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Rationing of Hospital Services in the Australian Health System

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This article reports on the rationing in the Australian hospital sector and explains why it has been undertaken. It also briefly overviews the Australian health system in order to provide a necessary background for the issue of rationing itself. Rationing of hospital services has occurred because governments in Australia have limited hospital sector resources trying to ensure the containment of their health budgets. The resources available to hospitals have been insufficient to ensure that the supply of services meets the demand for such services. Therefore, in order to contain hospital budgets rationing has been required. Medicare, the universal health insurance system, assures that access to public hospital services is on the basis of clinical needs. However, due to the federal nature of government in Australia, the available services are determined by health system structural interrelationships and direct government regulation. For example, services provided in the community sector, and funded by the Commonwealth government, are prime candidates for being removed from the hospital sector by State/Territory governments. Similarly, expensive services with a wide range of usage are candidates for regulation to contain costs.

Key words: assessment of health care needs; Australia; budgets; economics, hospital; health services administration; health system agencies; hospitals

This article attempts to provide a brief overview of the Australian health system before examining some of the intrinsic aspects of the health system which result in rationing of the acute care health services. A number of complex issues will be summarized. The views expressed in this paper are those of the author and should not be taken to represent the attitude of the Commonwealth Department of Finance and Administration.
Rationing as a goal, in and of itself, is not openly pursued by either the Commonwealth or the State and Territory governments. What is openly pursued is the need for cost containment. However, the relationship between containing costs and rationing services is becoming more explicit and there is, like in other countries, a growing debate on the need to openly ration services in some fashion. Rationing will be considered from the perspective of the two main funding entities in the health system: a) the Commonwealth Government, and b) State and Territory governments.

Overview of the Australian Health System

In order to understand the methods and implications of rationing by the two levels of government, it is necessary to understand the interrelationships between different aspects of the Australian health system. These are briefly described below. A more detailed synopsis of the Australian health system is provided in the OECD's review of health systems (1). Although this synopsis was prepared in 1994, the fundamental elements of the system have remained the same. Figure 1 presents the key features of the Australian health care financing system, including financing of non-acute care service.

Figure 1: Australian health financing system (5).[view this figure]

Federal Nature of Government in Australia

There are three levels of government in Australia: the Commonwealth Government, State and Territory governments, and local governments. The Commonwealth and State/Territory governments play the major role in health issues.
The Australian constitution strictly delineates the responsibilities of the two levels of government. In general, the Commonwealth government is responsible for matters associated with the national good (primarily defense and customs) and the States/Territories are responsible for matters such as education, health care, law and order, etc.

In practice, the distribution of responsibilities becomes blurred. This is further exacerbated by what is termed vertical fiscal inequality. This refers to the situation when State and Territory expenditures exceed their revenue raising abilities and States/Territories become reliant on the Commonwealth government in the provision of financial assistance in form of direct grants for the assurance of services for their population (e.g., health, education, etc.).

Reforms in the Health Care System

Public sector budget caps have controlled public expenditure growth. However, the demand for services has continued to grow unabated. The pressures of health care costs containment have led to a variety of reforms implemented at the microeconomic level. Such microeconomic reform has included: structural reform aimed at improving efficiency and productivity (particularly at the hospital level); shifting of the focus of health funding to patients rather than providers; a greater focus on outputs and outcomes as opposed to inputs; contracting out of medical and non-medical services (and the concomitant focus on performance indicators and measures); a greater emphasis on increasing competition in health service provision; and privatizing public health infrastructure (such as hospitals).

In broad terms, the reforms are moving in the same direction as the New Zealand health sector reforms in the 1980s and early 1990s (1). The New Zealand reforms sought to fundamentally re-orient the health sector towards a more market-driven strategy and were based on a number of initiatives already introduced in the United Kingdom (such as contracting, performance indicators, budget holding, etc.) (1). The changes introduced in New Zealand were sweeping, and were thus implemented quite quickly.

Australia, in comparison, has not approached the health system reform with the same degree of coordination and vigor. The reforms have not been designed to alter the fundamental structure of the Australian health system but are instead aimed at improving productivity of the existing structure.

A possible explanation for such incremental reform is that Australia, unlike New Zealand, has a Federal system of government that has made it difficult to institute across-the-board reforms in all States and Territories. In fact, the health system in Australia can be viewed as consisting of seven separate State systems loosely unified by the Commonwealth government's overarching health framework.

