SENATE COMMUNITY AFFAIRS COMMITTEE

Hearing into the Private Health Insurance Bill 2006 (provisions) and related Bills

Supplementary submission from Australian Health Management

Australian Health Management (ahm) provided a written submission to the committee and appeared as a witness before the Committee on February 2, 2007. During questions, several Senators asked ahm to provide data and research concerning the effectiveness of the health management programs offered by ahm over the last 7 years.

The following is a brief synopsis of ahm's research. Some of the information in this report has been included in peer reviewed international journals and some is being prepared for publication.

In its opening statement, ahm made the point that the new legislation provided health funds with the opportunity to develop self management programs to complement the current clinician / patient delivery methodology which dominates the Australian Health delivery system. Reference was made to the National Chronic Disease Management Strategy that indicates that self-management can deliver effective outcomes for 70% of people suffering with chronic disease.

The following data supports the effectiveness of health management programs that focus on self-management in the Australian environment.

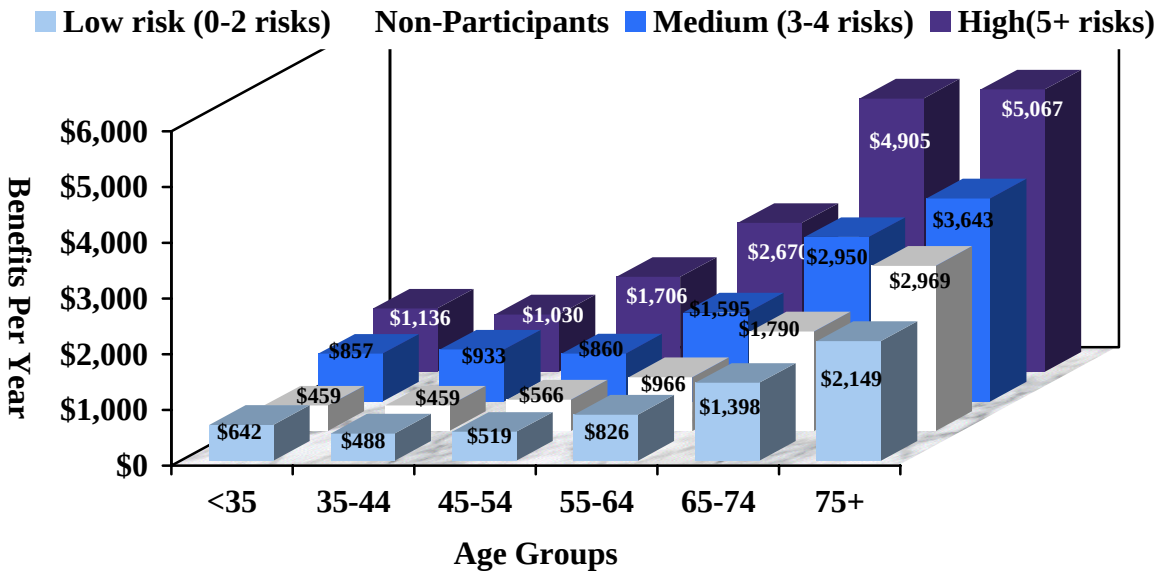
1. The impact of modifiable risk factors on health care costs.

The following graph indicates the impact of health risks on health care costs. ahm measures the following risks: weight, exercise, nutrition, blood pressure, disease, smoking, alcohol, stress, life satisfaction, job satisfaction, perceived health and job satisfaction.

The left hand axis indicates private health insurance costs and as such does not include primary care. The right hand axis measures risk categories: low: 1-2 risks; medium: 3-4 risks and high 5 or more risks. The population is split into 5-year age cohorts.

The "non-participants" group is the control group who did not participate in the program. This group is matched for age and gender.

HIGH RISK MEANS HIGHER DRAWING RATES



This study has been repeated in several populations and indicates clearly that the greatest potential for savings in the management of populations is to prevent the escalation of risks, which will prevent the escalation of costs.
In this study a person with 0-2 risks (low risk) in the 45-54 year range has an average cost of $519. In the age and gender matched control group, which includes people with all levels of risk, the cost is $566. If the number of risks increases to 3-4 (medium risk) the costs increase to $860. If they move into the 5+ risks (high risk) while still remaining in the same age cohort the costs will increase to $1,706.

