1998 Annual Report

Contact details

The Private Health Insurance Ombudsman can be contacted in the following ways:

Street and postal address

Private Health Insurance Ombudsman
Suite 1201, Level 12
St Martins Tower
31 Market Street
Sydney NSW 2000

Telephone, fax and e-mail

Inquiries and complaints: in Sydney
(02) 9261 5944

Inquiries and complaints: all other areas
1800 640 695 (Freecall)

Consumers requiring translators:
13 14 50 (Translating & Interpreting Service)

Deaf, hearing or speech impaired:
13 25 44 (National Relay Service)

E-mail: info@phicc.org.au

Home Page: http://www.phicc.org.au

Administration: (02) 9261 5855

Facsimile: (02) 9261 5937

Hours of operation

8.30 am - 5.00 pm (Sydney time)
Monday - Friday

Readers with inquiries about the Ombudsman or this report should contact the Director, Corporate Services at the above address.

Information for Senators and Members is available from Mary Perrett, Private Health Insurance Ombudsman, at the above telephone and fax numbers.

ISSN 1327-5305

Private Health Insurance
OMBUDSMAN

The Hon Dr Michael Wooldridge MP
Minister for Health and Family Services
Parliament House
CANBERRA ACT 2600

Dear Minister

Section 9 of the *Commonwealth Authorities and Companies Act 1997*, requires me to furnish a report of the Omubsman's operations for the financial year.

I have pleasure in submitting to you for presentation to the Parliament my third Annual Report, for the period 1 July 1997 to 30 June 1998.

The report has been prepared in accordance with government guidelines for the preparation of annual reports and financial statements.

Yours sincerely

Mary Perrett
OMBUDSMAN

18 September 1998

Suite 1201 Level 12
31 Market St Sydney NSW 2000
Telephone (02) 9261 5855
Facsimile (02) 9261 5937
http://www.phicc.org.au
Complaints Hotline 1800 640 695

Contents

Ombudsman's Overview

This is my third and last Annual Report. My three year term as Complaints Commissioner and now Ombudsman expires on 1 November 1998.

Relations with industry

As could be expected in a situation where an external complaints body was imposed on an industry by legislation, relations between the health insurance industry and the Complaints Commissioner have been a mixed bag. Since my office commenced operations in April 1996, the industry associations and most of the health funds have been co-operative. A few funds have been extremely helpful, and I have appreciated their support, especially in the set-up phase of the office. A few health funds are hostile. Unfortunately, one of these in particular, a medium size fund, is very reluctant to negotiate remedies for its members who lodge complaints against it.

Complaints Commissioner's success

Despite the mixed reception, the Complaints Commissioner's office has been a success for consumers. Without any fanfare from the Government of the day or the industry when it was created in late 1995, we at the Complaints Commissioner's office forged an independent organisation which has assisted 5877 people directly and sent thousands of brochures into the community to help people understand health insurance.

An independent survey of the Complaints Commissioner's customers, conducted during the reporting year, indicated a high level of consumer satisfaction with the Commissioner's service.

The health funds' customer service to members has improved since the Complaints Commissioner commenced operations.

Most health funds have upgraded their communications with their members to some extent. All now advise their members of significant changes to fund rules and most have improved the brochure material they give to new and upgrading members. While only one small fund gives its members a comprehensive policy document, some health funds now give their members membership brochures that resemble policy documentation.

The Ombudsman receives fewer complaints about petty sums of money and minor procedural irregularities these days. I assume this is because some segments of the health insurance industry are more inclined to resolve these matters internally.

A few health funds have also introduced formal internal complaints mechanisms. The frequency of complaints to the Ombudsman about these funds has reduced significantly over the last two years.

Health fund advertising has improved too. On occasions in the past, some health funds' promotions have been misleading, especially when promises of '100% hospital cover' and 'immediate cover' were made. The signs are that future advertisements and promotional material will be fairer for consumers.

Advertising guidelines

The Australian Competition and Consumer Commission and the Ombudsman published guidelines, developed jointly, in consultation with the industry and consumer groups, entitled 'Guide to the Trade Practices Act for the promotion of private health insurance'. The Guide was published in April 1998 and was the impetus for improved standards in advertising.

Mary Perrett Private Health Insurance Ombudsman

Move to an Ombudsman

The Private Health Insurance Complaints Commissioner became the Ombudsman during the reporting period. At the same time, legislation was amended to enhance the operations of the Ombudsman and to widen the jurisdiction. Being an Ombudsman's office, the emphasis is more towards providing advice and mediation than it was.

Unfortunately for health insurance members, the Ombudsman was not given the necessary powers to be fully effective in complaints which cannot be settled by agreement.

Ombudsman as Arbitrator

In February 1998, by Ministerial Determination issued under the National Health Act 1953, the Ombudsman became the arbitrator of disputes between private hospitals and health funds about hospitals' eligibility for payment of default benefits at a new, higher level, known as the 'second tier'. Arbitration procedures and guidelines are being developed.

Future

For the future, I hope that the Ombudsman's office and the health insurance industry can work more closely together. It is important that they do, to bring about some improvements for health fund members in areas which are not necessarily being addressed in the various discussions within the private health industry and Government circles at the time of writing. These areas involve five contentious issues between the Ombudsman and some sectors of the industry.

Issues to be addressed

The first issue is the need for plain language policy documentation and clear, timely notification of all significant rule changes. I am surprised that the need for these is still contentious in some quarters of the industry.

Second, the status of health fund rules governing members' entitlements and obligations must be addressed. All health fund members are bound by the rules which are not publicly available.

While the law requires all new health fund rules to be scrutinised, it is a matter of concern that the system does not always work. For example, one large fund has introduced new rules, about the rights of people who transfer their health insurance from another fund to it, which I believe are contrary to the conditions of registration set out in the National Health Act 1953.

The other issues are:

- the need for rate and benefit protection for people who pay premiums in advance;
- the appropriate test to be applied to determine whether an illness or ailment is a 'pre-existing' one; and
- whether health insurance benefits should be payable when a member's treatment may be covered by workers compensation or common law damages.

At the time of writing, I am preparing discussion papers on some of these issues for dissemination to health funds and other interested parties.

Conclusion

Overall, I am happy with the achievements of the office during the first three years of operation. While there are important issues still to be addressed, significant progress has been made in a number of areas and we have been able to provide valuable assistance and advice to thousands of health fund members from all parts of the country.

I am confident that the existence of an industry Ombudsman will increase people's confidence in health insurance.

Role and Function

Introduction

The Private Health Insurance Complaints Commissioner (now Ombudsman), is an independent statutory corporation established by the Health Legislation (Private Health Insurance Reform) Amendment Act 1995 (the 1995 reform legislation) which amended certain parts of the National Health Act 1953.

The Health Legislation Amendment Act (No. 2) 1998 changed the name of the Private Health Insurance Complaints Commissioner to the Private Health Insurance Ombudsman (referred to in this annual report as the Ombudsman) and also included a number of measures designed to assist the Ombudsman to provide a more efficient operation.

Under the new arrangements, the Ombudsman can investigate problems raised by partners and dependants of private health fund contributors and can make recommendations to resolve complaints directly to doctors and hospitals.

Previously, the Commissioner could receive complaints only from fund contributors and could recommend remedial action only to the funds themselves.

The Ombudsman adds value for those who insure privately by providing an independent means of resolving problems about private health insurance.

