The AIHPS second Roundtable focussed on the issue of Integration for Improved Chronic Disease Management and Prevention in Australia. There were four presenters at the Roundtable and each identified through each of the presentations that the integration and chronic disease issue is one of significance and also an area in which the health system often fails. The objectives for the Roundtable were to consider whether there are gaps in the current policy agenda that can and should be addressed, what research evidence is still required to improve policy design and implementation and to also identify issues that require policy and research attention (e.g. workforce, financing for prevention).

A large number of initiatives within Australia and internationally have been developed in recent years to address the challenges posed by chronic disease. These range from programs focused on single risk factors to those which are more focused on clusters of health risks and conditions. Increasing attention has been directed towards how to integrate these different but related phenomena, as integrated models of care and approaches to prevention have been demonstrated to reduce the burden of disease and the cost to the health system across the world (Gross, Leeder et al. 2003).

A series of presentations by leaders from international collaborative centres, non-government and academic organisations gave those that attended the Roundtable an insight into the issues currently faced by providing the best quality health outcomes and education to the community, issues surrounding chronic disease and integration and the need for independent and quality health policy advice and implementation.

A number of key elements were highlighted by each of the presenters at the Roundtable which AIHPS need to take into consideration to continue this debate and discussion.

- Lessons in Integration
- Chronic Disease surveillance
- Public versus private debate
- It's all about the money
- Future challenges

Dimensions and Lessons in Integration

The current approach to public health reform in Australia is fragmented, with many separate strategies and approaches. This approach is also constrained in terms of effectiveness, efficiency and equity (NPHP 2001).
It was identified that the dimensions of integration include:

- Clustering of health conditions and risk factors
- Clustering of interventions – in settings and population groups
- Integrating financing – pooling across Commonwealth/state; public/private
- Integrating services – coordinating care across public/private/non-government
- Integrating system-level efforts – prevention across the health system; intersectoral partnerships

Although integration involves a degree of cohesion there are lessons in integration that all the best efforts do not always produce a favourable outcome – "You can integrate all of the services for some of the people, some of the services for all of the people, but not all of the services for all the people" (Leutz 1999). Integration is not just about the design of policy, but also how it is implemented and how to work at a system level whilst taking into account the needs of the community in terms of social, cultural and economic factors.

Through the Policy Observatory's there has been better integration and implementation of policy, particularly in international settings. In using existing templates for integration and implementation from different health settings across the world, the observatories have been able to identify balances and also similarities that work in their own policy frameworks.

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It was identified that the limited success of Australia's public health efforts to date, stems from the focus on specific problems or issues and that there is the use of multiple program that often target the same population groups and/or the same service providers (NPHP 2001; ANAPHI 2005). This was discussed further through the work in the US on integrated delivery networks (Burns & Pauly 2002) through two forms of integration, horizontal and vertical. While the forms of integration varied across hospitals and markets, their economic performance was generally the same. Nothing seemed to work and this is apparent in the Australian health system in which data should be made available on all treatments, there should be no restrictions for research.

Privacy issues in integration.

There already exists a significant amount of knowledge about what works. Therefore the most overriding challenge before all of us is applying what we know now rather than later.

Chronic Disease surveillance

A number of chronic diseases were identified as being the current foci for international and national governments and organisations. Chronic diseases such as cancer, diabetes, heart disease and obesity in all population groups remain as the target areas of chronic disease surveillance and program funding. Currently there is not a good support base in the community to provide continuing care that link with other services. Other self-support programs with chronic conditions, such as diabetes, have been identified and have been provided with the resources and care givers to reduce hospital readmissions and to give support back to the communities.

In Canada, the Public Health Agency formed a number of alliances following the success of the Canadian heart health initiative (WHO integration collaboration). This initiative was also successful as it was:

- Interdisciplinary
- An example of a community coalition
- Involved multi-level coordination, and
- Built public health capacity to comprehensively target heart health

These alliances have been formed federally and provincially in Canada and the federal government has provided a substantial amount of funding to assist the provinces to coordinate and implement public health projects. Other programs such as the Community Action Program for Children and the Tobacco Initiative (in Canada) have represented the disparities that have occurred until now. Canada Health has formed integrative approaches using an integrated chronic care model. Engaging healthcare teams, community supports etc, was a non-existent interface for chronic disease surveillance until now.