Clearly, programs that prevent the escalation of modifiable risks are the most effective strategy for the containment of costs in a population.

2. The cost impact by program type.

ahm offers a range of health management programs to its members.
These include:

Total Health Assessment only (THA)
This is a validated self-reported health assessment questionnaire with 40 questions that cover physical and psychosocial risk factors. Participants receive a health profile with suggested health improvement strategies including appropriate screenings and a comparison between their chronological age and their health age. This has proven to be a strong motivator for change.

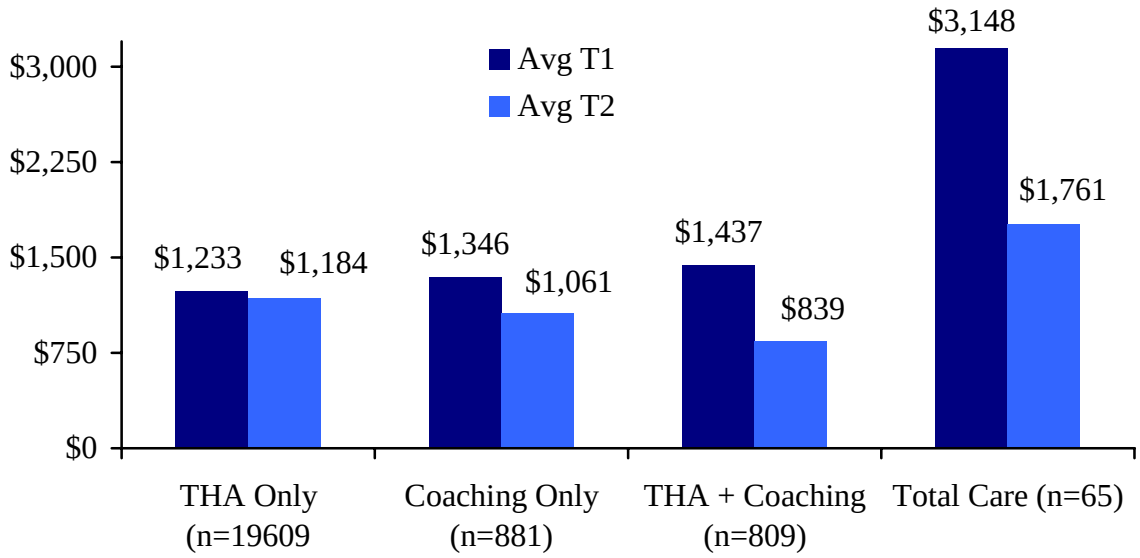
THA plus telephonic coaching.
This program includes 4 telephone calls from a health professional over a 12-week period with reviews at 26 and 52 weeks. The program involves motivational interviewing, participant goal setting and structured behaviour change techniques.

Coaching only
This allows participants to access health coaching without completing the THA

Total Care
This is an intensive telephonic support program for people with complex co-morbidities. It involves liaison with the treating doctor who establishes the care plan. The program also provides care coordination and advocacy.

The following data is an evaluation of the program outcomes. A comparison is made of the claims cost 12 months before the program (T1) and 12 months after members have participated in the program (T2). The T1 data acts as a control group.

COST OUTCOMES 2005-2006



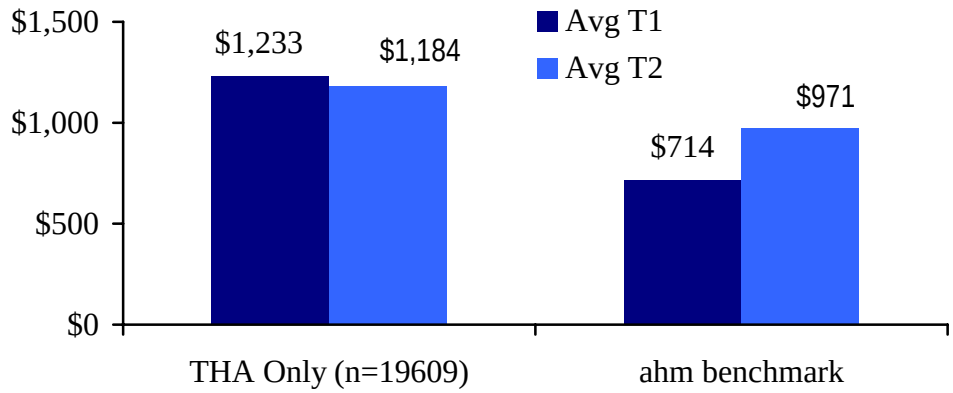
The study shows that the greater the level of intervention the better the claims outcomes.