Functions

The main role of the Ombudsman is to deal with complaints about private health insurance arrangements. The full functions of the Ombudsman, as provided by section 82ZRC of the National Health Act, are to:

- deal with complaints and conduct investigations
- publish aggregate data about complaints
- make recommendations to the Minister or Department of Health and Family Services
- make available and publicise the existence of the Private Patients' Hospital Charter
- promote an understanding of the Ombudsman's functions.

In 1997, the Ombudsman was also given jurisdiction to deal with complaints concerning the health funds' management of the Federal Government's new Private Health Insurance Incentives Scheme.

In 1998, by Ministerial Determination under Schedule 1 of the National Health Act, the Ombudsman has jurisdiction to arbitrate disputes between private hospitals and health funds regarding second tier default benefits payable in respect of health fund members.

Who can make a complaint?

Complaints may be made in writing, by telephone, fax, e-mail or in person by:

- health fund members
- doctors and some dentists
- hospitals and day hospital facilities
- health funds
- persons acting on behalf of any of the above, including a family member, a lawyer or friend.

What can the Ombudsman do with a complaint?

The Ombudsman is able to deal with complaints by:

- mediation
- referring the complaint to the health fund with a request to report to the Ombudsman with its findings and any action it proposes to take. If the Ombudsman is not satisfied with the fund's explanation or proposed action, the Ombudsman may investigate the complaint
- referring the complaint to the Australian Competition and Consumer Commission
- referring the complaint to any other appropriate body.

The Ombudsman is also able to investigate the practices and procedures of health funds and the Minister is able to request the Ombudsman to undertake such an investigation.

What happens at the end of a complaint or investigation?

The Ombudsman is able to recommend that:

- health funds, hospitals, doctors and dentists take a specific course of action in relation to a complaint
- a health fund changes its rules.

In certain circumstances, the Ombudsman may request that a health fund, hospital or doctor provide a report on any action taken as a result of the Ombudsman's recommendations.

Section 82ZSG of the National Health Act provides various grounds for the Ombudsman to decide not to deal with a complaint. These include if the complaint is trivial, vexatious or frivolous, if the complainant has not taken reasonable steps to negotiate a settlement, if the complainant does not have sufficient interest in the subject matter of the complaint, or if another organisation is dealing adequately with the complaint.

How staff resolve complaints

The Ombudsman deals with most complaints by telephone and fax. Where complainants have not attempted to resolve their complaint with their health fund, staff will usually refer complainants back to the fund in the first instance. Where complaints are complex or where informal contact with the health fund is unable to resolve the problem, the Ombudsman will write to the health fund seeking further information.

Staff of the Ombudsman's office keep complainants regularly informed of developments about their complaint, usually by telephone.

The Ombudsman will always advise complainants of the outcome of a complaint lodged with the Ombudsman, by phone or letter.

Samantha Gavel, Sasha Andrews, Nicole Castaldi

Performance

Introduction

The Ombudsman received 3088 approaches in the reporting period 1 July 1997 to 30 June 1998. This was made up of 1966 complaints and 1122 inquiries. Figure 1 shows the number of complaints received each month in 1997/98, compared with the previous reporting periods. Figure 2 shows the number of inquiries received each month for the same period.

Recording complaints

All new approaches to the office are recorded as inquiries or complaints. Inquiries are usually handled on the spot, with staff providing callers with simple advice or referring them to other appropriate organisations.

An approach to the Ombudsman's office is recorded as a complaint if it meets the criteria contained in the National Health Act 1953. A complaint must be:

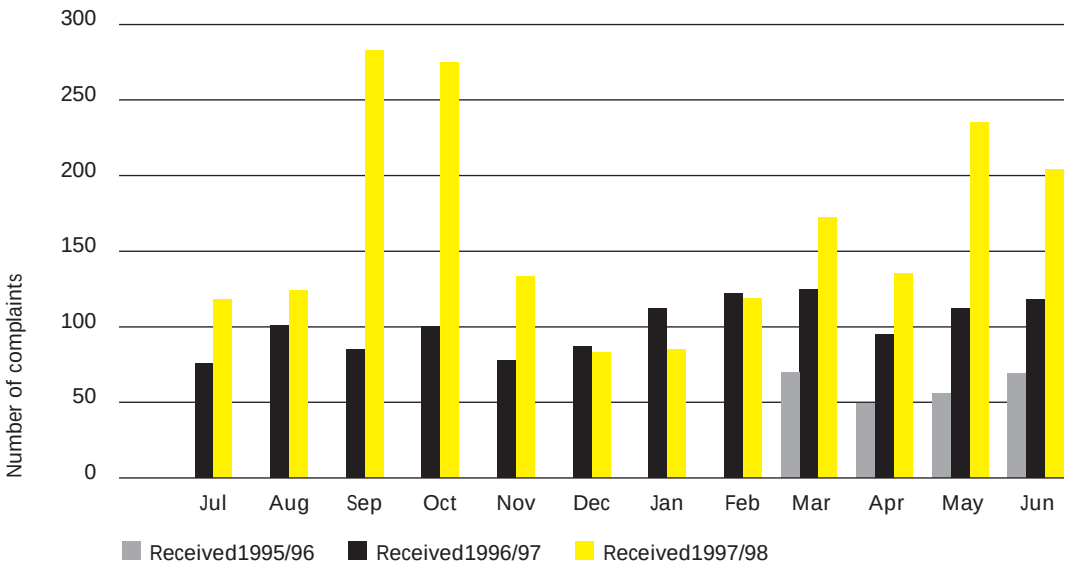
- an expression of dissatisfaction with any matter arising out of or connected with a private health insurance arrangement
- made by a health fund member, hospital, doctor (including some dentists), a health fund or someone acting on their behalf
- made about a health fund, hospital, doctor (including some dentists).

Complaints are further categorised by the way they are dealt with:

Problems

Dealt with by referring the complainant back to the health fund, hospital, doctor or dentist. This occurs where, in the view of the Ombudsman, the complainant has not made an adequate attempt to resolve the problem or the Ombudsman is able to suggest to the complainant other ways to approach the problem with the health fund, hospital, doctor or dentist.

Figure 1: Complaints Received



Grievances

Dealt with by staff of the Ombudsman dealing with the complainant's grievance directly by providing additional information or a clearer explanation.

Disputes

Dealt with by contacting the health fund, hospital, doctor or dentist about the matter. This may be done by telephone or in writing.

These steps are shown in Figure 3.

