Chronic disease management: the role of private health insurance

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Introduction

In 2007, a series of major reforms to private health insurance (PHI) were introduced with the passage of the *Private Health Insurance Act 2007* (PHIA). One of the key reforms, in fact ‘the most significant new measure’ according to the then Health Minister Tony Abbott, was Broader Health Cover (BHC). BHC allows health insurers to offer benefits to members for programs that either prevent or substitute for hospitalisation, or that help patients with a chronic disease better manage and reduce the effects of that disease. In effect, these reforms were intended to give health insurers a more significant role in keeping their members healthy.

A range of benefits was expected to flow from this initiative. Evidence from overseas shows that patients covered by such programs stay healthier for longer, and have their chronic conditions better managed. Health insurers could benefit because over time they would face fewer, less expensive claims. PHI members could benefit as well, as fewer expensive claims should reduce some of the cost pressures that drive health insurance premiums to rise. More broadly, the health system could benefit because a healthier population should reduce pressure on public hospitals, as well as reduce costs overall.

Several years have passed since the introduction of BHC so it is timely to look at its implementation and begin to assess its impacts. As a preliminary step, this paper will focus on reporting on the uptake of BHC services, including the range of chronic disease management programs (CDMP) now available, the benefits paid for these and any evidence pointing to the effectiveness of these programs.

Whether BHC has benefited the health system and led to lasting improvements in health outcomes is probably too early to say. A wide range of variables would need to be considered and given the multidimensional and complex nature of the system it may be too difficult to assess this. Instead, this paper aims to fill some gaps in knowledge about the implementation of BHC, in order to contribute towards a better understanding of the role such programs can play, and to promote further debate and investigation. Because health insurance is subsidised by the Australian taxpayer via the private health insurance rebate, there is also a public interest in a better understanding of the impact of these programs.

The paper will start by providing some brief background information on private health insurance arrangements, as well as the challenges emerging from increasing rates of chronic disease, before moving to a discussion of BHC and its role.

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Background

Private health insurance in Australia

Australia’s health system is characterised as a ‘mixed system’; one where a publicly funded financing scheme operates alongside private health insurance. Most medical practitioner services are subsidised or provided free through the universal national insurance scheme, Medicare, while public hospital treatment is provided free to public patients. Private health insurance helps with the cost of a range of non-Medicare funded services, such as dentistry and private hospital treatment and assists patients avoid long waiting lists in the public system.

Some 12.6 million Australians are currently covered by private health insurance. Some 47 per cent have private hospital cover, and around 54 per cent have cover for ancillary services, such as dentistry. Generally, Australians have been encouraged to take-up cover using a mix of policy ‘carrots’ (the private health insurance rebate) and ‘sticks’ (the Medicare levy surcharge). The stated goals of encouraging private health cover are to relieve pressure on the public system—although there is debate over whether it does this—and to provide patient choice.

Reflecting its important role in the health system and the need to protect consumers, private health insurance is closely regulated by the government. For example, premium increases must be approved by the Minister for Health and there is close oversight of the financial solvency of insurers. While successive governments from both main political parties have sometimes pursued different policy approaches from time to time, both express ongoing support for and commitment to private health insurance and our ‘mixed system’.

Chronic disease in Australia

A growing proportion of Australians are reporting they are living with a chronic disease or condition, or are at risk of developing a chronic disease, such as diabetes. In 2010–11, around one in three Australians reported they had high cholesterol, which is a key risk factor for heart disease. One in ten adults showed signs of chronic kidney disease; while 8 per cent had either diabetes, or were at risk of developing diabetes. Around one in five adults with diabetes were not even aware they had the condition. Nearly 63 per cent of adults were considered overweight or obese, up from 56 per cent in the mid-1990s. In terms of exercise, just 43 per cent of adults met the recommended guideline of

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at least 30 minutes of moderate physical activity a day. Lack of sufficient exercise is a risk factor for a range of chronic conditions.7

Addressing and managing the health needs and escalating costs associated with the growing incidence of chronic diseases are major challenges for governments, health insurers and individuals.

**Broader Health Cover reforms**

In 2007 a raft of legislative reforms were made to private health insurance arrangements with the passage of the *Private Health Insurance Act 2007*.8 In addition to consolidating private health insurance provisions under one Act, these reforms also introduced the concept of Broader Health Cover (BHC). BHC allowed health insurers to broaden their suite of products so they could cover disease management and health and wellness programs—although notably, benefits for recreational or sports purposes remain excluded.

