Submission to The House of Representatives Standing Committee on Health inquiry into Chronic Disease Prevention and Management in Primary Health Care

The House of Representatives Standing Committee on Health
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HCF Submission to inquiry into Chronic Disease Prevention and Management in Primary Health Care

The Hospitals Contribution Fund of Australia (HCF) is pleased to make a submission to the House of Representatives Standing Committee on Health into Chronic Disease Management Programs (CDMP) and chronic disease prevention in primary care (the Inquiry).

The overall burden of chronic disease on the health care system is substantial and increasing and that preventing the development, or delaying the progression, of chronic disease must be the highest priority.

This submission argues that private health insurers have an important role to play in helping to identify and managing chronic disease and that the industry (and HCF in particular) has already taken a leadership role by launching innovative chronic disease management programs. We will share with you examples of best practice by describing HCF's programs that have been delivered at large scale across Australia.

We show what evidence we have about the effectiveness of our CDMPs. We will also share with you some of the challenges we have faced implementing these interventions and we will highlight how certain structural and regulatory constraints diminish the health and financial impact of these interventions.

We argue that primary care, or more specifically General Practice, is a key environment to identify and engage patients in CDMP and that constructive and collaborative relationships between health insurers and general practitioners (GPs) are important and necessary to effectively tackle chronic disease. Already there are nascent examples of this collaboration and such innovation should be allowed to flourish.

About HCF

HCF is proud to be Australia's largest not-for-profit health insurer, and is the trusted insurer for more than 1.5 million members nationwide.

HCF has made, and continues to make, a significant investment in CDMPs which is in excess of our market share (as reported by the Private Health Insurance Administration Council – See Attachment A – Confidential and Not for Publication). Our vision has steadfastly been that HCF looks after the health needs of members better, and therefore we have required that CDMPs need to:

- Improve the health and wellbeing of HCF members
- Be an acceptable and satisfying experience for HCF members
- Reduce overall costs to contributors.

There are parallels in our approach and the much vaunted work of Donald Berwick and the Institute for Healthcare Improvement (www.ihi.org/):

> The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":
>
> - Improving the patient experience of care (including quality and satisfaction);
> - Improving the health of populations; and
> - Reducing the per capita cost of health care.

HCF data shows that in any given year approximately 1.6% of HCF members consume half of our hospital product benefits. That is around 20,000 members consume over $700 million. When we examine these services a significant proportion of this expenditure relates to treatments for chronic disease, in particular cardiovascular disease, diabetes, osteoarthritis, chronic kidney disease and mental health conditions. Chronic disease makes up at least 60% of the expenditure in this high cost group.

Our journey began in 2005 when we launched a number of small scale pilot projects with suppliers of CDMPs in order to determine whether these programs work and whether they are acceptable to participants. The results of these pilots were encouraging and by the time the Private Health Insurance legislation changed in 2007 we had gained sufficient experience to embark on large scale initiatives.

The case for chronic disease prevention

Chronic disease and the afflictions that it brings continue to grow around the globe. Australia is no exception. With an ageing population and increasingly common sedentary lifestyles chronic disease continues to grow and account for the majority of morbidity and burden of health. Cardiovascular (CVD) disease and diabetes are two of the most prevalent chronic diseases affecting Australians today. There were approximately one million Australians living with diagnosed diabetes in 2012[1] and diabetes is the fastest growing chronic condition in Australia, with more than 100,000 Australians newly diagnosed with this disease each year[2,3]. By 2033, if left unchecked, 3.6 million Australians will be afflicted with type 2 diabetes[4]. Cardiovascular disease is the leading cause of death in Australia, claiming 45,600 lives in 2011 (31% of all deaths)[5].

Projected healthcare expenditures for Australia from 2003 to 2033 estimate a 436% increase in healthcare costs related to diabetes, from $1.6 billion (1.9% of total expenditures) to $8.6 billion (3.5% of total expenditures)[4]. Of this enormous increase in direct diabetes-related spending, most ($6.7 billion) is attributed to type 2 diabetes. For this same 2003–2033 time period direct costs from cardiovascular disease will continue to be the most expensive among diseases, with expenditures projected to rise from $9.3 billion (11.0% of expenditures) to $22.6 billion (9.2% of expenditures), less dramatic but still a 142% increase in cost over this 20 year period[4].