The cost of delivering all the programs to the population in this study was $532,380.
The demonstrated net savings were just over $1.2 m ($1,253,500)
The average net saving per participant was $380

The individual program costs and savings follow. The benchmark data is the control group costs. This is a group matched for age and sex who did not participate in the program. Apart from providing a benchmark against which the cost effectiveness of

the programs can be measured, it also indicates that those who enrol in the programs have higher average claims costs than those who do not enrol. This would indicate that ahm has enrolled those people most requiring assistance with risk reduction.

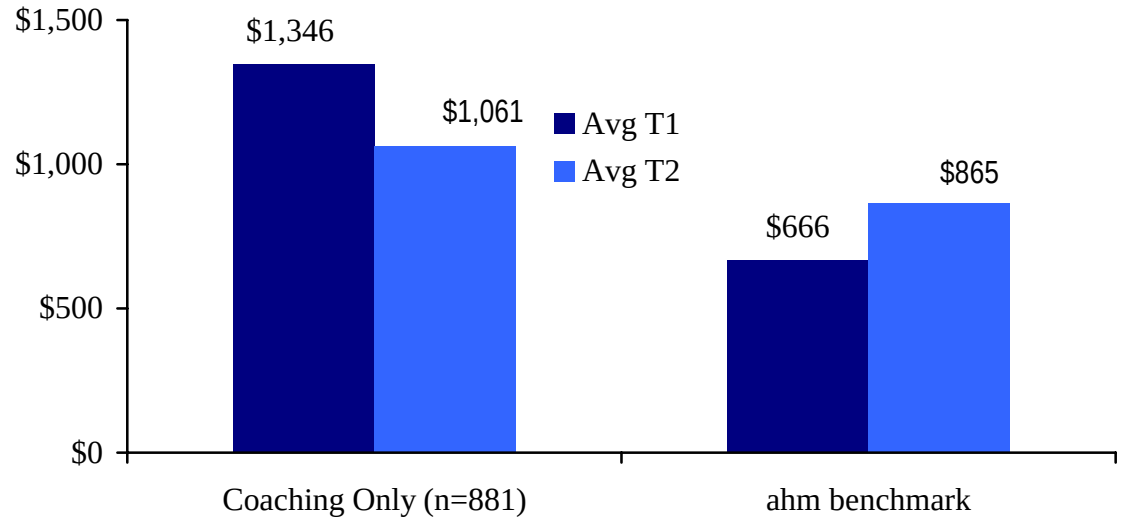
COST OUTCOMES 2005-2006 (THA ONLY)