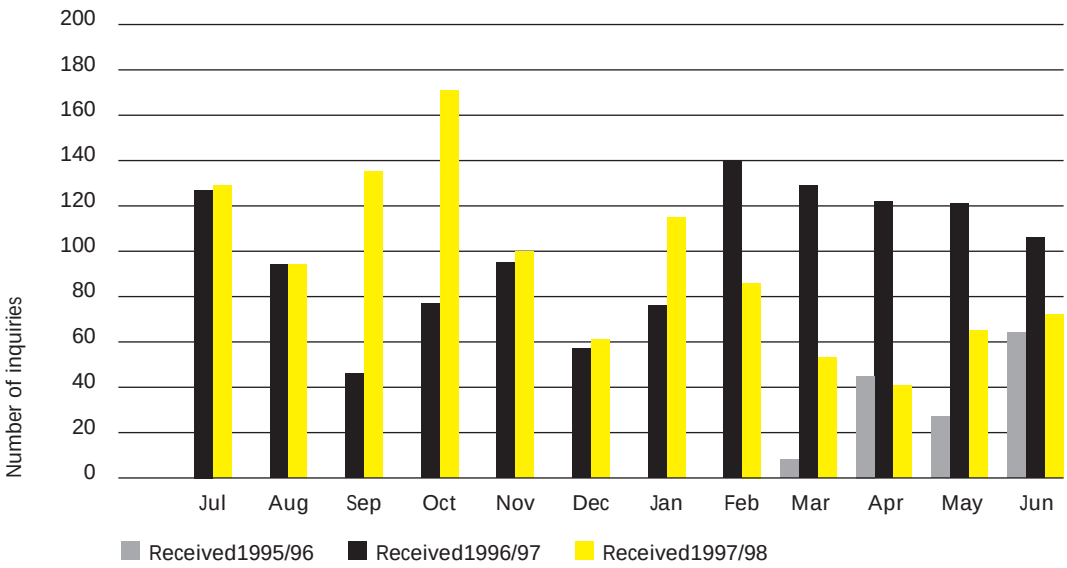
Most complaints are made by health fund members about their health fund. Complaints can also be made by health fund members (about hospitals, doctors and some dentists), by hospitals (about health funds, doctors and some dentists), by health funds (about other health funds, hospitals, doctors and some dentists), and by doctors and some dentists (about health funds or hospitals).

Workload

The office received 1966 complaints in 1997/98 (an average of 164 complaints per month), compared with an average of 101 complaints received per month in the previous year.

The office finalised 1963 complaints during the year (an average of 164 per month), compared with an average 95 complaints finalised per month in the previous year. The number of complaints received and finalised each month is shown in Figure 4.

Figure 2: Inquiries Received



Performance

Figure 3: Steps in handling approaches to the Ombudsman

Inquiry

Timeframe
Immediate
Actions
General information, advice, referral to appropriate agency
Outcomes
Provide advice, brochures & other information, referral

Problem

Timeframe
Immediate
Actions
If complainant has not attempted to resolve matter with fund or provider, refer back
Outcomes
Referral to health fund or provider

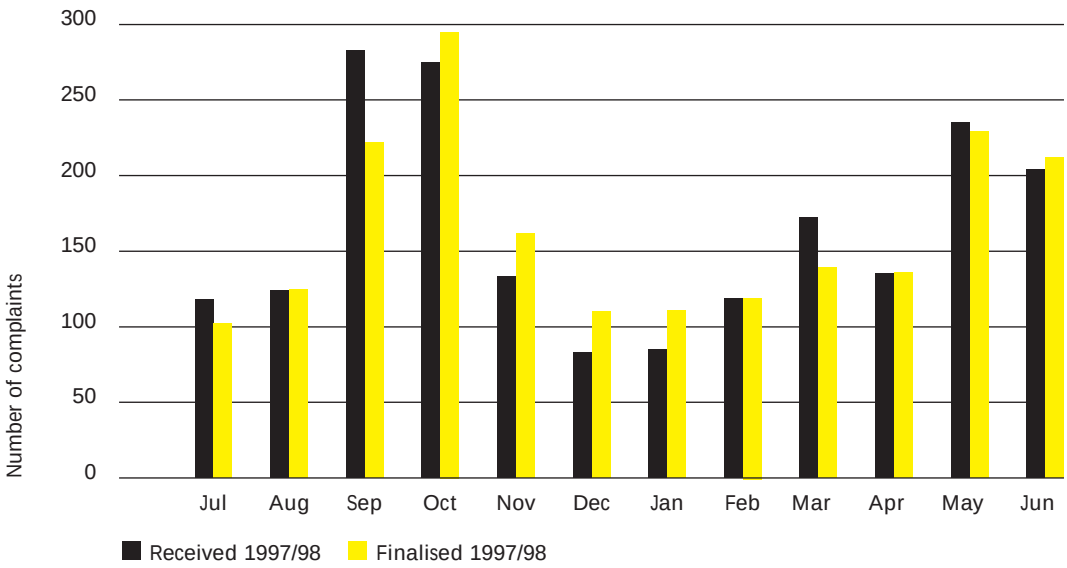
Grievance

Timeframe
Usually within 24 hrs
Actions
Complainant provided with an explanation or information to resolve matter, or there is no avenue for the Ombudsman to take up the matter
Outcomes
Detailed information

Dispute

Timeframe
Depends on the nature and complexity of matter and responses from health fund and provider
Actions
PHIO contacts health fund or provider to obtain report, mediate dispute or investigate matter
Outcomes
Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal Recommendation by Ombudsman

Figure 4: Complaints received and finalised



Issues

The largest single issue complained about was recorded as 'cost' (slightly above 23% compared with 11% in 1996/97). Overwhelmingly, cost complaints concern the cost of health fund premiums, although some cost related complaints were about the differential charging of privately insured patients by some health providers and alleged lack of informed financial consent to health providers' fees and charges.

Complaints about benefits accounted for slightly below 23% of all complaint issues (compared with 33% in the previous year), followed by complaints about waiting periods, including complaints about application of the pre-existing ailment rule (12% compared with 16% in the previous year). Complaints about information accounted for 11% of all complaints received (12% previously) and these concerned issues such as misleading information, inadequate information and the lack of appropriate information.

Complaints about membership accounted for 11% of complaints received (the same as the previous year) and included concerns about the cancellation or suspension of a health fund membership.

The remaining 20% of complaints (up from 17% in 1996/97) dealt with a wide variety of other specific issues such as health fund rule changes, the quality of customer service, premium payment difficulties, private patient elections in public hospitals, the Private Health Insurance Incentives Scheme, health fund and hospital contracting arrangements and other complaints not elsewhere counted (NEC).

Graphs of this information are provided in Figures 5-11.

Complaints by State/Territory

Most complaints were received from NSW (32% compared with 34% previously), with 20% from Victoria (up from 16% in the previous year), 29% from Queensland (up dramatically from 13% in 1996/97).

7% of complaints were received from South Australia (9% previously). Complaints from Western Australia fell from 7% to 4% and the proportion received from Tasmania and the Northern Territory were similar to the previous year at 4% and 1% respectively. Details are provided in Figure 12.

Time taken to resolve complaints

Of the complaints finalised during the year, most complaints were resolved within one week (60% up from 52% in the previous year). A further 18% of complaints were resolved within 1 month (31 days), with no change from the previous year, and another 10% within 2 months (62 days). There was a small increase in the proportion of complaints requiring longer than 2 months to resolve (up from 9% to 12%). Information about all complaints received in the reporting year is provided in Figure 13.

Many health funds respond to informal telephone requests for information by Ombudsman staff and this explains why many complaints are resolved in less than one week.

Who was complained about

Most complaints were made about health funds (1889), followed by hospitals (59) and doctors and dentists (64). Because some complaints concern a health fund as well as a hospital, doctor or dentist, the total number of organisations or people being complained about (2012) adds up to more than the total number of complaints (1966).

The number of complaints received each month against health funds, hospitals and doctors is provided at Figure 14. The information has been further broken up into problems, grievances and disputes that make up the three-tiered complaint resolution process.

Complaints about health funds

A summary of problems, grievances and disputes regarding health funds compared with a health fund's market share is provided in Figure 15. Of the grievances, problems and disputes about health funds, MBF attracted the single highest number (39% of all complaints about health funds, compared with 16% in 1996/97), followed by Medibank Private (down from 29% to 23%), National Mutual Health Insurance - including HBA, Mutual Community and Territory Mutual - (steady at 9%), Government Employees Health Fund Limited/Australian Health Management (down from 10% to 6%), HCF (also down, from 9% to 5%) and NIB (down from 7% to 4%). Australian Unity, Manchester Unity and HBF of WA were the subject of 2% of all problems, grievances and disputes. All other funds received less than 1% of the total number of complaints received or fewer than 20 complaints each.

