determined a 50/50 split between in-person and online health checks.

Bupa is also testing an education portal that provides personalised content as well as referral pathways to customers who are at risk of or recently diagnosed with Type 2 diabetes.

Targeted testing continues to refine the health checks, build out the education portal and identify other aligned propositions before scaling to more customers. This is part of a broader program of work to better support the health needs and journeys of Bupa customers.

Bupa also provides guidance, information and support for people who are managing long-term health conditions or health issues, including diabetes, via Bupa Telehealth Health Coaching. Participants in the program can have up to six phone calls over six months with a Bupa Health Coach, who is a qualified nurse or dietitian.

HBF: The COACH Program ®

HBF has offered The COACH Program at no cost to members managing an eligible chronic condition including type 1 and type 2 diabetes. The virtually delivered health coaching service provides up to 6 monthly sessions delivered by HBF's team of dietitians and physiotherapists. Each coaching session includes a follow-up letter sent to both members and their primary GP – the letter summarises coaching discussions and goals and actions to close nay identified clinical guideline treatment gaps.

HBF: Health Checks

HBF pays benefits for Health Checks covered on most extras policies. Conducted by a pharmacist, a health check assesses risk of developing cardiovascular disease and Type 2 diabetes. Recipients receive a results report inclusive of lifestyle recommendations aimed at reducing risk for Type 2 diabetes and cardiovascular disease.

HBF: Health Check Plus

Health Check Plus provides follow up health coach calls to recipients of a health check who have modifiable risk factors. Delivered by qualified health coaches, the service provides guidance to members to address lifestyle risk factors that put them at increased risk of Type 2 Diabetes.

HCF: The COACH Program ®

HCF provides The COACH Program at no cost to eligible members with a diagnosed heart condition or diabetes. This is a 4 to 6-month structured phone-based coaching program delivered by HCF's in-house nurses, dietitians and pharmacists. After each call, health coaches send a follow-up letter summarising phone discussions and goals and actions as discussed over the phone. The program is designed to help members:

- Identify gaps in their healthcare within Australian guidelines.
- Build a personalised heart or diabetes disease management plan.
- Understand and manage their medication.
- Control modifiable risk factors like blood pressure, cholesterol, blood glucose and weight.
- Develop a healthy approach to nutrition and safely increase physical activity.

This program was previously delivered to HCF members by NPS Medicine Wise in June 2020 but has been delivered in-house since February 2022. A formal evaluation is pending.

HCF: Victor Chang Heart Health Checks

HCF has partnered with the Victor Chang Cardiac Research Institute to deliver heart health checks at no cost to eligible members, encouraging them to engage in preventative health checks annually before symptoms arise, and to identify major risk factors contributing to heart disease and diabetes. At different times throughout the year at selected HCF locations, members can get:

- A blood pressure, total cholesterol and blood sugar reading by a heart health check specialist (registered nurse) from Victor Chang.
- Relevant health advice from a heart health check specialist.
- A snapshot of their heart health with follow-up recommendations into further clinical support and HCF's health and wellbeing programs in less than 10 minutes.

HCF: CSIRO Total Wellbeing Diet

HCF partnered with Digital Wellness to provide eligible HCF members access to the evidence-based CSIRO Total Wellbeing Diet. The CSIRO Total Wellbeing Diet combines a higher protein, low-GI eating plan with proven weight loss tools to help improve habits and create lifelong positive behaviours – all facilitated and supported by a number of digital tracking tools. There are 3 ways HCF members can access the program:

- Free access to the CSIRO Total Wellbeing Diet 16 Week Program, if you have hospital cover and meet clinical and other eligibility criteria.
- A 20% discount on the CSIRO Total Wellbeing Diet 12 Week Program with eligible extras cover.
- A 20% discount on the CSIRO Total Wellbeing Diet 12 Week Program through HCF.

HCF: Healthy Weight for Life Essentials

The Essentials program is an 18 week program that aims to support eligible HCF members in developing healthier habits, losing weight and preventing the onset of various chronic conditions like heart disease and diabetes.

This personalised program is led by trained dietitians and allied health practitioners to help individuals reach their health and wellbeing goals. It includes:

- H-ADAPT - a comprehensive 360 degree personal assessment of current eating, drinking and exercise habits and how mood, attitudes and feelings may be influencing personal choices.
- 4 personal dietetic telehealth consults spaced 4 to 6 weeks apart over 18 weeks.
- Additional unlimited phone, sms, email and personal message board access to the full specialised allied health Care Support Team.
- The Healthy Weight For Life portion planning and lifestyle modification system.
- Digital Member Hub - personal online tracking and resource web portal.

HCF: Healthy Families for Life

HCF supports members with expert-led resources to support children and their nutritional needs. These resources can help parents role model healthy eating behaviours from their child's birth to the teen years, encouraging positive eating habits, healthy growth and reducing the risk of chronic conditions in their future.