Chronic diseases and their effects may be prevented, delayed, or better controlled by incorporating healthier lifestyle behaviours such as healthier eating, increasing exercise, reducing stress, and improving individual self-management of conditions. These changes can have a positive impact in reducing hospital admissions and other medical treatments and procedures[6]. Furthermore, healthier people have improved productivity and contribute more to the overall economy.

The challenge private health insurers face is whether the effects of any CDMP can be sufficient to impact on hospitalisation and readmission rates, especially given that there may be a lag of many years before unhealthy behaviours result in hospitalisation.

HCF Examples of Best Practice Chronic Disease Prevention

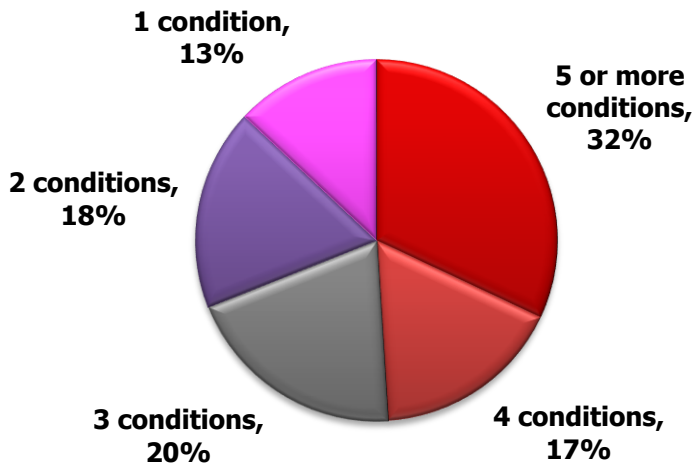
My Health Guardian

HCF launched My Health Guardian (MHG) in 2009 as a long-term strategy to improve the health and well-being of members with chronic health conditions. This population health program has, at any one time, provided telephone based support to as many as 27,000 HCF members across Australia. Delivered by registered nurses experienced in motivation and behaviour change techniques, it promotes healthy behaviours and adherence with medications and GP action plans. It also empowers members to be more actively engaged in their health. It promotes standard Australian guidelines for follow-up care with clinicians and fosters deeper understanding by members about their condition, treatments and aggravating factors.

At least one or more of the following conditions are supported by the program:

- **Atrial fibrillation**
- **Diabetes mellitus**
- **Coronary artery disease**
- **Congestive heart failure**
- **Chronic obstructive pulmonary disease**
- **Chronic kidney disease**
- **Inflammatory bowel disease**
- **Asthma**
- **Osteoarthritis**
- **Osteoporosis**
- **Hypertension**
- **Rheumatoid arthritis**
- **Sleep apnoea**

All participants have at least one of the above chronic conditions, and many have more than one:



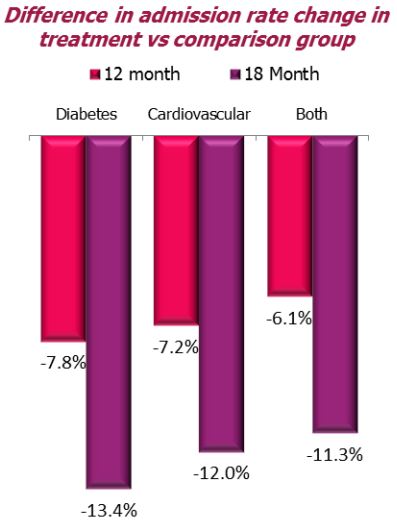
These telephone-based interactions are guided by an information system that provides nurses with patient data, assessments, and individual action plans tailored to patient data and assessment responses.

In addition to nurses' clinical judgment, there are standard processes and procedures in place as well as standard surveys and individual action plans defined by participant responses and needs. Outbound telephone call frequency to members is determined by factors including disease severity, current health status, well-being level, and self-management of their condition(s).