Figure 5: Complaints received by issue

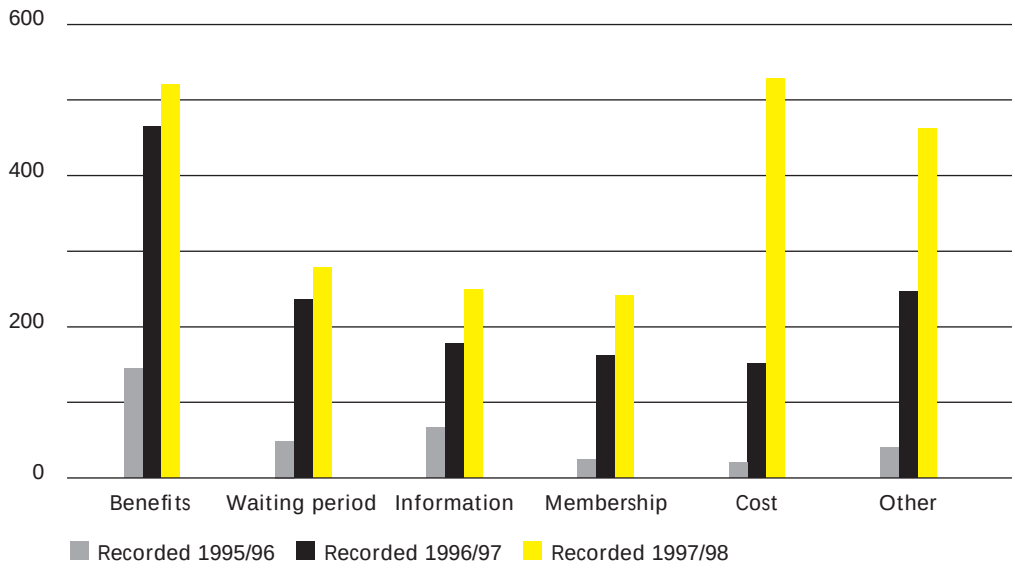
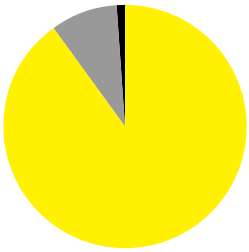
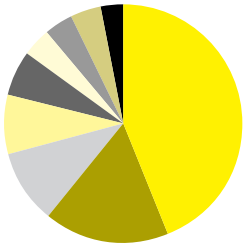


Figure 6: Cost complaints



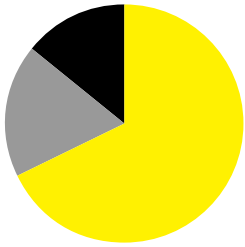
Premiums	90%
Fees & Informed Financial Consent	9%
Dual Charging	1%

Figure 7: Benefit complaints



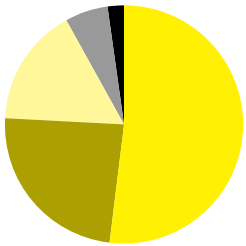
Extent of Cover	44%
Amount	17%
'Gap' payments	10%
Excess	8%
Other	6%
Limit Reached	4%
Compensation	4%
Delay in payment	4%
Out-of-pocket	3%

Figure 8: Waiting period complaints



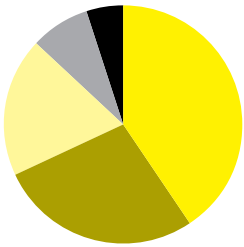
Pre-existing Ailment	68%
Obstetric	18%
General & Benefit Limitation Periods	14%

Figure 9: Information complaints



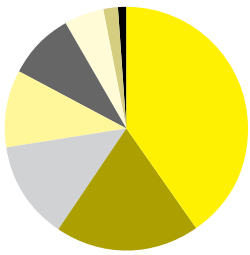
Oral	52%
Printed	24%
Lack of Notification	16%
Written	6%
Radio & Television	2%

Figure 10: Membership complaints



Cancellation & Suspension	41%
Transfer / Continuity	28%
Arrears	19%
Young People	7%
Not the Contributor	5%

Figure 11: Other complaints



Fund Rule Change	41%
Service issues	19%
Incentives	13%
Premium Payment Problems	10%
Complaint NEC	9%
Contracts	5%
Private Patient Election	2%
Acute Care Certificates	1%

Care should be taken in interpreting the number of complaints received against each fund. The number of complaints will depend on many things including positive aspects, such as how well a fund advertises and promotes the services of the Ombudsman to its members, as well as negative factors associated with a fund's practices.

Complaints about hospitals

Complaints about hospitals usually concern unexpected out of pocket expenses due to incomplete or misleading advice provided around the time of admission or as a result of confusion by the health fund member about the extent of their health insurance cover. As the number of complaints about hospitals is small, no information is presented here about complaints received in relation to their geographic distribution, hospital speciality or ownership.

One large hospital was the subject of 3 complaints, while 6 hospitals were the subject of 2 complaints each. All remaining hospitals complained about were the subject of one complaint each.

Complaints about doctors and dentists

Most complaints about doctors concern the lack of informed financial consent. As the number of complaints about doctors is small, no information is provided here about complaints received in relation to their geographic distribution or medical speciality.

Figure 12: Complaints by state/territory

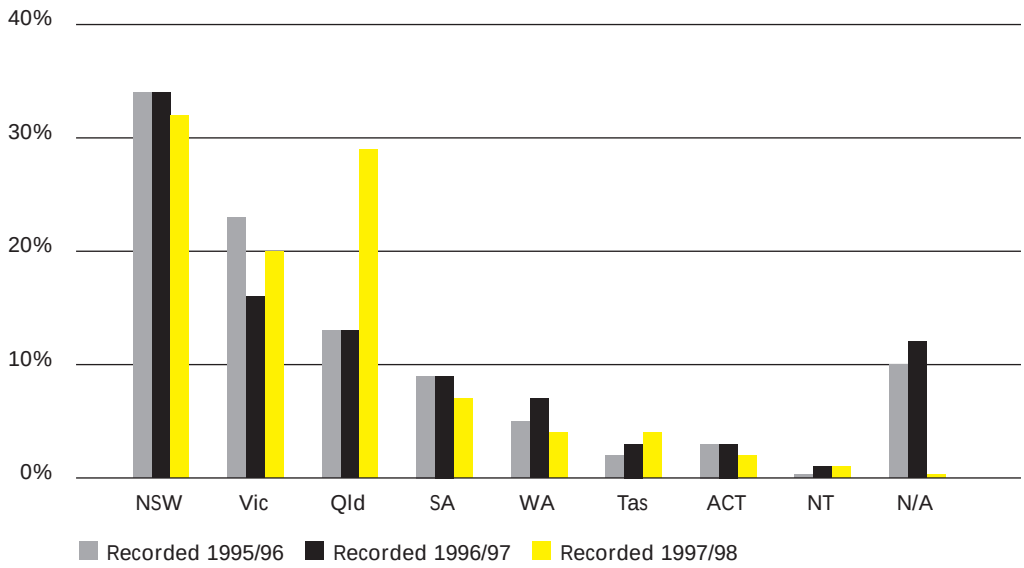
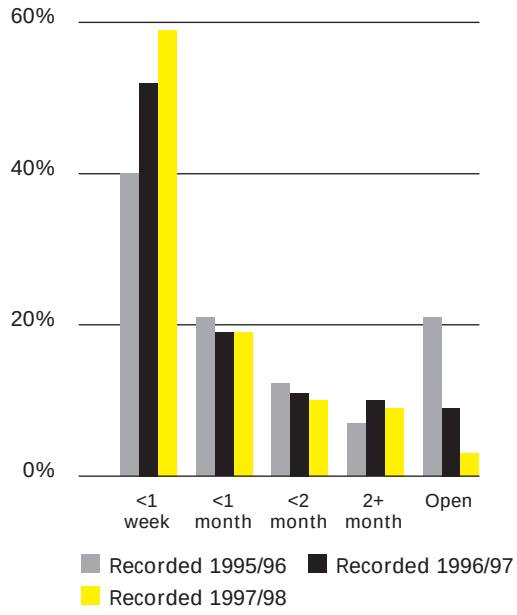