Until 2003, private health insurers could offer ancillary benefits to members for so-called ‘lifestyle products’ such as those related to sport or recreation. These benefits were curtailed in December 2003, however, when the Howard Government imposed a requirement on insurers to remove benefits for products which were primarily for sport or recreation, unless they were part of an ‘approved’ health management program to ameliorate a specific health condition.9 The restrictions were in response to growing concerns over the increase in claims being paid on ‘lifestyle products’ such as camping equipment and the impact on the escalating cost of the private health insurance rebate.10

The introduction of BHC was broadly welcomed, particularly for its role in supporting those with chronic conditions, although some criticisms also emerged.11 These criticisms will be discussed in a later section.

BHC is not specifically defined in the legislation. It is the general term used to describe the broader range of services that health insurers can now cover. The main types of services permitted under BHC are defined in the Act and explained below; notably, BHC does not cover services where a Medicare benefit is already payable, such as those provided by a General Practitioner (GP).

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9. The changes became a condition of registration and were enacted through regulation. See Department of Health and Ageing, ‘Removal of lifestyle benefits from ancillary products additional conditions of registration’, 4 September 2003, *Private health insurance circular PHI 23/03*, accessed 18 September 2013; see also Senator K Patterson’s *Government supports decision by health insurers to remove ‘lifestyle’ benefits*, media release, 4 September 2003, accessed 18 September 2013.
10. Senator Patterson indicated lifestyle benefits constituted less than 1 per cent of all benefits paid. See ibid.
11. Examples include MS Australia, MND Australia and Palliative Care Australia. For an overview of responses see Senate Standing Committee on Community Affairs, *Private Health Insurance Bill 2006 [provisions] and 6 related bills [provisions]*, Senate, Canberra, 2007, p. 5, viewed 27 February 2013.
Hospital-substitute services

Under BHC, insurers are allowed to offer general cover for a broad range of treatment services that substitute for, or prevent, hospitalisation—hence these are called hospital-substitute services. Examples of hospital-substitute treatment include services associated with early discharge from hospital, wound management and the provision of intravenous therapies such as chemotherapy, but only where such services are provided out of hospital. Previously such services were not permitted to be covered by private health insurance. While such services are not the main focus of this paper, data on usage of these is presented below.

Chronic disease management programs (CDMPs)

BHC also includes programs designed to assist patients better manage chronic diseases such as diabetes. These are known as chronic disease management programs (CDMPs). CDMPs can assist patients with chronic diseases to better manage their condition, reduce their risk factors and/or delay disease progression. CDMPs involve the development of a written treatment plan which specifies the types of services that are to be provided and funded, the frequency of these services and their duration. It also requires the health insurer to arrange for the coordination of services and the monitoring of patient compliance. CDMPs can be either directly provided by health insurers or contracted out to a service provider on behalf of the health insurer.

The sorts of conditions CDMPs cover include cardiovascular disease, diabetes, and mental health problems. Typically, services that can reduce risk factors, such as smoking cessation programs and weight loss programs are also covered. Services can be delivered by a range of health and allied health professionals, including dieticians, physiotherapists and psychologists.

Many insurers now offer tailored health coaching services to help members quit smoking, lose weight, manage stress or increase their exercise. An early example is HCF’s My Health Guardian launched in 2009. It provides members with access to personal ‘health coaches’ to help them stay healthy by providing advice on diet and exercise. It also provides more specialised assistance for those with chronic conditions. Another example is BUPA’s Coach program which is a telephone-based coaching program, offered to members who have experienced a cardiovascular or stroke-related illness.

More recently, health insurers have been developing and offering mobile health apps that support healthy lifestyles.

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12. Definition under Section 69-10, Private Health Insurance Act 2007. Note that hospital-substitute treatment is classed as ‘general treatment’ for the purposes of health insurance. Excludes services for which a Medicare benefit is payable (such as General Practitioner services), unless these are specified in the regulations.
13. For example, HCF’s ‘My Health Guardian’ is provided by another company called Healthways.
15. For example, BUPA offers a range of mobile apps, from help with improving fitness to better nutrition.
Pilot projects

In addition to the wide range of hospital-substitute and disease management programs, health insurers were also permitted to offer members participation in pilot projects that trial and develop new models of service delivery and/or general health care treatments. Such projects must be offered on an interim basis, be voluntary and not impose a cost on the participant. These pilot projects are not discussed further in this paper.