In addition to this all HCF members have access to a website and mobile app with health assessments, health actions plans, personalised health support from health coaches, educational materials, and health behaviour tracking.

Evaluation Results

Our first study on clinical outcomes of MHG, and the only large-scale study evaluating the effectiveness of an Australian CDMP, measured the impact of MHG on hospital admissions, readmission and length of stay for members with heart disease and diabetes (See Attachment B). Results demonstrated that the MHG program was effective in reducing the occurrence and severity of hospitalisation after 12 and 18 months of program participation[7]. The MHG study population, in comparison to disease-matched HCF members who were eligible but elected not to participate in MHG, displayed significant decreases in hospital admissions and readmissions after both 12 and 18 months, and in average length of hospital stay after 18 months.



The magnitude of impact increased over time for all measures.

Our recently published (April, 2015 – See Attachment C) follow-up study evaluated the longitudinal value of the MHG program for members with heart disease and/or diabetes. The intent was to confirm prior results and determine if the decreased hospital utilisation was sustained over an extended intervention period.

Over the 4 year period, program participation resulted in significant reductions in hospital admissions (−11.4%, $P < 0.0001$), readmissions (−36.7%, $P < 0.0001$), and bed days (−17.2%, $P < 0.0001$). The effect size increased over time for admissions and bed days. The relative odds of any admission and readmission over the 4 years were 27% and 45% lower, respectively, in the treatment group[8].

In addition to the above studies on hospitalisation HCF also review a number of clinical metrics. The following health indicators have been self-reported by participants:

Pair-matched data (first and last data point readings for members continuously enrolled members for more than six months and still currently actively enrolled)	At May 2015
Increase in positive perception of health	4%
Smoking rate reduced	29%
Reduction in number of participants with 3 or more unhealthy nutritional habits	15%
Obese members' weight reduced	8%
Poor or no understanding of prescribed medications reduced	7%
Reduction in number of participants doing physical activity less than twice a week	31%
Reduction in number of participants who have no current list of medications	5%
Reduction in number of participants who have not recently had meds reviewed	11%

Each year we conduct, in part for the purposes of the funding model established with Healthways, a satisfaction survey of My Health Guardian and the results have consistently shown high levels of satisfaction and, most importantly, zero dissatisfaction. Interestingly the level of satisfaction increases with severity of condition(s); length of time on program; and with age.

Healthy Weight for Life

In addition to the My Health Guardian program HCF offers members access to an integrated weight management program called Healthy Weight for Life. This program is available at no charge to members who are overweight or obese and have diabetes, heart disease or osteoarthritis.

The program is an 18 week course that combines Very Low Calorie meal replacements (VLCD), graded activity, on-line tracking and follow up by email, SMS and telephone.

The program has been research by independent bodies, such as the CSIRO, among others (www.healthyweightforlife.com.au/kicstart-news-articles.php).

Given that being overweight aggravates these three chronic conditions, the objective of the programs is to improve management of the disease and reduce complications by weight reduction.

The 18-week, 3-phase programs focus on achieving 7-10% weight loss via:

- **comprehensive portion planned eating and drinking plan to effectively reduce long term energy intake**
- **short term partial VLCD (KicStart™)**
- **increased physical activity**
- **mindful eating and drinking habits**

In addition to the above the Osteoarthritis Management program focuses on:

- **Muscle strengthening – help stabilise joints and improve joint function**
- **Range of motion – reduce joint stiffness and improve function**
- **Pain management – non-medication strategies and understanding medication**

Evaluation

Healthy Weight for Life has consistently shown results in terms of reduced weight loss.

Overall the program has an exceptionally high completion rate of 79%, and furthermore weight lost in one-year follow up has been largely maintained. A critical part of this program is the structured member follow-up provided. E-mail, SMS, web tracking and encouraging telephone calls are used to help get participants back on track when their progress falters.

