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.

Response

Diabetes is one of the fastest growing health challenges for Australia. Many experts will comment on the epidemiology of diabetes, the connection with obesity, and advances in treatment. This submission will not repeat the facts, rather comment on three opportunities to improve the prevention and management of diabetes to reduce its harm and prevent unnecessary costs for the health system.

Health funds want to help their members stay well, as we pay for a significant proportion of healthcare delivered to people living with diabetes. Reducing the burden of treatment for people living with diabetes provides benefits to the individual, to health funds, to governments and to the community as a whole.

Health funds across Australia help their members living with diabetes through a range of measures, including offering support services, phone advice, and traditional access to dental care and private hospital care.

Several fund members need significant support for hospital services, as evidenced by our annual high cost claims report. This report details the twenty most expensive claims for diabetes care in 2022, including eight claims of over $100,000 and several claims where members were in hospital for over 100 days (see attachment). Many of these hospitalisations included foot ulcers, poor blood circulation and gangrene – some of which would have been preventable with better diabetes management.

Overall, a significant proportion of spending on private hospital care is directly attributable to diabetes or closely associated. This includes spending of over $190 million in 2021-22 for bariatric surgery.

Opportunity 1: Remove unnecessary regulation so health funds can deliver a wider range of services as part of Chronic Disease Management Plans (CDMPs)

Health insurers can offer Chronic Disease Management Plans to assist people living with diabetes or the risk factors for it. The objective of these programs is to help at-risk people avoid diabetes and its wide-ranging consequences or manage the condition to live a healthy, productive life and prevent hospitalisation.

CDMPs are governed by the *Private Health Insurance (Health Insurance Business) Rules 2018* (the Business Rules), which currently prohibit funds paying nurses and nurse practitioners, among others, to provide CDMP services. The defined list of eligible health professionals in these Rules is out of step with best practice, and it is exacerbating a shortage of healthcare options caused by Australia's health workforce crisis. Removing the defined list from these Rules would provide Australians with faster access to quality healthcare.

PHA has engaged with the Australian College of Nurse Practitioners and the Australian Practice Nurse Association, who highlight the role that nurses can play in supporting people with chronic disease, including diabetes. Along with a developing academic literature base supporting the use of a wider range of practitioners in CDMPs, the Australian Government has several policy positions that support the advocated changes, including:

- The Nurse Practitioner Workforce Plan (2023) which has a goal "to remove barriers affecting the [nurse practitioner] workforce".
- The Strengthening Medicare Taskforce Report (2023) which articulates a vision where "health care professionals work to their full scope of practice."
- The current Unleashing the Potential of our Health Workforce Review, which is examining how health practitioners can work to the full extent of their skills and training, so Australia optimises its workforce across a stretched primary care sector.

Removing out-of-date definitions for CDMPs within the Rules would address these Albanese Government goals and provide more flexibility to funds to provide healthcare to people at risk of diabetes and living with diabetes. Making the recommended changes to the Rules would then provide incentives for the sector to participate in more detailed discussions about specific models using the best available workforce.

Opportunity 2: Reform the Prescribed List of Medical Devices so Australians do not pay exorbitant prices for insulin pumps

Insulin pump therapy can be life-changing for people with diabetes. It can help people control their condition to live a happier, healthier life. It can also reduce their risk of complications and prevent the need for ambulance use, emergency department care and other expensive hospital treatment.

Australians with private health insurance are currently paying exorbitant prices for insulin pumps through their funds due to the Australian Government's Prescribed List of Medical Devices for the private health system. Despite private health insurers being one of the largest collective buyers of these devices, they are unable to obtain globally competitive rates due to the protected pricing system maintained by the Prescribed List. This failure to index or price match devices means Australians currently pay double what they should for this safe and effective technology. For example, one of the most common pumps in Australia, the t:slim x 2 insulin pump with basal-IQ technology, costs Australians $8574. The same device costs £3150 (AU$6136) for people living in the UK and NZ$4500 ($AU4137) for people in New Zealand.

A recent report published by PHA, Australia's surgical surcharge: How Australians are paying too much for medical devices through the prescribed list of medical devices, details the damaging impact overpricing of generic medical devices has on Australia's health system and private health insurance premiums.

Opportunity 3: Create a modern health system that provides more out-of-hospital care options

Australia's health system is under unprecedented strain. Demand for healthcare is growing at an unsustainable rate, driven by the dual burdens of our ageing population and the rise of chronic

disease, including diabetes.[1] This places pressure on access to care and healthcare costs for both patients bearing out-of-pocket costs and taxpayers more broadly.