Figure 13: Time to finalise complaints



Resolving complaints

Most complaints are resolved by providing an independent and impartial explanation of the health fund member's problem, or by providing additional information (54% in 1997/98, up from 42% in 1996/97). Payments made by health funds or accounts written off by hospitals resolved 11% of complaints finalised during the year (down from 12% previously). Payments by health funds may have resulted from a health fund agreeing with the Ombudsman that the fund member was entitled to payment of a benefit under the terms of the member's level of private health insurance cover, or the payment being made on an ex gratia basis to a loyal member.

Figure 14: Complaints by object by month

Month 1996-97	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Type of Complaint													
Fund													
Problem	26	19	58	92	32	16	13	17	13	18	30	28	362
Grievance	29	39	124	96	37	13	22	42	53	37	115	105	712
Dispute	57	60	96	85	61	49	43	53	95	68	85	63	815
													1889
Hospital													
Problem	2	0	1	0	0	1	0	0	0	1	0	1	6
Grievance	2	2	4	0	0	0	1	1	4	0	1	1	16
Dispute	6	1	5	4	2	1	2	1	5	4	2	4	37
													59
Practitioner													
Problem	0	2	2	0	3	1	1	4	0	2	2	3	20
Grievance	2	0	2	0	0	0	1	3	10	7	5	2	32
Dispute	0	2	0	1	0	4	1	1	1	0	2	0	12
													64
Total	**124**	**125**	**292**	**278**	**135**	**85**	**84**	**122**	**181**	**137**	**242**	**207**	**2012**

Figure 15: Complaints (Problems, Grievances and Disputes) by Health Fund

Name of fund	No. of complaints	% of total	Health Fund market share(1)
ACA Health Benefits Fund	1	0.1	0.1
AMA Health Fund Ltd	1	0.1	0.1
Army Health Benefits Society	12	0.6	1.5
Australian Unity Health Limited	42	2.2	2.9
CBHS Friendly Society	11	0.6	1.0
CDH Benefits Fund (3)	2	0.1	0.0
CPS Health Benefits Society	2	0.1	0.1
CUA Members Benefits Friendly Society	1	0.1	0.4
Geelong Medical & Hospital Benefits Association Ltd	2	0.1	1.1
Goldfields Medical Fund Inc	3	0.2	0.2
Government Employees Health Fund Ltd	113	6.0	3.0
Grand United Corporate Health Ltd	5	0.3	0.4
Grand United Friendly Society	9	0.5	0.4
Health Care Insurance Ltd	4	0.2	0.1
Health Insurance Fund of WA Inc	2	0.1	0.4
Health-Partners	2	0.1	0.6
Healthguard Health Benefits Fund Ltd	1	0.1	0.1
Hospital Benefits Fund of WA Inc	36	1.9	8.0
Hospitals Contribution Fund of Australia Ltd	98	5.2	8.7
IOOF of Victoria	15	0.8	0.2
IOR Australia Pty Ltd	12	0.6	0.7
Latrobe Health Services	9	0.5	0.4
Lysaght Hospital and Medical Club	0	-	0.2
Manchester Unity Friendly Society in NSW	39	2.1	0.9
Medibank Private	437	23.1	27.0
Medical Benefits Fund of Australia Pty Ltd	732	38.8	18.5
Mildura District Hospital Fund	1	0.1	0.3
MIM Employees Health Society	2	0.1	0.3
National Mutual Health Insurance Pty Ltd	164	8.7	10.6
Naval Health Benefits Society	9	0.5	0.4
NIB Health Funds Ltd	66	3.5	5.0
NSW Teachers Federation Health Society	8	0.4	2.0
Phoenix Welfare Association Ltd	0	-	0.2
Queensland Teachers Union Health Society	7	0.4	0.6
Railway & Transport Employees Friendly Society	8	0.4	0.4
Reserve Bank Health Society	3	0.2	0.1
SA Police Employees Health Fund Inc	1	0.1	0.2
SGIO Health Pty Ltd	6	0.3	1.3
St Luke's Medical & Hospital Benefits Association	7	0.4	0.5
Transition Benefits Fund Pty Ltd	1	0.1	0.4
Transport Friendly Society	2	0.1	0.1
United Ancient Order of Druids Victoria	4	0.2	0.1
United Ancient Order of Druids Grand Lodge NSW (3)	0	-	0.0
Western District Health Fund Ltd	7	0.4	0.3
Yallourn Medical & Hospital Society	1	0.1	0.2
N/A (See Note 2)	1	0.1	0.0
Total for Registered Funds	**1889**	**100.0**	**100.0**

1. Proportion of people covered by health fund as at 30 June 1997 reported in the PHIAC Annual Report.
2. One hospital lodged a complaint about the practices of many unnamed health funds.
3. Funds with less than 0.1% of market share.

An additional 10% (no change) of complaints were resolved by taking other remedial action, such as reinstating a membership or allowing the back payment of contributions where a membership had lapsed. In 20% of complaints (up from 18% previously), complainants were referred directly back to the health fund as the complainant had not fully explored their problem with the health fund, hospital, doctor or dentist. In these circumstances, the Ombudsman was able to suggest ways for the complainant to pursue the matter with the health fund, hospital or health provider. The reporting on outcomes in this report differs from previous years. This report contains information about all complaints finalised during the year - previous reports were based on the outcomes for complaints received during the year.

