Australian Health Insurance Association
Submission to the Australian Bureau of Statistics review of the Consumer Price Index

Introduction

The AHIA is the peak body for the Australian Private Health Insurance Industry. The AHIA represents 21 health funds, which provide healthcare benefits to over 10 million Australians representing 93 per cent of those Australians with private health insurance.

The AHIA currently utilises the Consumer Price Index and the various associated analytical series for a variety of industry purposes. The Index is of particular importance to the industry with regards to the premium regulation process, given that comparisons between the Index and annual health insurance premium inflation are utilised in the industry pricing regulation overseen by the Private Health Insurance Association Council (PHIAC).

1. Principal purpose of the CPI

1.1. The AHIA encourages the incorporation of a cost-of-use approach in addition to the acquisitions approach each quarter.

The AHIA believes that when considering financial aspects of the health sector, it is of vital importance to frame this data in the context of performance of the sector. Utilisation of health services in a given period is an important aspect of living standards of the population, and it should be noted that medical and other privately insured hospital services may not always have concurrent acquisition, payment, and consumption. Due to this, pure expenditure for a given period is not an adequate reflection of actual sector performance and consumption of services in that period.

1.2. The AHIA supports the introduction of supplementary indexes such as population subgroup measures.

Given the discrepant nature of health care in Australia across various population subgroups, the AHIA believes that the introduction of supplementary indexes including but not limited to population subgroup measures would be valuable to users of the Index.

Population subgroup measures would be useful for examining inflation in health expenditure and utilisation across the specified groups of the population, providing insight into issues such as the ageing population and health care utilisation in self funded retirees versus pensioners. The AHIA believes that such insight would be of use to both the health sector and the Government.

2. Compilation frequency of the CPI

2.1. The AHIA believes user needs would be better served by a monthly CPI.

While satisfied with the current quarterly publication of the Index for industry needs, the AHIA suggests that increasing the frequency of the Index to a monthly publication would bring the Index into line with other indicators of economic performance such as the Australian Government monthly financial statements, the Reserve Bank monthly board meetings and subsequent changes to interest and cash rates, and various other economic indicators. The AHIA suggests, however, that care be taken to highlight the more seasonal nature of a monthly indicator to avoid potential public and Government misconception of a monthly Index. It is the opinion of the AHIA that a rolling quarterly period figure would be of use for this measure.

2.2. The AHIA offers no comment on whether user needs justify the additional costs involved in a monthly CPI.

3. Evaluation of the deposit and loan facilities index

3.1. The AHIA offers no comment on whether financial services paid for indirectly via interest margins are appropriate services for inclusion in the CPI.

3.2. The AHIA offers no comment on whether the ABS methodology correctly measures the price change for this service.

4. Maintaining the relevance of the CPI

4.1. The AHIA believes the updates of CPI expenditure class weight updates should occur more frequently.

The AHIA notes from the Information Paper issued for the Review that basket and item weights in the Index are updated on a 6 yearly basis following publication of the Household Expenditure Survey for each period.

The infrequency of update is an issue of concern to the AHIA. Private Health Insurance is a frequently changing consumer purchase, with levels of cover changing for individual consumers on an annual or more frequent basis. Legislation regarding what a Private Health Insurance product can cover is regularly updated, and as such the product itself differs from period to period. Many of these changes are beyond the control of the health insurer, (e.g. policy changes announced in the last two Federal Government budgets). An example of such a situation is the introduction of Broader Health Cover by the Federal Government in 2007. Prior to this date, Private Health Insurance funds were unable to provide cover for preventive treatments and services provided as a substitute for in-hospital care. Following introduction of the Broader Health Cover legislation, health funds are able to provide coverage for services that do not require admission to hospital, Outreach Hospital in the Home services, and programs that encourage members to manage their own health care,

particularly in relation to chronic diseases. As a result, the quality of the Private Health Insurance product greatly increased following the introduction of this legislation.

The AHIA suggests that more frequent review of the Index expenditure class weights should occur to account for changes to products such as those outlined for Private Health Insurance. The AHIA also recommends that greater transparency be provided in relation to the relative contribution of each of the Index components and sub-components to the overall Index.