The Osteoarthritis Healthy Weight for Life program is an illustration of a CDMP that has wide support across the major health insurers including HCF. Importantly, the support by a number of insurers minimises the anti-selection risk an individual insurer faces as a result of portability legislation which promotes high-risk members moving to the participating insurer in the event that health providers encourage members of non-participating insurers to transfer to participating insurers in order to acquire these services.

It has been evaluated by researchers at the Institute of Bone and Joint Research, Kolling Institute, University of Sydney, the Centre for Health Exercise and Sports Medicine, University of Melbourne and the Rheumatology Department, Royal North Shore Hospital Sydney[9]. These researchers found that there is a strong dose-response relationship between the weight loss achieved on this program and improvement in the quality of life scores assessed using the SF-12 health questionnaire.

The study used 2,169 program participants. 92% had >3% reduction in body weight. 29% had weight loss in excess of 10% and the dose-response relationship is illustrated in the table overleaf:

	Baseline measures	Weight Loss (%) Categories						
		All (N=1811)	≤2.5 (N=130)	2.5-5% (N=301)	5-7.5% (N=462)	7.5-10 % (N=395)	≥10% (N=532)	Sig linearity
	Mean (SD)	Mean Δ (SD)	Mean Δ (SD)	Mean Δ (SD)	Mean Δ (SD)	Mean Δ (SD)	Mean Δ (SD)	
Weight (kg)	95.3 (17.5)	-7.63 (4.22)	-1.13 (1.12)	-3.73 (0.96)	-5.89 (1.28)	-8.25 (1.67)	-12.40 (3.44)	0.000
KOOS pain	55.9 (16.9)	13.85 (16.49)	9.10 (14.72)	10.01 (16.70)	13.02 (16.79)	14.14 (15.51)	17.63 (16.43)	0.000
Changes in SF-12 Composite measures								
Physical Health Composite Score (PCS)	33.4 (7.2)	6.65 (8.24)	3.16 (8.24)	4.07 (8.02)	6.73 (7.83)	6.65 (8.17)	8.60 (8.18)	0.000
Mental Health Composite Score (MCS)	43.2 (10.0)	5.25 (9.73)	3.58 (10.49)	2.38 (9.86)	5.11 (9.63)	5.89 (9.31)	6.66 (9.56)	0.000
Changes SF-12 Subdomains								
PF - Physical Functioning	3.5 (1.1)	0.53 (1.17)	0.23 (1.14)	0.27 (1.11)	0.50 (1.09)	0.50 (1.24)	0.76 (1.18)	0.000
RP - Role Functioning (Physical)	2.4 (0.7)	0.76 (1.01)	0.43 (1.06)	0.49 (1.02)	0.72 (0.98)	0.81 (0.99)	0.95 (1.01)	0.000
BP - Bodily Pain	2.8 (0.9)	-0.42 (1.64)	-0.57 (1.63)	-0.11 (1.68)	-0.38 (1.67)	-0.35 (1.61)	-0.62 (1.58)	0.000
GH - General Health	3.3 (0.9)	0.46 (0.87)	0.21 (0.86)	0.21 (0.85)	0.47 (0.87)	0.45 (0.90)	0.63 (0.83)	0.000
VT - Vitality	2.1 (1.1)	0.80 (1.12)	0.48 (1.18)	0.49 (1.20)	0.80 (1.13)	0.82 (1.07)	1.02 (1.06)	0.000
SF - Social Functioning	4.7 (1.3)	0.53 (1.23)	0.4 (1.27)	0.23 (1.10)	0.50 (1.22)	0.62 (1.20)	0.66 (1.27)	0.000
RE - Role Functioning (Emotional)	3.3 (0.9)	0.24 (0.96)	0.03 (1.08)	0.10 (1.01)	0.21 (0.95)	0.33 (0.92)	0.33 (0.93)	0.000
MH - Mental Health	7.6 (1.9)	0.83 (1.83)	0.42 (1.98)	0.37 (1.81)	0.82 (1.78)	0.91 (1.78)	1.10 (1.82)	0.000

It clearly shows that as weight is reduced that pain, physical and mental functioning improve across all subdomains.