Health Partners: Your Health Navigator Diabetes Management Program

Health Partners offers members the Your Health Navigator - Diabetes Management Program which can be delivered either in-home or via telehealth. Led by a qualified Diabetes Educator and supported by a Registered Nurse, this program identifies each participant's individual goals and they are provided a customised resource guide along with a blood glucose meter at no cost. The program sessions include:

- understanding your diabetes,
- maintaining good nutrition,
- keeping active and caring for your feet,
- managing your diabetic medication,

- taking care of your emotional wellbeing, and
- managing your diabetes long term.

Throughout the program, participants are assessed and measured against standardised tools to ensure that their progress is effectively monitored. With regular contact from a Your Health Navigator clinician, patients are consistently encouraged to stay on track, empowering the individual to get the best possible results.

HIF: Healthy Weight for Life Program

HIF offers a Healthy Weight for Life Program to eligible members with heart health risk factors, knee or hip osteoarthritis or type 2 diabetes. It includes:

- Online self-monitoring.
- Advice via phone, email and through an online portal.
- A portion controlled eating plan and meal replacement options.
- Exercise plan to improve fitness, assist with weight loss goals and to get people moving more.
- Muscle strengthening exercises to help stabilise joints, improve mobility and reduce pain.
- Community support through email, message board, post and SMS.
- Education to help people understand their condition and improve quality of life.

HIF offers eligible members with Type 2 Diabetes the Healthy Weight for Life Type 2 Diabetes program, which includes:

- 18 weeks of portion-controlled eating plan with meal replacement options.
- Exercise plan.
- Education and coaching.
- Personalised online self monitoring and tracking system including phone and mail options for people without internet access/ digital skills.
- Two-way personal motivation, support and guidance involving a support team of health professionals, including diabetes nurses and pharmacists.

Medibank: Type 2 Diabetes preventative health program

The Medibank Type 2 Diabetes Program is a 12-month personalised program that aims to help eligible Medibank members learn how to better manage type 2 diabetes through diet and lifestyle. The program was developed by Medibank with support from the Baker Heart and Diabetes Institute and Austin Health and is based on international evidence1 showing that a supported weight management program can help manage type 2 diabetes, sometimes to the point of remission.

The program is provided at no additional cost for eligible Medibank customers and includes:

- Up to 10 telehealth consultations (30-60 minutes in duration) with an accredited dietitian
- A suite of resources, including a program “how to” book, cookbook and activities guide
- Digital weight scales
- Up to 18 weeks of very low energy meal replacements delivered at no extra cost.

The program was launched nationally to eligible members in 2020. A formal evaluation is pending.

nib: Perx program

Perx is a digital program for chronic diseases focused on modifiable behavioural change. nib have partnered with Perx to deliver this program for members with diabetes. Users can track and manage daily or regular tasks provided to them from their health care professional, such as medication adherence, measurements, physiotherapy exercises and physical activity. Other features include:

- Pre-configured content and diabetes related tasks, access to the Perx community and provision of a personalised health summary.
- Members are also motivated and rewarded for completing tasks with 'real rewards' such as gift vouchers.

nib Healthy Weight for Life - Diabetes

The Healthy Weight For Life™ Type 2 Diabetes program aims to improve overall diabetes management (eg. blood glucose control, weight, blood pressure, cholesterol) and quality of life. The in-home program is suitable for individuals with a body mass index (BMI) ≥ 28 who have type 2 diabetes and are motivated to:

- Lose around 5-10% of their body weight.
- Improve their glycaemic control.
- Gently increase physical activity and muscle strength.

nib: Healthy Weight for Life Essentials

The Healthy Weight For Life Essentials program is a personalised goal orientated weight management program led by a team of specially trained dietitians. Participants are provided with 4 personal consults with a dietitian or allied health team spaced 4 to 6 weeks apart. The program focuses on a practical step by step implementation of the key pillars of sustainable long term healthy living and weight management.

nib: Care Support

This program gives eligible members access to an experienced registered nurse to help better understand their chronic condition and achieve their health goals. The program's length varies depending on individual needs. Included in the program:

- Individual support over the phone.
- An individualised care plan.
- Information and coaching to better understand your health.
- Coordination with the care team and referrals to health services.
- Support for any upcoming or unplanned admissions.

nib: Hospital Support Program

This program gives eligible members access to an experienced registered nurse to help navigate the health system and understand options before, during and after a hospital visit.

Phoenix Health: Diabetes First Programs

In collaboration with Dr's Kitchen, the Diabetes First programs are available to eligible members including:

- Australians who are overweight and high risk of developing Type 2 Diabetes or other related complications.
- Australians diagnosed with Type 2 Diabetes without insulin dependence.
- Australians diagnosed with Type 2 Diabetes with insulin dependence.