Total program costs = $392,180
Total net savings = $568,661

Program costs per participant pa = $20
Net savings per participant pa = $29

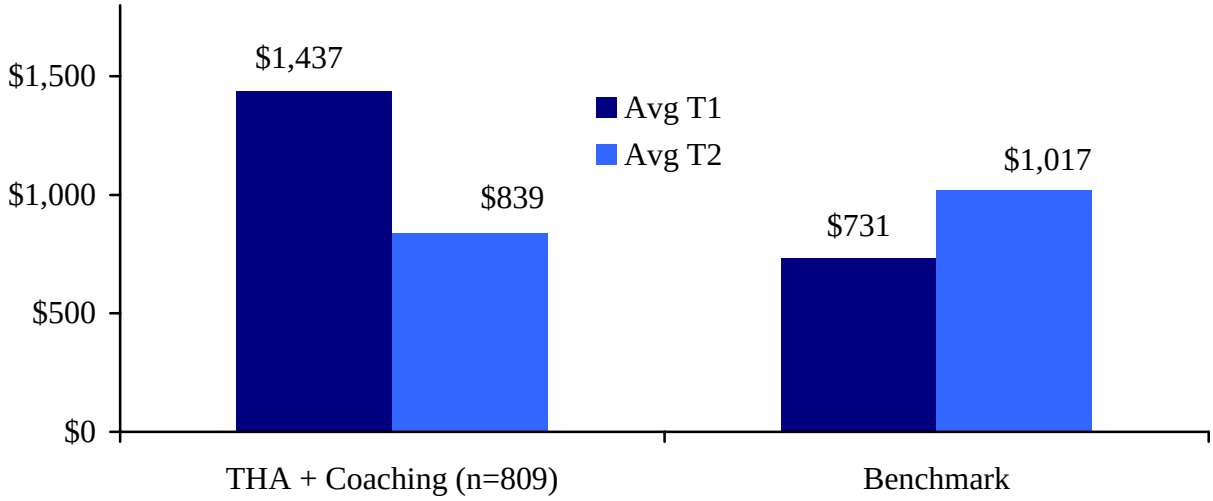
COST OUTCOMES 2005-2006 (COACHING ONLY)



Total program costs = $42,288
Total net savings = $208,797

Program costs per participant pa = $48
Net savings per participant pa = $285

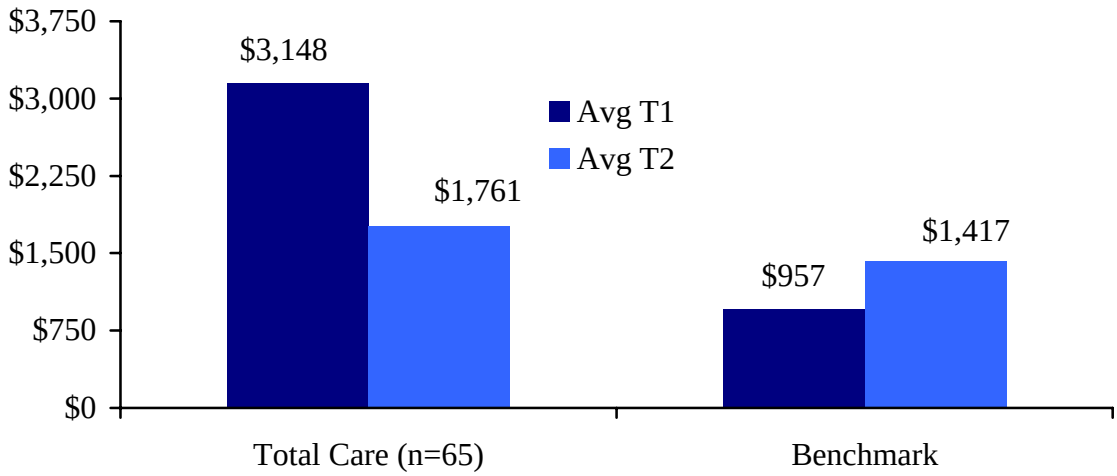
COST OUTCOMES 2005-2006 (THA + COACHING)



Total program costs = $55,012
Total net savings = $428,770

Program costs per participant pa = $68
Net savings per participant pa = $530

COST OUTCOMES 2005-6 (TOTAL CARE)



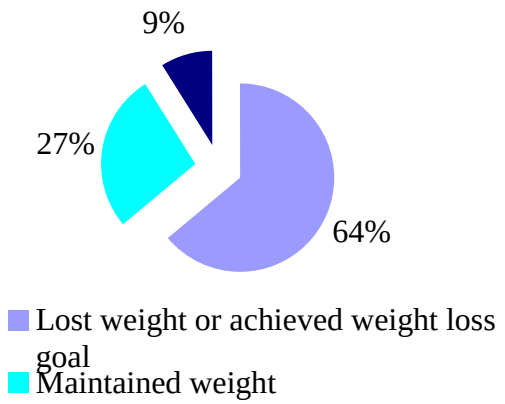
Total program costs = $42,900
Total net savings = $47255