The degree to which States have undertaken reform depends on a variety of factors, including the ruling political party, the demographic profile and size of each State, and the degree of fiscal pressure faced by the State governments. Reform also depends on the direction set by the Commonwealth government. For example, the Commonwealth and State governments have agreed to apply the excepted set of competition principles to all areas of activity, including the health sector, although the manner in which the principles are implemented is determined by the States (2).

Therefore, the pace and direction of the reform has differed significantly among States, causing difficulties for the unified approach to the health system reform.

Australian Health System

Community services. Private medical practitioners generally provide community medical services. Through its universal insurance system, Medicare, the Commonwealth Government provides financial rebates to patients to offset the costs of seeking medical care. Rebates are set at 85% of the medical benefits schedule fee (set by the Commonwealth Government). If medical practitioners charge a higher fee, the rebate remains at 85% of the medical benefits schedule fee and the additional costs are borne by the patient. Funding for community medical services is uncapped.

Acute care services. The broader hospital system in Australia is a mixture of public and private hospitals (3). The public hospital system is underpinned by the two principles of the Medicare program – universal coverage and "free" care at the point of admission to public hospitals.

The States/Territories are responsible for managing the provision and planning a full range of public hospital services for patients in accordance with the Medicare principles. Funding of public hospitals is provided by both the Commonwealth and the States/Territories. Total expenditure on public hospital services was capped with total government expenditure in 1995-96 accounting for approximately 66.8% of the total public and private hospital expenditure (4).

Medicare Agreements. The Medicare Agreements are bilateral agreements between the Commonwealth and each State and Territory concerning the provision of hospital and other health services specifying, among other issues: a) the level of financial assistance provided by the Commonwealth; and b) the acute care services provided to patients by the State/Territory.

The Medicare Agreements have been made for a five-year period from July 1, 1993, to June 30, 1998, and total Commonwealth funding to all States and Territories is approximately A$5 billion.

The Medicare Agreements are important from a Commonwealth Government perspective as they target funding towards specific hospital and hospital related services. For example, one component of

funding is provided as an incentive to increase the proportion of patients treated as public patients (i.e. patients are treated free of charges) in public hospitals. Another component of funding is provided to assist States and Territories to improve their strategic planning and management of hospital resources (5).
The Agreements are also important because they form the clearest set of guidelines on what services are considered to be hospital services and thus provided and funded by the States/Territories. For example, post-operative follow-ups of a patient are considered to be outpatient services that should be provided by the hospital free of charges to the patient. Nevertheless, the guidelines are not perfect and disagreements may arise. A new set of agreements are currently being negotiated between the State/Territory and Commonwealth governments. The new agreements are intended to take effect on July 1, 1998.
Program funding. Different aspects of the health system are funded by a multitude of different Commonwealth, State/Territory, and private sector programs and arrangements. The boundaries between programs cause barriers to the use of health resources in the most efficient manner possible (6). For example, although it may be more efficient to substitute community medical services with similar services provided in a hospital setting, there is a financial incentive for the Commonwealth government to prevent this.