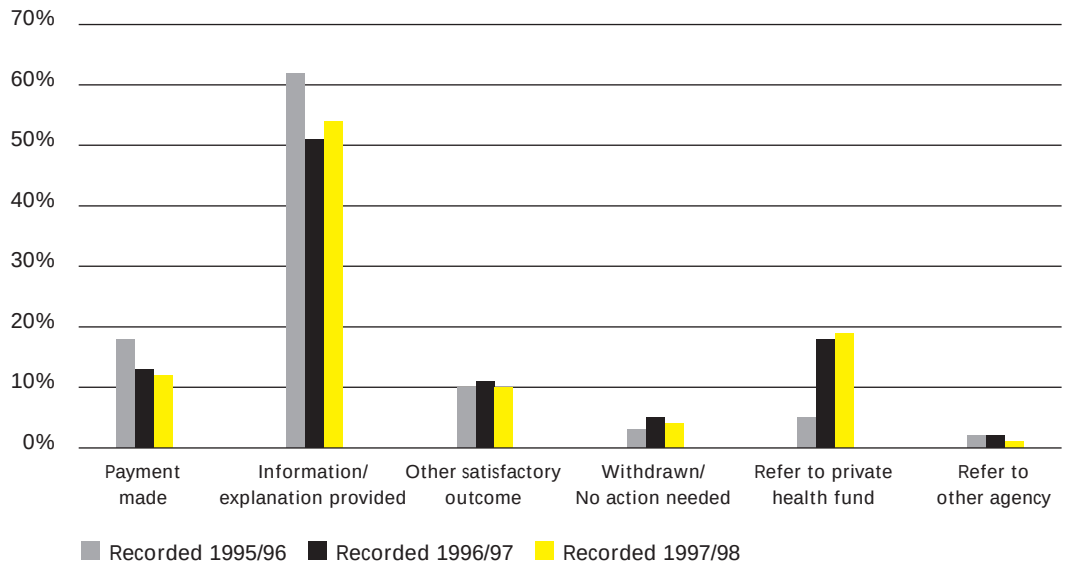
The Ombudsman referred three complaints to the Australian Competition and Consumer Commissioner under section 82ZSBA of the National Health Act 1953. There was one formal referral as provided for by section 82ZSC of the Act (to a health complaints agency in another State).

Information about the resolution of complaints is provided in Figure 16.

Type of complainant

The law provides that health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf can make complaints. Overwhelmingly, complaints were made by health fund members (99.25%), followed by hospitals/day hospitals (0.25%), doctors (0.25%) and Health Funds (0.25%).

Figure 16: Complaint outcome



How complaints were made

Most complaints were made by telephone (90% up from 87% in the previous year) and letter (8% down from 10% in the previous year). The remaining complaints were made by fax, personal visit or by Parliamentary Representation.

Investigations into health fund practices and procedures

There were no investigations conducted under section 82ZT of the National Health Act 1953 during the reporting period.

There were no investigations conducted under s.82ZTA of the National Health Act.

Inquiries

Any approach to the Ombudsman's office that does not meet the statutory definition of a complaint contained in the National Health Act 1953 is recorded as an inquiry.

Examples of inquiries include calls and letters seeking general information about private health insurance, requests for brochures, explanations about waiting periods and referring callers to other, more appropriate agencies.

Issues

Inquiries about specific health insurance issues or problems accounted for 42% of all inquiries (this compares with 50% in 1996/97). Questions about the payment of benefits accounted for 10%, and included questions about 'gap' payments, ways in which health funds calculate excesses, and delays in health funds making payments. Questions about the cost of services accounted for an additional 10% of inquiries and mainly concerned the cost of health insurance premiums. Other specific inquiries concerned a wide variety of issues such as the application of waiting periods, suspension or cancellation of a contributor's health fund membership or the service received from a health fund.

Half of all inquiries received by the Ombudsman were about general health insurance issues - ranging from requests for advice about the merits of a specific health fund to questions from consumers wanting to change funds. In response to questions about the merits of joining a specific fund, the Ombudsman does not recommend specific funds but provides the booklet "Insure? Not Sure?" which explains some of the health insurance terminology which consumers often find difficult to understand. This booklet also contains a list of all private health insurance funds in Australia and their telephone numbers. The Ombudsman also provides a brochure entitled "The Ten Golden Rules of Private Health Insurance". Other general health insurance inquiries were dealt with by providing telephone advice and a copy of the "Private Patients' Hospital Charter".

Some callers contacted the Ombudsman's office seeking general health and insurance information outside the Ombudsman's jurisdiction. Information was sought about Medicare, travel insurance and general insurance issues and complaints about hospital services. The Ombudsman refers these callers to an appropriate agency. This information is shown in Figure 17.

Response to inquiries

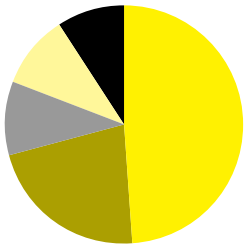
Most inquiries were dealt with by providing information, an explanation or brochure (75% compared with 74% in the previous year). Some inquiries received by the Ombudsman were more appropriately dealt with by another organisation and were referred elsewhere (11% compared with 12% in the previous year). Referral agencies included the General Insurance Inquiries and Complaints Service or one of the State or Territory health complaints' agencies. 9% of callers were referred to a health fund. The remaining callers contacted the Ombudsman to advise about difficulties with their health fund, but did not want the Ombudsman to take further action or lodge a formal complaint. This information is shown at Figure 18.

Nearly all inquiries were dealt with on the day they were received.

Inquiries by State/Territory

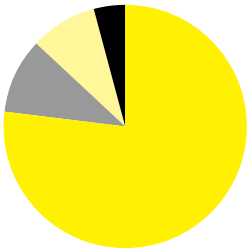
Most inquiries were received from NSW (25%, up from 22%) followed by Queensland (21% up from 10%) and Victoria (13% up from 11%). There was a fall in the proportion of callers from Western Australia (down from 7% to 5%) and South Australia (at 6%). In 27% of inquiries the geographic location of the caller was not recorded, down from 40% in the previous year. See Figure 19.

Figure 17: Inquiry issues



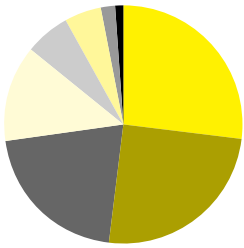
Benefits	10%
Cost	10%
General Inquiry	9%
Health Insurance Inquiry	49%
Other specific Inquiry	22%

Figure 18: Inquiry outcomes



Info & explanation provided	77%
Referral elsewhere	10%
Referred to health fund	9%
Other	4%

Figure 19: Inquiries by state and territory



NSW	25%
Vic	13%
Qld	21%
SA	6%
WA	5%
Tas	2%
NT	1%
Not recorded	27%

Complaint Issues

Introduction

Because complaints to the Ombudsman must be connected to a health insurance arrangement, unsurprisingly, the great majority of them are about health insurance funds. Matters involving hospitals and doctors are invariably about fees and accounts that fund members have been asked to pay. Complaints about the service that doctors or hospitals provide to health fund members are referred to the various state-based health complaints bodies.

Premium increases and other irritants

In the past year, a common cause of complaint was the relatively large increase in many health fund premiums. Around half these complaints were triggered by an extra element, such as: the lack of advance warning; the cutting of benefits at the same time the premium was increased; or the removal of discounts for payment in advance at the same time as the notification about the premium increase.

One fund gave two weeks notice to its members while changing all its hospital products and product names, introducing co-payments for many members, and providing no written information about premium comparisons for the product alternatives that were being introduced at the time of notification. This fund received many complaints about its premium increase. At the same time, a fund of a similar size wrote to its members advising a larger premium increase, but making no changes to its product range. The second fund received far fewer complaints about its premium increase.

The introduction of co-payments particularly annoyed some members. As one said to the Ombudsman's office: 'If I'd have wanted a co-payment or excess I would have opted for one. I didn't. But now the fund has said to me that I'm going to have one.' Some members complained that they did not receive the fund's advice until after the change had come into effect, and that they were unable to transfer to another fund without being penalised. Other members complained that they received their advice only a week or two in advance, but that the time was insufficient to review the changes and decide what was on offer at the fund.

One fund advised members about alternatives to their changed level of cover, but provided no details. This resulted in the fund's call centre being overwhelmed as members sought details of the changes and the alternatives that might have been available.

Another fund that had previously provided considerable advance warning of premium increases recently advised members of a premium increase with very little warning. This annoyed members who contacted the Ombudsman, many of whom said that they believed their business was being taken for granted by the fund.

