



## HC Coombs Policy Forum

# Workshop: International Developments in Health Systems

### Introduction

The HC Coombs Policy Forum took advantage of the visit of two experts on international health systems (Professor Ted Marmor of Yale University and Associate Professor Kieke Okma of New York University) to organise a round table discussion to share information and experiences on various aspects of health system management. There were 21 invited participants at the Workshop including senior members of the public service, academia and health sector organisations along with the two international health policy specialists.

The Workshop aimed to explore developments in health systems internationally and how comparative analysis of these might usefully be applied to the Australian health system. The working lunch meeting began with comments on cross border learning, aspects of health system management and themes common to diverse systems and current Australian reforms and emerging issues. There followed facilitated discussions on four topics with opening remarks by the visiting experts. The Chatham House Rule applied.

#### The questions to be discussed were:

1. How important is having a single (government) funder, in terms of ensuring appropriate care and in terms of cost control etc? How are other federations allocating responsibilities re funding, purchasing, providing health services?
2. What is the future of primary care and its relationship with acute and long-term care? What models are emerging to integrate care and to manage the financial risks of health systems?
3. What is needed to get the most from the health workforce as service demand increases and labour supply is squeezed?
4. Where does private financing fit in today? Co-payments to help control costs? Private insurance to offer choice (and/or help to control costs)?

Of these questions, time did not allow for addressing number 3, the issue of the health workforce. This may be explored in future workshops.

### Cross Border Learning

- > What can we learn from the analysis of international developments in health system management?
- > Cross border comparisons can offer perspective and illumination without necessitating the adoption or transplantation of another system.
- > If a system is perfect elsewhere, it doesn't follow that it can be fully or successfully transplanted.
- > Health policy, indeed all policy, is done in the context of one's own system, one's own history, culture and political structures.
- > However, it is helpful to explore the advantages and limits of similar health management systems looking at eg prevention, comparative effectiveness research and the use of IT and electronic records.

### Funding of Health Systems

- > The proposed reform in Australia recommends that the Commonwealth moves from funding 40% of hospital care to 60%. The money would be activity based rather than a block grant.
- > Medibank, Australia's initial universal health care program, was introduced in 1975, followed by the current system, Medicare, in 1983. The program underwrites the cost of attending medical practitioners including general practitioners, specialists, participating optometrists or dentists (for specified services only).

- > Despite the claimed advantages of a single funder in terms of patient orientation and allocational efficiency, it would also present the risk of reducing the variability and diversity of approaches. This could mean a lower level of innovation and higher costs.
- > Single source funding can also lead to significant internal fighting over the budget. Another potential disadvantage is that large organizations tend to lose management capacity.
- > It is important to get the correct incentives for cost control overall. Favouring one activity over another leads to cost shifting.
- > If marginal costs are roughly equivalent with the same proportion of responsibility across programs then cost shifting goes away eg one body is responsible for 40% of Activity A and also responsible for 40% of Activity B, there is no incentive to cost shift providing the margins are equal.
- > Cost shifting often means blame shifting.
- > The payment method is most important to the physicians and the total funding amount is most important to the government. The norm is for a mixed system with consultation and involvement on what will be expected and a ranking of stakes/interests and payment for performance/outcomes.

## Integration and Co-ordination across the Health Care System

### Primary Care

There are four different senses of primary care:

- Most important part of health care system as perceived by the general population
- First point of contact
- First stage in hierarchy of complexity
- Which practitioner to see

International trends are based on the assumption that increasing primary care results in less need for secondary care. Using GPs for all services may not be the best way. Nurse practitioners may perform a useful adjunct role.

### Integration of Care

- > The integration and co-ordination of care may involve the:
  - Co-location of services
  - Allocation of levels of care ie the right activity to the right person at the right time
- > The embrace of integration may need to be tempered with evidence of how it can be achieved. Managerial, legal and contractual arrangements may present difficulties and so need to be addressed carefully and explicitly.
- > Incentives for behavioural change amongst providers need to take into account existing cultural and social structures to be effective eg whether a national culture tends to be individualist or more corporate. Other considerations include permanence and voluntariness.
- > Recent Coordinated Care trials were not successful as a better way to control costs. However, there was evidence that patients received better care where GPs were given authority to coordinate care and funds were pooled. It may have needed more time and a larger trial to prove (or otherwise) cost effectiveness.
- > Electronic health records may be better as a central instrument for coordination by patients, though there is no international evidence for this as yet despite the large investments.
- > Potential barriers are:
  - Complicated medical care
  - Multiple ailments
  - Disadvantage in information, skills and availability for lower socio-economic groups
- > Health consumers experience failure across the boundaries and in the transitions between settings. There is a role for patient or consumer and community associations to balance professional associations in discussions on the design of health care systems.
- > Care integration is a challenge that has to be faced.

# The Role of Private Financing of Health Costs

- > What are the aims of a system of co-payments and deductions?
  - Control of moral hazard both ex ante and ex post
  - Reduce the fiscal illusion so that health consumers have some sense of the costs of medical treatment so acting as a political safety valve.
  - Reduce the economic cost of distortion inherent in taxation raised to cover health costs.
- > For most people, the small charge doesn't impact usage with the potential exception of low income families. Problems of equity and access, especially in acute care would have to be addressed.
- > Significant co-payments may be seen as equivalent to being taxed for being ill.
- > The cost of collecting the co-payments eats into revenue raising.
- > Different co-payments across substitutional products and/or services act as a means of directing or signalling behaviour. An example of this is the use of generic drugs. Another valuable instance is the co-payment for pharmaceuticals by pensioners which has led to a decreasing incidence of over prescribing.
- > The big question is to determine an efficient level of co-payment and at what point of service they should be required.

## Future Directions

The identified problems with transplanting policy ideas and models between systems and with the siren call of fads and fashions demonstrate the limits to policy learning across borders. So, it would be valuable to explore how to maintain or increase the flow of ideas for health care policy innovation. A future workshop could look at other sources of inspiration eg a longitudinal analysis reaching into the history of the existing health care system or openly encouraging and canvassing good ideas within and without the system, recognising that intergovernmental fiscal relations in health, though important, are not the only element in health care innovation.

## Background readings

Theodore R. Marmor, 'Health Reform and the Obama Administration: Reflections in Mid-2010', *Healthcare Policy*, pp. 16-22, Vol 6, No1, 2010

Jonathan Oberlander and Theodore R. Marmor, 'The Health Bill Explained at Last', *New York Review of Books*, August 19, 2010

Kieke Okma, et al, 'Six Countries, Six Health Reform Models? Health Care Reform in Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands' *Journal of Comparative Policy Analysis: Research and Practice*, pp 75-113, Vol 12, Nos 1-2, February-April 2010

Andrew Podger and Adrian Kay, 'Getting the most from the Health Reform package', IPPA National Roundtable 2010 – Health Reform

## Correspondence

Andrew Podger, Professor of Public Policy, Australian National Institute for Public Policy, ANU  
E [andrew.podger@anu.edu.au](mailto:andrew.podger@anu.edu.au)