Rationing of Hospital Services
Rationing of hospital services in Australia is mainly a by-product of: a) the feature of the Australian health system whereby access to hospitals is limited by the gatekeeping role of community medical practitioners, and b) all players in the health system actively seeking to contain growth in hospital expenditure and costs.
While all players seek to restrict hospital costs, the total effect is not additive as there is cost shifting among players. For example, the State and Territory governments may reduce their hospital costs but at the expense of patients and the Commonwealth government who pay more. This will be discussed in more detail below.
Gatekeeping
Gatekeeping is the role played by medical practitioners in determining whether patients should be admitted to hospital or whether medical treatment from other sources is more appropriate. Gatekeeping acts as a form of rationing of hospital services by substituting other services whenever possible. In this case though, unlike with Commonwealth and State/Territory government rationing, rationing is based on clinical rather than fiscal guidelines.
In the case of accidents and emergencies, adequately qualified physicians vet patients on arrival to hospital before being admitted for necessary treatment. In non-accident and emergency situations, the normal vetting routine involves presenting to a community physician who makes a decision as to whether or not the complaint warrants further attention. If so, the patient is referred to either a specialist or directly to a hospital if the complaint is serious enough. The specialists, in turn, consider the patient's situation to determine whether hospitalization or some other form of treatment is most appropriate.
Commonwealth Level Rationing
Prior to 1976, the Commonwealth Government had entered into Hospital Agreements with the States and Territories under which the Commonwealth was bound to provide 50% of net operating costs of the recognized hospitals (for up to 10 years) (7).
Since the estimated future costs were dramatically increasing, the Commonwealth pressured State and Territory governments into accepting the Commonwealth's contribution in the form of block grants, which were capped in any year. Thereby, the States and Territories shouldered the risk (both political and financial) of cost growth pressures in the hospital sector.
Under the latest set of hospital agreements, the Medicare Agreements, the Commonwealth continues to provide capped hospital funding. Any increase in funding is directly linked to an increase in the age/sex weighted population of Australia. The age and sex weights reflect hospital utilization patterns, by age groups, for men and for women (5).
Although the Commonwealth is able to limit hospital expenditure within a year, it is still exposed to demand and cost growth pressures over years. These pressures include aging of the population, increased per capita utilization of services, and demand for new technologies and new medical services.
The Commonwealth takes a pro-active role in minimizing the demand pressures associated with some (potentially) high cost new technologies and services. However, it is slow to act concerning other technologies that have the potential to add greatly to the cost of hospital care.
A good example of Commonwealth inactivity is the funding of exploratory knee surgery. When

originally included on the medical benefits schedule, the fee was based on the cost of an operation requiring anesthetists, surgeons, etc. Today, the same procedure is performed by arthroscopy in a physician's office, for far less cost. The Commonwealth has been slow in revising the fee in line with new technology though it is currently in the process of reviewing the cost versus fee structure of all items on the medical benefits schedule.

A new technology, likely to be expensive, may be regulated by the government. For example, when magnetic resonance imaging (MRI) was first introduced, the Commonwealth Government (in association with the State governments) limited the number of imaging machines available for public hospital use. Limiting the availability of such services reduces costs but also results in a shift of patients from the public to the private sector where there are no regulations. As the fees charged in the private sector tend to be significantly higher than the equivalent medical benefits schedule fees, the efficacy and ethics of this method of cost containment is questionable. However, in the 1998-99 Federal Budget, the Commonwealth government announced that it would review the way in which MRI services were provided to public patients, while still restricting the total number of MRI machines available for use by the public patients.

Experimental/new procedures such as lung/heart transplants are treated similarly to new technologies. The number of hospitals with heart/lung transplant units is strictly limited. Apart from the costs savings associated with regulating the availability of experimental procedure units, there is a clinical basis to such regulation, as medical personnel needs to perform sufficient numbers of operations in order to maintain their skills at safe levels. The Commonwealth Government is reasonably successful in minimizing the cost of pharmaceuticals because of the nature of the pharmaceutical market in Australia, which is characterized by the pharmaceutical benefits scheme. Under the pharmaceutical benefits scheme, the Commonwealth Government agrees to subsidize patients in their purchases of the listed pharmaceuticals. Therefore, patients have a financial incentive to purchase the listed pharmaceuticals and manufacturers have an incentive to list their products on the pharmaceutical benefits scheme.

In order to obtain listing, however, manufacturers must negotiate with the Commonwealth the price at which their products will be listed. Since the Commonwealth effectively has monopsony power in this situation, pharmaceutical prices are lower in Australia than in the European Union or the United States (8).

Cost shifting. Whereas imposing caps on hospital budgets by the State/Territory governments has been the main means of rationing hospital services, the Commonwealth may reduce its expenditure on hospital services by shifting some of the financial burden onto: patients, medical practitioners, private health insurers, and State/Territory governments.

(a) Patients. In 1976, the Commonwealth first imposed a special levy on the Australians that would provide an incentive for patients to take out private health insurance. In 1984, with a new political party in Government, the Commonwealth introduced the Medicare levy the purpose of which was to offset only the additional cost to the revenue of the first year of Medicare operation. Thereby, any relationship between the Medicare levy and Medicare outlays was lost. Thus, the original rationale for introducing a levy, to provide a price signal to patients of the cost of health care and to provide cost-linked revenue, was never realized (7).

