

**2006 ISDC Session Report**  
**Special Convened Session on the Dynamics of Health Care Reform and**  
**Meeting of the Health Policy Special interest Group (HPSIG)**

**Session Reporter: Gary Hirsch**

The Special Convened Session began with presentations of six papers that addressed various aspects of health reform at the local, regional, state, and national level. There was also a brief presentation on recent Dutch experience with health reform. These presentations were followed by a discussion of common issues facing those who attempt reform of health care systems. The final portion of the meeting was a discussion of future directions for the HPSIG and possible topics for a session at the 2007 ISDC.

The first presentation on health reform by Gary Hirsch drew on the experience of several states in the US to develop a causal model of health reform. These experiences suggested the importance of coalition building, proposed programs that are fine-tuned to meet the needs of specific groups, and financing that spreads costs evenly among multiple public and private payors. He suggested that successful health reform efforts would also have to shift spending toward “upstream” preventive services and reinvest savings. Gary’s work also drew on work from political science such as John Kingdon’s agenda setting model and on work by John McDonough in applying these models to health reform.

The next presentation by David Todd focused on the reform of depression services in the UK. Todd described how an SD model helped to support the introduction of “stepped care” reforms designed to reduce the overload on psychiatric services by moving more care “upstream” to deal with patients’ problems before they become severe. The model helped practitioners understand the potential benefits of reform and need to allocate resources to earlier steps in the care process.

Eve Pinsker then spoke about the effects of Federal and state spending cuts on the public hospital “safety net” that provides care for indigent, uninsured patients in Cook County (Chicago) Illinois. Her presentation described how these funding cuts have created a potential vicious cycle in which a resulting decrease in quality and effectiveness of services and demand for payment from indigent patients could lead to reduced public support for these services.

Geoff McDonnell presented the next two papers. One dealt with the transition of China’s health care system in line with market reforms and the problems that resulted. These included reduced access to care for poorer people and those living in rural areas and a shift to more expensive high tech medicine and away from cost-effective care provided by health workers in rural areas. Geoff’s other presentation described different world views of health care that guide people’s approaches to health reform (hierarchical control, market, network/professional) and how differences in those world views have become a barrier to reform. He also described some possible mechanisms for overcoming those differences such as generic models of health system processes that facilitate international comparisons.

A final presentation by Jim Thompson described a national model for projecting US health care expenditures over a four-year time horizon based on anticipated changes in utilization and prices. A key feature of the model is the role of pharmaceutical and medical device technology in both adding incremental costs by treating things not previously treatable and producing some savings by reducing complications of illness. Jim described how an insurance company has used the model to project the potential effect of particular developments such as an outbreak of pandemic influenza.

Etienne Rouwette then spoke briefly about recent Dutch experience with health reform. This primarily entailed a shift from a uniform National plan with a mix of public and private administration to mandatory private insurance with a basic package and competition among plans on the additional benefits. An unintended effect of the shift was a high rate of switching among plans (18-20% in 2006 vs. 3-8% previously) and possible adverse selection in which healthier people may have avoided higher cost plans.

The remainder of the discussion focused on future directions for the HPSIG and potential topics for a session at the 2007 ISDC. These included:

- Looking at some of the same topics across different countries. We could solicit country-specific papers on a topic, using the same template to facilitate comparisons.
- Considering financing at a National level, but capacity issues at a local level to help deal with differences in geographical distribution of resources. Ways of increasing capacity might include tapping non-traditional resources and streamlining the care delivery process. We could try to address these issues by working with policymakers at multiple levels.
- Two topics that were suggested as ways we could help to move care “upstream” toward more prevention of illness. One would be promoting the design of systems that partner health care with related social services. The other would look at effects of the environment on health care and vulnerability to illness and how adverse effects of the environment could be reduced. If we pursue either of these topics, we would have to better define what we mean by upstream interventions.
- Systems thinking training for health professionals was suggested as an additional function that the HPSIG might serve. In general, people felt that the HPSIG should be reaching out to the mainstream health community in order to have greater influence on policy.

We agreed to continue thinking about these and other topics and to communicate our ideas by e-mail in order to plan for next year’s conference.

At the conclusion of the session, Gary Hirsch was elected President of the HPSIG for 2006-2007 and David Rees was elected Vice President.