Each plan integrates clinical and medical practitioners over an intensive 12 week program (with 9 months' continuing support) to provide all aspects of education, continuous glucose monitoring, clinical support, medical intervention, nutritional support and self-management skills to prevent Diabetes progression and its associated complications.

The individualised programs seek to intervene to transform the health of individuals to help make behavioural and lifestyle changes that lead to overall health improvements and better management of health conditions.

Police Health: Healthy Weight for Life – Type 2 Diabetes Program

Police Health provide those with Gold Hospital cover or Gold Combined cover the opportunity to participate in the Healthy Weight For Life's Type 2 Diabetes Program, with no out of pocket cost to the member. The program runs in 3 phases over 18 weeks. Each six week phase of the program incorporates:

- Portion control eating plan (including KicStart™ VLCD meal replacements).
- Activity plan.
- Education and coaching plan.
- Personalised online self-monitoring and tracking system (phone/mail alternative available if you don't have internet access).
- Two-way personal motivation, support and guidance through phone, SMS, email, message board and posted communication by a central care support team of healthcare professionals and program navigators.

TUH: Healthy Weight for Life Programs

TUH offers eligible members access to a range of Healthy Weight for Life Programs. These in-home programs are suitable for individuals with a body mass index (BMI) ≥ 28 who have an existing chronic health condition (e.g. Type 2 Diabetes, cardiovascular conditions, osteoarthritis and more) and are motivated to:

- Lose around 5-10% body weight.
- Improve their overall health.
- Gently increase physical activity and muscle strength.

All the programs and tools are delivered directly to the individual's home so the entire program can be done in the comfort of their own home. They include:

- Risk factor management.

- Digital member hub.
- Monitoring and support through specialised health care team.

TUH: CSIRO Total Wellbeing Diet

TUH offers members access to the CSIRO Total Wellbeing Diet. This 12 week program includes:

- 5-star rated, scientifically proven program.
- An AI weight loss coach to help you lose more weight.
- A Protein Balance Power meal plan with healthy indulgence recipes.
- Access to thousands of recipes and meal plan options.
- Exercise plans.
- Easy tracking tools to monitor weight and food intake.
- Access to an online community.

TUH: Valion Chronic Care Coaching Program

TUH offers eligible members access to Valion's Chronic Care Coaching that offers tailored support through an individualised care plan designed to optimise member's health and improve the self-management of their chronic condition/s, including diabetes. It includes:

- A 16-week program.
- Nurse assessment, education and coordination.
- Video coaching sessions.
- Opportunity to include expert support on exercise and nutrition.
- Educational modules and participant app to track progress and interact with care team.
- Care navigation to connect with local services.

HCF Research Foundation Grants for diabetes research

Implementation and evaluation of the Australian guidelines for diabetes-related foot disease into hospital-based high-risk foot services: An evidence-based model.

Translational Research Grant with Prof Vivienne Chuter, Western Sydney University

Annually in Australia, diabetes-related foot disease (DFD) causes ~28 000 hospital admissions and ~5800 amputations at a cost of ~$1.6 billion. Outcomes are up to 38 times worse for Aboriginal and Torres Strait Islander people. Hospital-based interdisciplinary high-risk foot care services that adhere to best-practice DFD recommendations substantially reduce amputation risk. In 2021, the first comprehensive set of Australian Guidelines for the assessment and management of DFD ('the Guidelines') were released. The Guidelines include recommendations for specific subpopulations, including Aboriginal and Torres Strait Islander people.

This project will translate the Guidelines into high-risk foot services at Wyong and Gosford Hospitals (CCLHD), and John Hunter and Tamworth Hospitals (HNELHD). Firstly, a baseline gap analysis will be undertaken to compare current clinical care within these hospitals to the Guidelines. Additionally, clinicians and managers involved in the delivery of the high-risk foot services, as well as patients and their family members will be interviewed to identify barriers to, and facilitators for, implementation

of the Guidelines. Following this, a site-specific implementation framework for the Guidelines to be translated into clinical practice will be developed using a co-design approach. The primary aims of this project are to determine the effect of implementation of the Guidelines on pre-specified DFD key performance indicators (e.g. days in hospital, amputation rates, time to ulcer healing). The Guidelines will provide an evidence-based model of clinical care to help reduce rates of DFD, including amputation, subsequently reducing healthcare costs and improving patient-related outcomes.

HCF and RACGP Co-funded project - Enhancing prevention and primary care efficiency
Study to assess the feasibility and acceptability of a digital pre-visit patient assessment in general practice, led by Dr Gillian Singleton of the University of Wollongong.

This project will introduce a digital app that engages with patients before a visit to their GP and assesses their overall health. In addition, the app will provide patients with personalised access to resources designed to help them understand their risks for developing chronic disease and empower them to take action to improve their health. The app aims to help prevent 17 common chronic conditions including mental health issues, heart disease, diabetes and common cancers. This study will evaluate the effectiveness of the app, as well as the benefits and challenges that emerge from how patients engage with the app.