The Medicare levy was originally set at 1.25% of gross income and has gradually increased to its current level of 1.5%. In the 1997-98 Budget delivered by the Commonwealth Government, individuals with high incomes, without private health insurance, will be required to pay a higher levy of 1.75% (9).

(b) Medical practitioners. Medical practitioners are able to set fees to the level that the market will bear. However, it can be argued that the presence of a schedule of fees (the medical benefits schedule) set by the Government distorts the market by forming an expectation in the consumer as to the level of a "fair" fee. This distortion of the market can place downward pressure on the fees charged by practitioners. It should be noted though, that the Australian Medical Association (AMA) also publishes a schedule of fees that it believes are "fair". The AMA schedule fees are substantially higher than the medical benefits schedule fees.

(c) Private health insurers. The Commonwealth has provided substantial assistance to the private health insurance industry through subsidized accommodation in public hospitals and contributions to the health insurance reinsurance pool (a pool of funds used to recompense insurers disadvantaged with an above average proportion of high use, high risk members). The assistance was to compensate insurers for applying community rating to all members so that the same premium was paid regardless of the level of risk or utilization of hospital services (7).

However, the Commonwealth has gradually been reducing its level of assistance to the health insurance industry, forcing it to bear a greater proportion of hospital services costs. Insurance

agencies have responded by increasing premiums (10), which results in individuals shouldering greater financial burdens.

In the 1997-98 Budget, the Commonwealth has, for a variety of reasons, provided increased incentives for people to obtain private health insurance. At the same time, some structural changes in the health insurance industry are being undertaken to allow health insurers to provide a more effective and attractive product. The changes are being instituted in the belief that the outcome of the increased private health insurance coverage will be a reduced reliance on the public hospital sector. Recent data indicate that the number of private patients being treated in private hospitals is increasing (10). However, the number of public patients treated in public hospitals has not shown a corresponding decline (11). This may indicate that the total hospital expenditure (from both public and private sources) has been increasing.

State/Territory Level Rationing

With Commonwealth hospital contributions capped, and States/Territories responsible for hospital services (under the Constitution), State and Territory governments are exposed to side pressures for more hospital services (both increasing utilization of existing services and demand for new ones). Further pressure is placed on the States/Territories because Commonwealth funding has been indexed at a lower rate than growth in per capita utilization of hospital services.

The response of the State and Territory governments to an ever-growing demand for hospital services, with commensurate increases in expenditure, has been to cap hospital budgets and introduce a number of measures aimed at improving the efficiency of the hospital system.

Capping hospital budgets has prompted hospitals themselves to enforce strict budgetary control and implement service restraints. This has resulted in hospital managers doing the following: closing down wards and beds; restricting the number of operating theater sessions; rationing expensive services (e.g., expensive cancer chemotherapy is substituted with less expensive therapies); reorganizing hospital work practices; reducing payment to medical staff (though this is difficult in a highly unionized industry); dipping into capital funds to pay for recurrent costs; outsourcing medical services (such as radiology and pathology services); and outsourcing hotel services (e.g., food, cleaning, laundry).

Reduced access to hospital services has inevitably led to the creation of waiting lists. In 1996, the Australian Institute of Health and Welfare published a report on waiting times for access to Australian public hospitals (12).

The data supplied to the Institute of Health and Welfare were remarkably scant and did not allow for valid comparisons to be made between States and Territories. Some States did not participate fully, others were only able to provide data for a portion of their hospitals, and definitional differences existed between all the States and Territories. Lack of quality data is not surprising as waiting lists for hospitals is a very sensitive political issue which has caused a great deal of anxiety in the community (12).

Improvements in hospital efficiency appear to have had a positive result. This is indicated by the fact that public hospital admissions have steadily grown (by approximately 11% over the period 1991/92 to 1993/94), whereas the total State/Territory real recurrent per capita hospital expenditure has remained relatively stable – actually decreasing by approximately 5% over the same period. Per capita expenditure has increased by only 0.4% when considered over a slightly longer period (1990/91 to 1994/95) (13).

The introduction of casemix based funding of hospital services is the latest efficiency measure. The State of Victoria was the first to introduce a casemix funding in July 1993 and has been followed by other States and Territories. In each case, the structure of the funding system ensures that the total hospital budget is not open-ended.