Concerns over Broader Health Cover

Although BHC was broadly welcomed, a number of stakeholders raised concerns, particularly around its potential impact on the health system. A number of these were canvassed in a Senate Committee inquiry.16

One of the concerns was that BHC would lead to the emergence of so-called managed care. Managed care is a term used to broadly describe efforts ‘to influence the cost, mode of delivery or quality of health care’. Managed care is controversial, particularly in the United States where ‘it has been blamed for restricting patient choice, limiting professional medical autonomy in order to reduce costs and reducing the quality of health care’.17

Doctors groups in Australia have also opposed managed care.18 The Australian Medical Association (AMA) expressed its concern that under BHC, health insurers might seek to interfere in clinical decisions around patient care, for example, in relation to the most appropriate chronic disease management programs.19

Concerns were also expressed that BHC would create a ‘two tier’ health system because only patients with private health insurance would benefit from some of the programs that BHC would enable.20 Public patients reliant on Medicare would not have the same access to tailored disease management or prevention programs because Medicare did not directly fund these.21 Professor John Dwyer, former chairman of the Australian Healthcare Reform Alliance, noted:

The real concern about extending the benefits to those with private health insurance is that you extend the inequality that is already in the system.

16. Senate Standing Committee on Community Affairs, op. cit., pp. 4–7
18. Ibid., p. 30.
20. Ibid., p. 6.
21. Medicare benefits are available for patients with diagnosed chronic conditions who are being managed by their GP, but benefits do not cover prevention or coaching programs.
Allowing health funds to finance new ambulatory care is obviously going to be attractive to those rich enough to afford insurance, but in most cases it will only be attractive if the same care is not available under Medicare.  

A further concern was that the principle of community rating could be at risk. Community rating is an important feature of our health insurance arrangements as it prohibits insurers from discriminating against members based on age, health status or claims history. Some were concerned that BHC would encourage insurers—which already try to target younger, healthier members—to design products even more attractive to this cohort and thus diminish the principle of community rating.

An issue raised more recently is the relationship between BHC and risk equalisation arrangements. Risk equalisation plays an important role in spreading the burden of high cost claims across insurers, helping to keep them financially viable. Under risk equalisation, claims for older and/or high claiming members are ‘pooled’ and a proportion redistributed to insurers through the Risk Equalisation Trust Fund. This means that insurers with older members (who tend to make more claims) are not financially disadvantaged compared to those insurers with a younger membership.

Recently, the Private Health Insurance Administration Council (PHIAC), the industry regulator, reported industry concerns around BHC and risk equalisation. It noted concerns that while the cost of providing CDMPs is borne by the individual health insurer, risk equalisation arrangements mean that any savings stemming from a future reduction in claims due to BHC are potentially being lost to the individual insurer. This means that one of the financial incentives for offering CDMP is at risk of being diminished.

Another concern was that the full potential of CDMP was being ‘hobbled’ due to the exclusion of GP services.

**Usage of Broader Health Cover services**

Analysis of data collected by the Private Health Insurance Administration Council (PHIAC) shows that uptake of BHC services following the 2007 reforms initially was low. But since then, the number of BHC services offered and the amount of benefits paid to members have both grown steadily.

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26. Ibid, p. 34.
27. P. Wilson, op. cit.
In 2007–08, just nine of the 39 registered health insurers offered CDMPs to their members.\(^\text{28}\) By 2008–09, this number had grown to 14, before jumping to 30 in 2009–10 and 2010–11.\(^\text{29}\) Over the same period, the number of people covered for CDMPs more than tripled from 3 million in mid-2007 to 10.5 million in December 2012 (see Figure 1 below).\(^\text{30}\) Meanwhile, the number of people covered for hospital-substitute treatment services also steadily increased from 2.1 million in June 2007, to just over 6.9 million by December 2012.\(^\text{31}\) The number of hospital-substitute treatments increased sevenfold between 2007–08 and 2011–12, from 13,720 to 91,325.

**Figure 1: Persons covered for CDMP since 2007**

![Graph showing the steady increase in the number of people covered for CDMPs from June 2007 to December 2012.](source)

Source: PHIAC\(^\text{32}\)

In 2007–08, around 9,901 individual CDMPs were prepared by health insurers for members; by 2011–12 this number had increased substantially to 67,097.\(^\text{33}\) Benefits paid to members for CDMPs

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\(^{30}\) Coverage does not mean all these people would have claimed a benefit. PHIAC, *Statistical trends in membership and benefits*, data tables, Dec 2012, (all states), viewed 18 March 2013.