While consumer research shows Australians want more flexible healthcare options, Australia currently lags comparative health systems in the delivery of out-of-hospital care which can improve quality, efficiency, and patient experience while reducing adverse events. Studies show patient outcomes are equivalent to, or better than, traditional inpatient models, and that out-of-hospital care can reduce the risk of hospital admission by up to 80 per cent and readmission risk by up to 40 per cent.[2] Yet out-of-hospital services in Australia currently account for < 1-10 per cent of total activity across different models of care.

Without change, growing demand for healthcare in Australia over coming decades will fall almost entirely upon 'bricks and mortar' hospitals, further exacerbating wait times and existing bottlenecks, as well as cost inflation for public and private payors. Australia can do better. While 14.6 million Australians have private health insurance, the Private Health Insurance Act 2007 currently restricts what insurers can fund and provide for their members, including programs that could help prevent diabetes and out of hospital care options for people living with diabetes. This includes hospital substitution options where treatment and monitoring can be provided safely and more cost-effectively at home instead of in hospital.

A potential case study is advances in the pharmaceutical treatment of obesity-related insulin resistance and Type 2 diabetes. The development of the GLP-1 receptor agonists like Ozempic and Saxenda presents an opportunity to develop a hospital substitution model of care which can be evaluated against bariatric surgery as a comparator. In Australia, most bariatric surgery occurs in the private sector. It is an expensive and traumatic experience for patients involving high health insurance premiums for top tier cover, large out-of-pocket costs and a high failure rate. GLP-1 agonists have the potential to provide an alternative treatment pathway for people with insulin resistance, but this needs to come with the right integrated wrap-around services to retrain patients to adopt a healthy lifestyle long-term, and to collect outcomes data.

Health funds want the ability to fund these services as a hospital substitution program in a way that Is broadly accessible to patients, including using telehealth and remote monitoring techniques, and which doesn't generate co-payments.

The Australian Government's current default benefits policy also discourages private hospitals from creating and using more out-of-hospital care models because the policy requires health insurers to pay a minimum payment to hospitals for in-hospital care. This is stifling innovation in the private health system which cares for millions of Australians. You can read more about recommendations to improve out-of-hospital care in the 2023 report: There's no place like home – reforming out of hospital care.

Conclusion

Private health insurers have a vested interest in helping Australians stay well to prevent diabetes, and they are keen to support safe, cost-effective care for people living with diabetes and its

[1] Intergenerational Report 2023 (treasury.gov.au)

[2] https://www.privatehealthcareaustralia.org.au/wp-content/uploads/20230523_PHA-Report_Reforming-out-of-hospital-care.pdf

complications. The Australian Government has multiple policy options available to help private health insurers do this more effectively.

Attachment: Top 20 identifiable high claims for the treatment of diabetes, private health insurance 2022

Rank	Total Benefits Paid	Gender	Age Group	Description	Bed Days	Hospital Type
1	$127,515	F	70-74	Type 2 diabetes with poor blood circulation	77	Private
2	$118,595	M	55-59	Type 1 diabetes with poor blood circulation	65	Private
3	$112,186	F	60-64	Type 1 diabetes with poor blood circulation and gangrene	119	Private
4	$111,330	F	75-79	Type 2 diabetes with foot ulcer	179	Private
5	$103,257	M	80-84	Type 2 diabetes with poor blood circulation	63	Private
6	$103,058	M	75-79	Type 2 diabetes with poor blood circulation and gangrene	110	Private
7	$101,699	M	60-64	Type 2 diabetes with poor blood circulation	35	Private
8	$101,430	M	60-64	Type 2 diabetes with foot ulcer	68	Private
9	$99,671	F	85-89	Type 2 diabetes with foot ulcer	133	Private
10	$93,155	M	70-74	Type 2 diabetes with diabetic polyneuropathy	56	Private
11	$90,776	F	65-69	Type 2 diabetes with foot ulcer	161	Public
12	$89,474	M	70-74	Type 2 diabetes with hyperosmolarity with coma	28	Private
13	$89,289	M	85-89	Type 2 diabetes with foot ulcer	53	Private
14	$89,267	M	60-64	Type 2 diabetes with foot ulcer	57	Private
15	$84,943	M	70-74	Type 2 diabetes with poor blood circulation	36	Private
16	$81,759	M	65-69	Type 2 diabetes with poor blood circulation and gangrene	54	Private
17	$79,939	M	90-94	Type 2 diabetes with poor blood circulation and gangrene	45	Private
18	$79,528	M	75-79	Type 2 diabetes with foot ulcer	70	Private
19	$79,197	M	90-94	Type 2 diabetes with foot ulcer	65	Private
20	$78,170	M	70-74	Type 2 diabetes with foot ulcer	71	Private