Program costs per participant pa = $660
Net savings per participant pa = $727

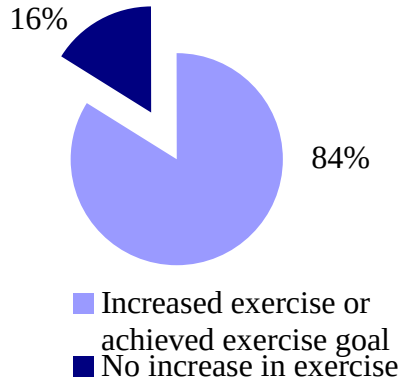
3. Goal Achievement

ahm programs are self management programs in which participants choose the goals they wish to achieve. The following are the results of the interventions in terms of goal achievement after the 12-week intensive coaching period:

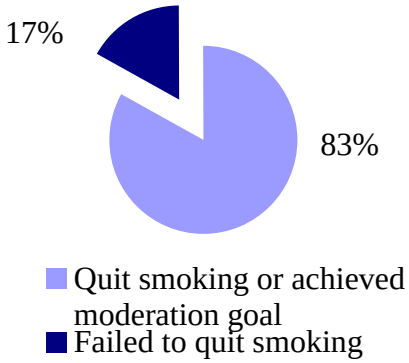
Weight loss goal



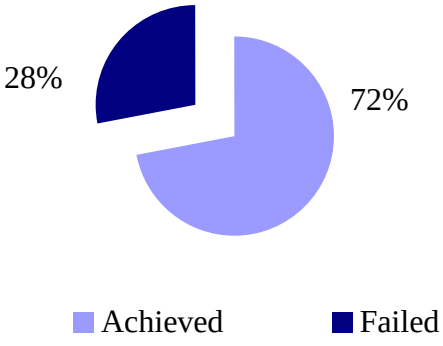
Increasing exercise goal



Quit smoking goal



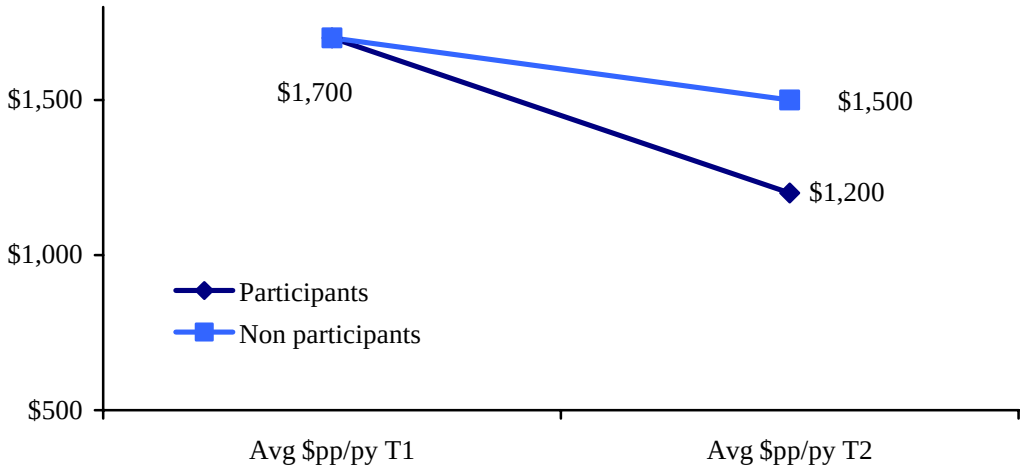
Visit my GP goal



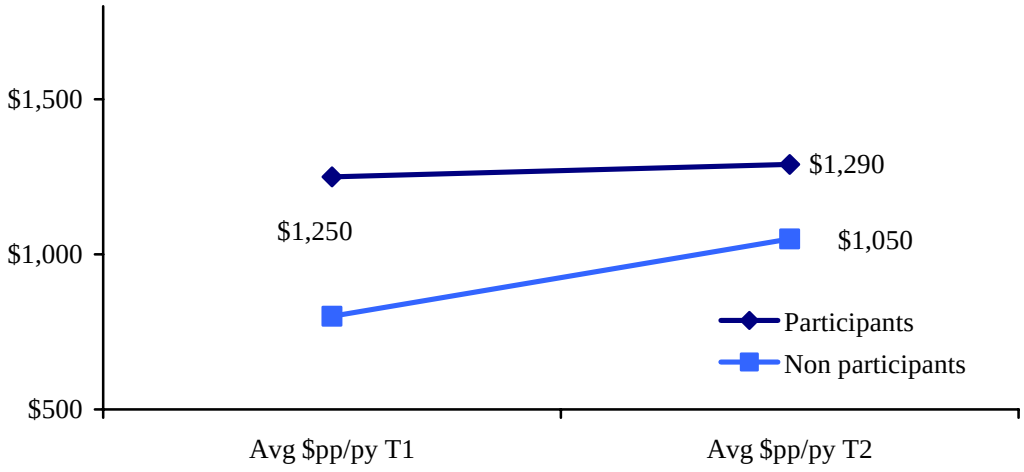
4. Disease specific outcomes

The following reports indicate the success of the programs by disease. The study measures the claims costs of participants for the year prior to enrolment and the cost during the first year of the program. This is benchmarked against a matched group of members who did not participate in the program

Diabetes program outcomes

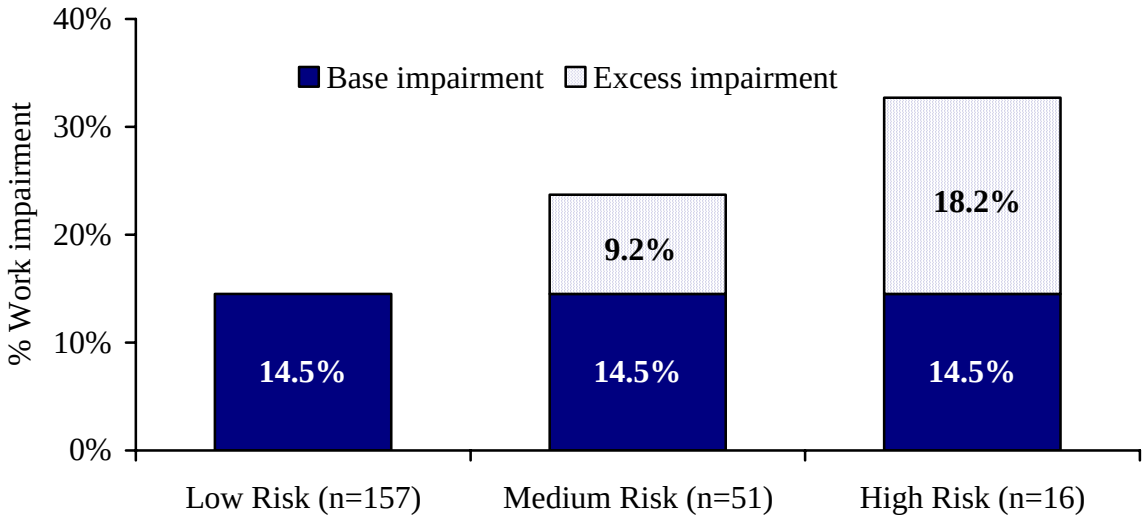


Arthritis program outcomes



5. Collateral benefits in terms of increased productivity

The following study, published in the American Journal of Health Promotion *(Mar 2006, Vol 20, No 4)* shows the lost productivity directly related to health risks in the Australian workforce. It indicates that workers with 5 or more health risks (high risk) are likely to lose an extra 18% of their productivity.



*Low risk = 0-2 risks, medium risk = 3-4 risks and high risk = 5+ risks
**Base impairment is that level of impairment you would expect to see in somebody who is low risk.

The Association of Two Productivity Measures With Health Risks and Medical Conditions in an Australian Employee Population, Musich et al., 2006

Any health status improvement achieved as the result of programs offered under Broader Health cover will also have a positive impact on the productivity of people still in the workforce. Similar studies in the US and Europe indicate that the greatest impact of health status is not in the costs of intervention but in the impact on lost productivity.