My Helping Hand

HCF launched the My Helping Hand program in October 2006. It provides 24-hour telephone based relapse prevention support for our members with a mental health condition. The program is run by mental health nurses and psychologists and aims to help members learn to identify the triggers that cause relapse and to help them take measures to prevent relapse. It is available to HCF members who have had greater than 3 overnight and/or 15 same day psychiatric admissions in the previous year and are aged 18 – 75 years.

This is a niche program run over 12 months and we have on average 30 members participating in the program at any time.

Evaluation

Recent internal studies have shown that K10, a measure of mental health, improved by an average of 4 points (from an average score of 23.4 to 19.5) for those participating in the program. Improvements such as this were also seen in an independent review of the program published in the Australian and New Zealand Journal of Psychiatry (See Attachment D):

Telephone case management reduces both distress and psychiatric hospitalization
Gavin Andrews, Matthew Sunderland

Objective: The aim of the present study was to improve the health care of people repeatedly admitted to private hospitals.

Method: An open trial in which frequent utilizers were offered telephone case management over a 12 month period, was conducted.

Results: An average of 24 phone calls were made to the 99 who remained in the programme for the 12 months. Psychological distress declined significantly over the 12 months, and the number of days in hospital was reduced compared to the previous year.

The cost benefit ratio was 1:8.4.

Conclusions: The changes in well-being and hospitalization over the 12 months were substantial and are unlikely to be due to regression to the mean. A prospective randomized controlled trial comparing telephone case management with treatment as usual is indicated.

The HCF Research Foundation

The HCF Research Foundation (the Foundation) is charitable trust which was set up in 2000 to encourage research and enquiry into the provision, administration and delivery of health services in Australia for the benefit of HCF contributors and the public generally.

Over the last 15 years HCF has made a number of donations since inception to bring the corpus of the Foundation to $50 million. Each year, we aim to commit approximately $2 million dollars from investment income towards research that will benefit our community through improvements in the way that health services are provided, how patients are supported during and after care and prevention of adverse events such as falls in hospital.

Each year, we are proud to see the exciting outcomes of the research that we fund helping a variety of Australians across a diverse range of health situations. The Foundation's activities include funding research projects selected through a highly competitive grant process, and funding a select number of Direct Partnerships with an expectation that this method of funding will both improve the availability of monies for health services research and assist in the translation of research. Some examples of our Partnerships include:

- The Australian Prevention Partnership Centre: A major new $22.6 million partnership research centre to ensure health policy makers can access the best research evidence about what works to address lifestyle-related chronic disease.
- Supporting Associate Professor Adam Elshaug (University of Sydney): Professor Elshaug is an internationally recognised researcher and policy adviser with expertise in reducing waste and optimising value in health care.
- The Royal Australian College of General Practitioners: This partnership provides specific funding to General Practitioners to undertake health services research.

These projects, amongst many, are outlined in more detail at the following website: www.hcf.com.au/about-us/hcf-foundation/. We would encourage you to read them and see how good quality health services research, funded appropriately, can make improvements to the health system for everyone's benefit.

Challenges we have encountered delivering Chronic Disease Management Programs

In implementing large scale CDMPs we have encountered a number of challenges which will be of interest to the Inquiry and highlight areas of consideration in "best practice" CDMP. These are summarised below.

Fragmented health system dissipates the return on investment

Calculating a return on investment for a CDMP is a difficult task. This difficulty arises because, firstly, there is potentially a long time lag between initiating an intervention and the resulting change in hospitalisation rate. Chronic disease, by its very nature is slow and progressive and therefore the effects of CDMPs are too. It may take many years for the impact of a program to manifest but future returns have to be funded by today's dollars.

Secondly, the return on investment calculation is dependent on who measures it and what part of the health system they are responsible for. So, for health insurers whose products only cover events in hospital the only source of return on the investment in CDMP is from a reduction in hospitalisation rates (we measure bed day utilisation as the key metric). Whilst arguably, CDMPs may save PBS drugs, GP visits, emergency room visits, outpatient investigations and specialist consults, none of these savings would accrue to private health insurers and therefore the economic viability of these programs is eroded.