There is little the Ombudsman can do to assist consumers who are aggrieved by premium increases. It is well known that the reasons for the increases are mostly outside the control of health funds. Regarding service issues, all the Ombudsman can do is exhort health funds to improve their services to members. It should also be noted that the current regulatory arrangements can sometimes inhibit health funds' ability to give adequate advance notice of premium increases.

Adequate notice of policy changes

While many complaints about inadequate notice are about the timing of notices, others relate to the way the notice was given. Complaints about lack of adequate notice can be grounds for remedial action.

Case example

Ms A had been a member of her health fund for ten years. When she went into her local branch to make a claim, she took the opportunity to check her level of cover for obstetrics, as she was planning to start a family. The customer service officer informed her that her level of cover provided no benefits for obstetrics at all.

Ms A was extremely surprised to hear this, because when she originally joined the fund, she had made sure obstetrics was included in her cover, as she eventually intended to start a family.

The customer service officer explained that obstetrics cover had been removed from her level of cover some eighteen months previously and that all members had been advised by letter of the change. Ms A had no recollection of receiving such a letter. She upgraded her cover on the spot to include obstetrics. She also asked the fund to send her a copy of the letter they had sent out to members concerning the removal of obstetrics from her original cover.

When she received the copy of the fund's letter, Ms A soon realised why she had no recollection of receiving any information about the change to her cover. The letter was presented as an announcement of good news, with detailed descriptions of positive changes to her cover such as higher benefits for certain items. On page two of the letter there was a short statement to the effect that some levels of cover had been 'rationalised' or had changed benefit entitlements and referred the reader to an attached brochure for details.

The removal of obstetrics benefits from Ms A's level of cover was not mentioned until the bottom of page three of this brochure.

Ms A believed that this letter did not give her adequate notice of the changes to her cover. Not surprisingly, she had missed the bad news about the removal of obstetrics benefits, because it was so well hidden. If she had seen the notification, she would have upgraded to a higher level of cover immediately, because she was planning to start a family.

She wrote to the fund and requested that they waive the waiting period for obstetrics benefits because of their inadequate notice of the changes to her cover. The fund wrote back insisting that she would have to serve the waiting period.

The Ombudsman believed that Ms A should not be disadvantaged by the fund's inadequate notice of the removal of obstetrics benefits from her cover. The Ombudsman also believed that Ms A's case was strengthened by the fact that she was a long serving member of the health fund and had shown good faith by upgrading her cover as soon as she realised she was not covered for obstetrics, prior to conceiving her baby. She had also offered to back pay her contributions at the higher level.

The Ombudsman approached Ms A's health fund with these arguments. It accepted them and agreed to waive the waiting period and cover Ms A for her confinement, if she back paid her contributions at the higher level of cover to the date when obstetrics cover was removed from her previous level of cover. Ms A was happy with this outcome.

Contract of insurance

Some health fund members who approach the Ombudsman are surprised to learn that they have not got a fixed term contract and that their health fund can increase the cost of premiums and change any other conditions at any time. When people contract with a health fund for health insurance, they agree to be bound by the 'rules' of the fund. Fund 'rules' invariably give the fund the right to change any conditions under which it offers its health insurance products unilaterally, at any time.

However, most people who pay for their health insurance six monthly or yearly in advance expect the price and their entitlements to be fixed for that period. They believe they have entered into a contract with their health fund for the duration of the paid period.

Unfortunately this is not the case with some funds. With these health funds, if the price of the product goes up during the period, the fund will seek to increase the premium rate by adjusting the payment date to reflect the increase. Similarly, benefits can be reduced. A few health funds have even restructured their products and unilaterally changed benefits for major items, effective during periods paid for.

Under trade practices law, health funds are not entitled to increase the cost and restructure benefits like this, during paid up periods, unless they have given their members very clear warnings about the possibility of changes during the period, at the time of payment. In all cases where warnings were not clear, the Ombudsman has recommended that the member's premium and entitlements remain at the old level for the duration of the period paid for.

Confusion about entitlement to hospital benefits

Confusion and uncertainty about the level of cover for hospital treatment continues to be an issue for some members. It is crucial that health fund members confirm their level of cover before they go to hospital but even when they do, they can get caught with unexpected bills. The situation has become very complex. These days there are several factors to take into account before the level of a member's cover for treatment as a private patient is clear.

Factors to consider

Most members need to ask whether their health fund has a contract (known as a purchaser - provider agreement) with their chosen hospital and if this is the case, what that contract covers by way of benefits. If there is no agreement between the two organisations relating to the member's treatment, the benefits payable are unlikely to cover all of the hospital's accommodation costs and there will probably be other out of pocket costs. Where there is a contract, it may not provide for the payment of benefits for everything.

The date the contract expires can also be critical. In a few cases, the contract has expired just before the member's admission, leaving the member exposed to a larger bill than expected.

Second, new members, ones who have upgraded their cover in the year before treatment and even members who have recently transferred from one fund to another need to consider whether waiting periods apply. In particular, the waiting period for pre-existing ailments may apply to them. (Pre-existing ailments are discussed at the end of this chapter on page 35).

Further, benefit limitation periods may apply. These are waiting periods under another name. They have the effect of imposing additional waiting periods, beyond the standard ones, for entitlement to the full amount of benefits in private hospitals for specified treatments (eg. for obstetrics, mental illness, plastic surgery and IVF).

In addition, some members have to remember that their policy includes an excess and that this means that they will have to pay the first, say, $500 of the hospital's bill or whatever the agreed amount is.

A final and crucial factor for some is to be sure that they have a policy that covers them for the treatment they need. A few members have discovered after the event that they hold a policy which wholly or partly excludes benefits for certain specified treatments (eg. obstetrics, cardiac treatment, orthopaedic surgery or treatment for mental illness).

Despite their best efforts, problems have occurred for members who have contacted their health funds and the hospitals of their choice, before admission, to check that the fund will pay benefits to cover planned treatment. Even after doing all that they can to make sure, some people have been unpleasantly surprised to find they were not covered when they were discharged from hospital.

These situations are extremely difficult to resolve. It is usually unclear whether someone in the health fund gave out wrong information, whether someone in the hospital made a mistake when examining the level of cover, whether the member misunderstood the advice given or whether a combination of all of the above occurred.

Case example

When Mr B turned 18, he took out single cover with the health fund his father had always had the family covered by. His parents had separated but Mr B had remained on his father's policy. When he joined as a single member, he thought he had continuity of cover, not knowing that his father's hospital policy had lapsed about a year before.

Six months after he joined the fund, Mr B went to see his doctor about an ear infection that was the latest in a series of ear infections. His doctor told him that he had a problem with his ear canal and he needed an operation to fix it.

Mr B went to the hospital to book his operation immediately. The hospital advised him to check his health insurance cover with his health fund before admission.

On the same day Mr B went to his health fund's branch office to check that he was covered for the operation. There is no agreement about what the staff said, but Mr B came away believing that he was covered for the operation. He did not know that his ear condition would be classified as a pre-existing ailment under the fund rules and that therefore there was a waiting period of a year for his operation. In any event, he still believed that he had continuity of cover from his father's family policy.

When Mr B was admitted to the hospital it did not check with the health fund to verify his cover. It accepted his word that his health fund would pay benefits for his operation and said that he would have nothing to pay. He had the operation and some time after, he received a bill for the total amount.