The effect on rationing has been interesting. Previously, services were provided until funds were depleted. Governments were then under political pressure to “top up” hospital funding. Under casemix based funding, the government specifies a target number of services to be provided, the cost of which will equal to the amount of hospital funding available. Funds provided are calculated to be sufficient to cover the previous years level of services plus a small increase, if a hospital is efficient. This transfers budgetary responsibility to hospital administrators, who are under increased pressure to ensure that they meet their budgets. Evaluation of the impact of casemix funding appears to indicate that technical efficiency has improved (14).

Cost shifting. As is the case with the Commonwealth, the States and Territories may reduce their expenditure on hospital services by shifting some of the financial burden onto: patients, private health insurers, and the Commonwealth government.

(a) Patients. As part of hospital costs containment, State and Territory governments are rationalizing the number and location of hospitals while still attempting to adhere to their commitment under the Medicare Agreements of ensuring that all public patients have access to necessary public hospitals.

There are obviously additional costs associated with increased patient travel and reduced patient choice of hospital. However, whether the benefits of rationalizing services outweigh the costs has not been determined.

(b) Private health insurers. State and Territory governments can shift some of the financial burden of hospitalization on the private insurers by raising charges for private patients treated in public hospitals. This has occurred in conjunction with the Commonwealth reduction of its own subsidizing for private patients in public hospitals (15). In addition, State/Territory governments encourage public hospitals to treat as many private patients as possible in order to decrease the burden on the public patient budget. However, the Commonwealth did not previously permit realistic costs to be charged for services provided to private patients in public hospitals (11). Public hospitals responded by adopting the strategy of co-locating a private hospital with a public hospital. This can take the form of a separate hospital being built on the grounds of a public hospital or the conversion of a floor(s) or ward(s) from public to private status. The Commonwealth has recently allowed public hospitals to increase their fees to match private hospital fee levels.

(c) Commonwealth government. Due to the split of responsibility for which health services are funded by the Commonwealth and State/Territory governments, there is a range of health services which can be shifted from the hospital setting (and therefore State budgets) to the community setting (i.e., the Commonwealth budget). Examples of some services that can be shifted out include: non-urgent accident and emergency type services which can be easily treated by community medical practitioners (e.g., bumps and scrapes); radiology and pathology services; pharmaceutical services (i.e., provision of pharmaceuticals by community pharmacists rather than hospital pharmacies); pre-operative medical check-ups; and post-operative medical follow-ups and treatment (i.e., outpatient services).

Funding responsibility for such services can be shifted because the Commonwealth subsidizes the same services provided outside the hospital sector. For example, the Commonwealth will fund pathology tests ordered by a community medical practitioner. However, when such services are provided as a part of hospitalization, the Commonwealth's view is that such services should be funded from the hospital budget and that the Commonwealth provides significant financial assistance to the States and Territories for this purpose.

Cost shifting is difficult to measure because information on cost shifting is held by the State and Territory governments and there is a natural reluctance to provide the Commonwealth with suitable information on the extent of cost shifting. Nevertheless, the Commonwealth has estimated that State and Territory governments' costs shift approximately A$75 million per year (16).

Summary

Rationing of hospital services has been carried in Australia despite the political rhetoric to the contrary. The underlying reason for rationing is that funding of public hospital services is limited and inadequate to match the ever-growing demand for services. The most common approach to rationing, by all players in the system, is to reduce the availability of services and to improve the efficiency of the hospital system. This can be achieved by regulating the types of services provided in the public sector, the fees charged for services, and the method of funding hospital services. However, as there is a possibility for patients to move from the public to the private sector, rationing in the public sector may have little or no impact on the total hospital expenditure levels. Cost shifting is another rationing approach used by the Commonwealth and the State/Territory governments to restrict access to "their" services, and thereby limit their expenditure on hospital services. In some instances, cost shifting appears to have no logical basis at a system wide level (e.g., privatizing hospital pathology laboratories). In other cases, such as shifting costs to consumers, it can be argued that cost shifting, to a certain degree, rectifies a market distorted by a lack of price signals. It is ironic that scarce resources are utilized to prevent such cost shifting, which would actually improve the efficiency with which health services are provided.

However, regardless of the situation, the fact remains that cost shifting redirects precious resources away from the provision of health services – which makes it a perverse form of cost containment.

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