The AHIA also notes that constancy of expenditure class weights for six yearly periods fails to account for the rapid growth of health expenditure as a proportion of GDP. Poor reflection of increasing contribution of health care inflation to overall inflation would be occurring in the Index series in the periods between reviews.

4.2. The AHIA offers no comment on whether the ABS should consider the use of alternative expenditure weight sources between HES cycles.

4.3. The AHIA offers no comment on ABS strategies to keep the CPI contemporary.

4.4. The AHIA believes improvement of measurement of services in the CPI is essential - as a minimum, the Health component of the CPI requires improvement in the classifications used.

Currently the AHIA utilises the Health component of the Index for a variety of industry purposes. Of particular note is the use of the Index in the premium regulation process, where inflation in premiums is compared to general inflation, and in a more focused manner on health inflation.

Issues experienced by the AHIA regarding the Health component of the Index in the past have been largely centred around the lack of transparency concerning the actual types of products underlying the component – and in particular the underlying apportionment and weighting of each component utilised to derive the health component of CPI. For example medical expenditure, hospital expenditure, and health fund premiums. This level of data was publicly available in previous years, and the AHIA strongly suggests that public dissemination of this data should be resumed.

The AHIA further contends that review of the current sub-components underlying the Health component of the Index is necessary to identify whether these sub-components are in fact appropriate and useful indicators to reflect the actual increases in the cost of health care. The AHIA notes that from its understanding of the health insurance sub-component of the Index that data relating to premiums from the previous year is used in the calculation. This means the health insurance sub-component is an invalid reflection of real health inflation in the period in which the Index is calculated. The AHIA suggests that review should be undertaken to determine whether the proportional contributions allocated to each sub-component are in fact reflective of the real contribution each type of health expenditure makes to health inflation in a given period.

4.5. The AHIA offers no comment on quality adjustment in the CPI.

5. Commodity Classification

5.1. The AHIA offers no comment on commodity classifications used to construct the CPI.

5.2. The AHIA offers no comment on whether there are any purposes for which the industry based IOPC and the purpose based CPICC should concord.

6. Analytical Series

6.1. The AHIA offers no comment on the usefulness of the current suite of ABS analytical series.

6.2. The AHIA offers no comment on the usefulness of the Average Retail Prices data.

6.3. The AHIA believes both a real and a seasonally adjusted CPI in addition to an unadjusted headline CPI would be particularly be useful for the Health component of the Index.

The AHIA notes that the Index is used extensively in legislative purposes, including the regulation of the private health funds premium adjustment process. Health care is a highly seasonal sector, with clear peaks and troughs occurring throughout the year. For example, utilisation of hospital services tends to be lower in the December quarter each year. The AHIA believes that a seasonally adjusted Index would provide legislators and other users of the Index with a measure of the true inflationary trend without the interference of seasonal noise.

7. Other Issues

7.1. The AHIA offers no comment on the importance of spatial measures and their potential use.

7.2. The AHIA supports the extension of CPI coverage beyond the 8 capital cities.

As noted earlier, utilisation of health services is a widely discrepant variable across different subgroups of the country, including geographic divisions. Numerous issues surround health care access in different geographical areas. One such area is with respect to hospital size in rural and remote regions.

The Productivity Commission's Research Report into Public and Private Hospitals, published December 2009, noted that hospital size and location have implications for resource efficiency and cost differentials. Smaller hospitals located in remote regions may be less likely to take advantage of economies of size, and are also likely to treat a very different casemix from that in metropolitan areas, leading to the appearance of inefficiency in these remote regions.

The AHIA contends it would be of use to the health sector to add an analysis of inflation in defined geographical areas to enable the comparison between various hospitals and regions in Australia, and to use this analysis as a basis of addressing cost differentials and potential inequities in the system.

A further example of potential use through the extension of CPI coverage by geographical area would be increased insight into health cost pressures on indigenous populations. The gap in life expectancy between indigenous and non-indigenous populations in Australia remains unacceptably high, and the AHIA believes it would be of use to understand financial pressures regarding inflation in communities with indigenous populations. Dissemination of the Index into geographical regions would provide a strong starting point for this understanding.