\(^{31}\) Ibid.

\(^{32}\) Ibid.

also rose from around $4.4 million in 2007–08, to around $59 million in 2011–2012 (as shown in Figure 2 below).³⁴

**Figure 2: CDMP benefits paid to members since 2007**

![Graph showing CDMP benefits paid to members since 2007](image)

Source: PHIAC³⁵

Not surprisingly, the amount of CDMP benefits paid are highest among older age groups, probably reflecting the fact that these older age cohorts are more likely to experience chronic disease and have more risk factors. In the December quarter 2012, out of the $13.6 million paid for CDMPs, $10.5 million in benefits was paid to those aged 60 and older.³⁶ Benefits paid for hospital-substitute treatment services are also higher among older age groups. Of the $7.8 million in benefits paid in 2012, just over $4 million was paid to members aged 60 or older.³⁷

Given the growth in chronic conditions looks set to continue, there would appear to be significant potential for further take-up of services such as CDMPs.

**Assessment of Broader Health Cover**

While the available data show that utilisation of all BHC services has grown, assessing the effectiveness of these services in improving overall health long-term will be harder to determine, and will require more detailed data. However, there is emerging evidence to suggest that CDMPs are

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³⁵. Based on aggregating quarterly data from PHIAC, ibid.
helping participants achieve improvements in their diet, exercise levels and weight management. Medibank Private reports that its ‘Get Healthy’ program resulted in a range of benefits:

- 94.86 per cent of participants made better food choices
- 80.25 per cent increased their levels of exercise and
- 71.77 per cent lost weight, either fully achieving a weight loss goal (33.94 per cent) or partially achieving a weight loss goal (37.83 per cent).  

One health coaching program funded through CDMP reported a 30 per cent reduction in hospital presentations for patients who used the service, compared to those who didn’t, according to The Medical Observer Weekly.  

However, assessing the effectiveness of these programs requires a longer-term, independent evaluation, and more detailed data analysis. Such analysis could also compare BHC outcomes with those from publicly funded coaching programs, such as the New South Wales (NSW) Get Healthy Service.

Conclusion

The rising incidence of chronic diseases is a growing problem which will substantially add to the cost of health care, not to mention diminishing quality of life. Services offered by health insurers that could ameliorate these costs, such as chronic disease management programs, are being increasingly utilised, but the longer term benefits remain to be properly assessed. Early signs indicate these programs can help improve health outcomes for some members and help them manage their conditions, at least in the short term, but more detailed data and analysis will be required to determine the extent of this. Whether any improvement in health is cost-effective over time also remains unclear.

Therefore, further research is warranted. Given the knowledge gaps that have been identified, rigorously measuring and evaluating the effectiveness and outcomes of BHC programs and comparing these to similar publicly funded programs could be a priority.

A number of initial concerns around the potential negative impacts of BHC may still need addressing, if these remain potent. Consultation with stakeholders and health policy experts over the adequacy of BHC arrangements would be useful for identifying ongoing concerns and views generally on BHC’s impacts, both positive and negative.

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39. P Wilson, op. cit.
40. The Get Healthy Service was introduced in 2009, for residents of NSW, the Australian Capital Territory and Tasmania. An evaluation of the service was completed in 2013 and is available on the Get Healthy Service website.
If BHC is to fully deliver its potential benefits including better managing chronic conditions, barriers to its future take-up would need to be identified and addressed. Some potential barriers have been identified already: one being the operation of risk equalisation, which could be inadvertently acting as a financial disincentive to insurers developing BHC programs. Another is determining whether the exclusion of GP services is inhibiting expansion, as some claim. Further investigation may also identify other impediments which may need to be addressed.

For those Australians without private health insurance and reliant fully on Medicare, it will be important from an equity perspective to ensure they are not disadvantaged by the operation of health insurer funded CDMP programs. The development of state government funded health coaching programs might help ameliorate this risk as might the development of Medicare Locals, with their greater focus on prevention and community health needs. In conclusion, a more detailed analysis addressing these issues is warranted if the potential benefits of BHC programs to improve health and reduce health care costs are to be fully realised.