Likewise, a Federally funded primary health care CDMP might accrue the benefits in terms of GP and PBS savings but not any savings in public hospitals which would accrue to the states and territories.

Impact of Risk Equalisation

Australia's system of private health insurance is characterised by community rating and a Risk Equalisation (RE) arrangement which pools risk across the competitors by age, State and cost of claims.

The 2007 Private Health Insurance Act enabled the costs of CDMPs to be included in RE, however, when CDMPs effectively reduce hospitalisations there is also a reduction in the amount returned to the insurer by RE (in the face of unchanged contributions to the RE pool which are based on age and State).

HCF calculates the net effect to be that approximately 40% of the costs our My Health Guardian program are covered by the RE pool, but that 47% of the savings are lost to competitors who fail to manage their hospitalisation risk through similar CDMPs. The effect increases if the savings grow to be much larger than the costs of a program.

HCF sees a strong case in favour of reforming the RE pool to, in the first instance not penalise private health insurers that have proactively use CDMPs, and secondly to remove any disincentive currently stifling the take-up and use of CDMPs more broadly across the private health insurance industry.

Measuring success

Measuring the impact of CDMPs on hospitalisation is especially challenging when delivering an operational program in which it is not feasible to allocate people to a control group. A randomised controlled trial is good to measure the effects of a pilot, but does not work in a large-scale operational program.

Comparison groups always introduce an element of bias into the measurement which we try to minimise by statistical matching techniques. For example some of our analyses depend on using the group of members who were invited to join the program but declined to do so. This "declined" group is then stratified by age, gender, conditions and number of conditions to match the intervention group.

Another method we have used is a time-phased approach which randomises participants to an early or late start group with an interval between the enrolments of these two groups. This provides a better statistically randomised comparison and does not deny anyone access to the intervention, however it is not always feasible to randomise participants up-front and there may be bias introduced by the timing itself.

Our experience has been that "best practice" should be that on-going monitoring and measurement are thought out prior to program launch and that all of the necessary data elements are properly captured from the start of the program.

Engagement with patients

The nature of private health insurance is such that the first indicator that a member has a chronic condition can be when a claim for hospitalisation is received. In such cases the chronic condition has possibly lasted for years and has then become severe enough to warrant hospital intervention. Arguably, the disease has substantially progressed and is therefore less able to be modified by behavioural and lifestyle interventions.

We have a view that timely and properly targeted intervention is important, and that to achieve this relationships need to be deepened so that we understand our members better and collect relevant health information in order for us to cater for members' specific health care needs.

Currently private health insurance data is limited to patchy information about hospitalisation events and is inadequate for insurers to properly play a proactive role in earlier targeted interventions. For example, population health statistics would indicate that there should be at least 75,000 HCF members with diabetes[10], however using all our existing data sources we can only identify 43% (32,000) of these members. In addition to collecting more comprehensive data directly from members, health insurers need to integrate with external data sources such as PBS data and Medicare data for the effective and timely delivery of CDMPs.

Intervention too early has an unmeasurable impact and intervention too late (when disease has progressed too far) is less effective. Finding the best time for a CDMP intervention is a significant challenge for insurers and something which primary care with its fuller clinical picture of the patient is better placed to achieve. Therefore, engagement with primary care is important for any insurer driven CDMP.

Engagement with ~~primary~~ ~~care~~ general practitioners (GPs)

It is important for the Standing Committee to be conscious of the distinction between what is termed 'primary care' and GPs. To highlight this distinction we have deliberately noted the heading to this section in the manner above.

Such a distinction is important in the context of private health insurance. Private health insurance is legislatively prohibited from funding GPs but, collectively through ancillary private health insurance, is probably the largest funder of primary care in the country through funding areas such as dental, optical, and physiotherapy services. In these later areas of primary care HCF has developed innovative funding models utilising sound evidence-based research principles (www.hcf.com.au/more-for-members/).