The National Chronic Disease Strategy is an Australian initiative which has influenced other international chronic disease models, such as that found in Canada which requires multi-level, ministerial agreement and commitment both at Federal and Provincial levels of government to provide an intersectoral health living network with a "wholistic" public health plan.

Public versus private health debate

Discussion surrounded the private insurance sector and why so much money is being incorporated into the private health system, when government-funded initiatives such as Medicare are seeing their demise.

What can private health offer those that can afford the "privilege"? Private health insurance could be seen as an empowering mechanism for younger people to control and help their own health status, and most health funds provide other incentives, such as remedial massage and other alternative therapies. There is evidence that a decentralised system of health can work, such as the example of what is underway in Germany.

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Currently in the private health insurance field, companies such as MBF and Medibank Private have the largest share in insurance money, and there is 41 other providers competing for consumer's money. However, the private health insurance field only pays 7% of the health bill in Australia, which is dispar ant to current costs. Insurers are deemed not for profit, but as the Commonwealth pays 30 cents for every dollar that insurers pay, the insurance companies should engage the government a little more on how this money is being spent.

So why do people prefer private to that of public in terms of their healthcare? Of most importance to people is that of "jumping the queue". Most elective surgery is done in private health hospitals and funded by private health insurance. There is better "hotel" accommodation in private hospitals – one bed instead of 4 or more in a room. There is the choice of doctor and better access to the latest technologies.

In Australia, the Victorian Health Promotion model is moving in the right direction, in terms of showing what happens to health as it moves through various risk factors (refer to triangle model – Paul Gross presentation)

It's all about the money

Both public and private health is all about the return on investment and to develop better strategies to improve benefits to insurers and members, but also its shareholders.

Kaiser Permanente was identified as a prime example of where private health is going in the United States. It is a leading not-for-profit, integrated health care organisation that has over 8 million voluntarily enrolled members. This also shows that there has been the translation of successful results back into the provision of a better health system for those insured. Kaiser Permanente is equitable in every sense, it is prepared to measure health outcomes and has shown that translation is not just a problem of health equity.

Funding needs to be in place to evaluate and implement programs. Money needs to be well invested and there needs to be health economists and not accountants balancing the books. There is a need to show the return on investment. If we do not get the evidence of the cost of chronic disease right now, where will we be in the future in terms of cost analysis and funding going to the right place.

Beds cost, GP's cost, and everything is driven by budgets and the cost of health to the government and the community.

Are there real life solutions to the cost of health? An example of a system that works is the review of the extended care plan of general practice. General practitioners are not afraid of administrative requirements, but the time required to commit to administrative task does not leave suitable time to provide quantity of service to patients. This reflects however the real cost of health care data as this administrative data and clinical feedback on patients is not being shared to researchers – there is no transparency.

In Canada there has been an opportunity for the governments and the provinces to explore a better health care system i.e. through better and more open communication lines – 24 hour phone access to physicians in isolated areas.

There may be an option to overcome the cost of insurance through the reinsurance pool or cashing out Medicare. However, high cost cases may cause problems down the track, as there needs to be investigation of out of hospital costs and further funding to put into this pool to reduce hospital readmissions. Medicare will always be in place, in some form or another, however the option of a medical savings accounts or having reinsurance is an option that governments need to investigate.

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The current Australian health system has the ability to identify or realise its returns on investment i.e. PBAC and the pharmaceutical industry. Other government and industry groups i.e. PBS, NBS do not appreciate the investment in pharmaceuticals. As stated, there is a need as much of implementation rather than the need for new policy.

Future challenges

The challenge is positional. What are we trying to influence in the current health system? We need to engage in useful dialogue and try to work around the following issues in terms of their influence on improving current health policy and its implementation:

- Evidence base
- System-wide integration
- Research Capacity
- Setting Priorities
- Investment
- Privacy – data linkage issues

From the Canadian perspective, Australia should be a partner for international technical collaboration, bilateral technical and scientific cooperation as it has many similarities with the Canadian health model (i.e. socio-political structures, decentralised systems and jurisdictions and an Indigenous population.)

There should be a needs-based responsiveness. Need to know, what the need is and how to address it, also having an evidence base to identify the need is integral. There also needs to be a measure of the responsiveness to this need.

There are three distinct levers in the health system – funding, structured organisation and the consumer. Consumers need to be involved and demand that research be open and data collection be transparent, privacy issues are a real problem for an integrated health system to move forward and for chronic disease surveillance to improve.

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