Most of our CDMPs rely at some point on interaction with GPs, whether it is in the identification of our own members who have chronic conditions, supporting GP Active Care Plans, or seeking authorisation from GPs before a member begins a program.

Our strong view is that GPs are uniquely positioned to alter the course of chronic disease because they are more likely to:

- have a long term relationship with their patients
- have a trusting relationship with their patients
- have information about which patients have chronic disease
- have influence to help motivate patients
- manage the flow on use of resources like radiology, pathology and hospitalisation.

However, general practice is oft-reported as a time-poor environment driven by a fee-for-service funding mechanism (CMBS) and, while the clinical need to prevent or better manage chronic disease in patients is well recognised, the means and time to do so are often inhibiting factors. Furthermore, irrespective of whether or not GPs are trained in motivational and behaviour change techniques, we constantly receive feedback on the challenges associated with resourcing effective interventions in general practice.

Awareness of the availability of support programs like My Health Guardian is not necessarily sufficient to get engagement with primary care. In 2014 HCF implemented a flag in the GP practice management system, *Medical Director,* which highlights the availability of our CDMPs to GPs when one of their patients meets the clinical eligibility criteria. The system easily enables the GP to provide the patient with the pamphlet by print or email.

Since the inception of this technology which has recommended our CDMPs thousands of times to GPs' eligible patients, there have only been a handful of instances when the material has been provided to the patient. The lesson we have learned is that there is a vast difference between making something visible, accessible and easy for GPs to prescribe and their actual usage by GPs.

Consequently deeper and more meaningful engagement is needed such as may be achieved through innovative collaboration with primary care. It is impractical for private health insurers to do this with individual GPs and other primary care providers, but hopefully the recently created PHNs will make better engagement possible. Solutions need to be co-created with GPs for them to work, and insurers like HCF are keen to collaborate.

Limitations of telephone based interventions

Notwithstanding the success we have achieved through telephone based CDMPs there is a limit to the impact of a series of telephone conversations.

We believe that in some cases a higher level of intervention is required. Remote telemonitoring is one such frontier that HCF is exploring. In early 2014 we launched what we understand to be Australia's largest remote telemonitoring initiative in collaboration with Telstra and Healthways Australia. This enhancement of our My Health Guardian CDMP provides home based monitoring of blood glucose, blood pressure and weight to 3,300 HCF members with diabetes, hypertension or congestive heart failure. The program is being evaluated by researchers at the George Institute for Global Health and results will be published in 2016.

HCF also supports a range of home based services such as home based nursing, antibiotic treatments, wound care, chemotherapy, physiotherapy, and rehabilitation.

Future directions for CDMP

HCF's experience shows that large scale CDMPs can improve health and reduce hospitalisations but that the magnitude of the impact differs depending on the type of chronic disease. We have also found that many factors detract from the value of CDMPs including:

- Targeting the intervention to the right members
- Poor integration with primary care
- Costs of delivery of the program
- Risk Equalisation discouraging CDMPs
- Value accruing to other parts of the health system

Given these factors, and notwithstanding public commentary by the three major for-profit funds with regard the importance of addressing the burden of chronic disease, it is demonstrably clear from the latest industry data that these for-profit health funds are withdrawing from investing in CDMPs (See Attachment A – Confidential and Not for Publication).

In contrast, while HCF has a 12 per cent total market share, we now provide approximately 50 per cent of the private health insurance industry's investment in CDMPs.

We have written elsewhere that this is clear evidence of market failure with regard the investment of private health insurers in CDMPs. On this fact alone it is also clear that current approaches, including legislation and regulation, need refinement (www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Cooperatives).

We also see the recently established PHNs as one possible way of achieving greater collaboration with GPs on CDMPs not only for those with private health insurance but, through the utlisation of our experiences as outlined in this submission, for the wider community.

New models must empower the consumer, support community based and home based services, provide suitable technology (e.g. monitoring, integrated record keeping), and be driven by new funding approaches.

Our view is that this already beginning to happen and that such innovation and pilot projects should be nurtured. Over time the best models will emerge and expand.

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www.abs.gov.au population clock – 23.8 million Australian population.