His health fund refused to pay on the ground that the operation was for a pre-existing ailment and he had not served the 12 month waiting period for pre-existing ailments.

The Ombudsman recommended that the bill be split equally between Mr B, the health fund and the hospital. The hospital and Mr B agreed to do this but the health fund has so far refused to pay anything.

Who bears the responsibility for hospital accounts?

It is common practice for hospitals to ascertain a patient's health insurance status at the time the person makes a booking. People often assume that the hospital will make sure that their cover is adequate. Many do. At the same time a lot of health funds encourage their members to contact their health fund to check, before committing themselves to expensive treatment.

The National Health Act requires that contracts between hospitals and health funds for the provision of services to health fund members (purchaser-provider agreements) contain a clause obliging contracting hospitals to advise fund members of their out of pocket costs before treatment. Strictly speaking, this does not mean that hospitals are obliged to check their patients' levels of health insurance cover with health funds, although many do so. If a hospital fails to check or makes a mistake about a patient's cover, the legislative provision makes little difference to the member, who is often asked to pay any outstanding accounts.

Unfortunately, cases arise where there has been a breakdown in communication between the hospital and health fund about a member's level of cover and as a result, the hospital has given the member the wrong information. People tend to rely on the advice given by the hospital about their cover because they assume superior knowledge on the part of the hospital staff. Mistakes can have serious financial implications.

Who should bear the responsibility of ensuring that a health fund member has adequate cover for treatment? As a general principle, it is reasonable to expect people to ensure that they can pay the costs of treatment before they are hospitalised as private patients. However, many fund members do not have enough information to do that.

To be certain that exclusions, waiting periods and extended limitation periods do not apply, health fund members need to know details of proposed treatment. The person needs to know the precise Medicare item number for the procedure in some instances. The doctors and hospital involved will be best placed to provide these details. Even then, in a few cases, it is not possible for a health fund to determine conclusively whether an ailment is pre-existing until after surgery has been performed.

Furthermore, no member will ever be in a position to be absolutely certain about the contractual arrangements between the hospital and health fund at any given time, without checking with the fund.

The problem in many of the cases concerning confusion about hospital benefits that have come before the Ombudsman is this: none of the parties involved had enough information on their own to determine conclusively whether the member's health insurance policy would provide adequate benefits for the treatment. The hospital, the health fund and the patient are usually dependent on each other, and sometimes the doctors involved, for relevant details. If one fails to ask the right question of another, there is a likelihood that the wrong advice about private health insurance cover will be given.

Naturally, the problems members can face are exacerbated when they are admitted as private patients in emergency situations, particularly after hours.

Complexity of health insurance is the essential cause of the difficulties outlined above. Most hospitals and health funds have now recognised the value of instigating systems which minimise the potential for error. A few hospitals have advised that they will upgrade their systems following the Ombudsman's investigation of complaints.

Misleading oral information

Most complaints about misleading information involve a conversation between the member and their health fund.

Disputes about allegedly misleading oral advice are notoriously difficult to resolve where there is no concrete, objective evidence to support the allegation. Unfortunately, a significant number of complaints to the Ombudsman involve this element and they are often not resolved to the complainant's satisfaction.

The Ombudsman has no power to interview hospital or health fund staff about disputed conversations fund members say they have had over the telephone or at a branch office. Sometimes this makes little difference because by the time the complaint is made, it would be unreasonable to expect the staff member to recall it.

In disputes about oral advice, the advice has to be evaluated and judged in the context of the entire conversation. The quality of answers given depends on the questions asked. Sometimes, the person seeking the advice does not provide the full picture and so the advice given can be inappropriate or incomplete, through no fault of the adviser. At other times, the person seeking the advice has a misconception to begin with and this can lead to a misinterpretation of correct information. Also, it is always possible that the person giving the advice made a mistake or lacked the appropriate knowledge and consequently provided wrong information or advice. In the majority of disputes about oral advice, it is impossible to get a satisfactory account of the entire conversation.

Reaction of health funds

Health funds vary in their approach to allegations of misleading advice. Fortunately, some keep comprehensive computer records of members' contacts and these records are often helpful in resolving the problem, occasionally in the member's favour. Unfortunately, one large fund that has a policy of recording only unusual contacts has a rather unhelpful attitude to its members' allegations of misleading advice. Its standard response is that its staff would not say what-ever it is alleged that they said. Yet this fund has ignored requests for information about why it can be so confident, for example by providing details of its staff training programs and systems for ensuring accurate advice is given.

This fund's formal response to a formal request for information was that it was disappointed that it was called upon to provide any evidence. It felt that unless the complainant could provide concrete proof to back up her version of the conversation, its corporate assurances should satisfy both her and the Ombudsman that she was wrong.

A disturbing number of complaints about the application of the pre-existing ailment rule involve allegations of misleading oral advice and people who joined during membership drives offering to waive waiting periods. A common allegation is that staff at the health fund led them to believe that the waiting period for pre-existing ailments would not apply.

These complainants say their fund told them that the waiting period would not apply if their treating doctor wrote a letter to the fund. This advice would be only half true. In the letter, the treating doctor would need to give enough information to satisfy the fund that the patient's ailment did not fit the definition of a pre-existing ailment at the time the patient joined the fund, upgraded their cover or transferred to the fund.

Case example

Mr C was advised by his doctor that he needed an angiogram. He was not sure about his health insurance cover and asked the doctor's secretary to contact his fund, with his membership number and details of the procedure, to confirm if he was covered. The secretary telephoned the fund and was advised that Mr C was covered. Mr C was admitted to hospital for the angiogram.

The angiogram showed a need for angioplasty. Mr C and the doctor's secretary assumed that the member was covered for this because the angiogram was covered, and the doctor's secretary again booked him into hospital.

Some months after the angioplasty, the hospital sent Mr C an account because his fund refused to pay benefits. The fund refused to pay because Mr C held a policy that excluded cardiac treatment. About the time when the Ombudsman began to investigate the matter, the fund realised it had mistakenly paid for the first operation and asked the hospital for repayment. Mr C was then sent another account from the hospital for the first procedure.

After considerable contact between the Ombudsman's office, the hospital and the health fund, the fund paid both accounts after the hospital wrote off a small amount. The involvement of the doctor's rooms and the fact that the secretary had made notes of her dealings with the fund was the crucial factor in the outcome. The fund's mistaken payment for the first hospitalisation appeared to support the complainant's account of the incident.

Hopefully, since the publication of the Guide to the Trade Practices Act for the promotion of private health insurance in April 1998, one element of some of the complaints about oral advice - misleading advertising - will no longer be present.

Mary Perrett, Ombudsman and **Allan Fels**, Chairman, ACCC at the launch of the 'Guide to the Trade Practices Act for the promotion of private health insurance'.

Guide to the Trade Practices Act for the promotion of private health insurance

The Private Health Insurance Ombudsman and the Australian Competition and Consumer Commission produced the Guide as a joint effort. It was released in April 1998 and is intended to address the issues underlying complaints made to both the Ombudsman and the ACCC about claims made by some funds in their promotional material.

The Guide was developed in consultation with, and the support of, the private health insurance industry and consumer organisations.

The main object of the Guide is to help the industry develop strategies which will improve compliance with the Trade Practices Act, reduce the need for regulatory intervention and assist consumers.

Misleading advertising and promotions

There were several incidents which gave rise to the need for the publication of the Guide to the Trade Practices Act in the past two years or so. The main concern during the reporting period was a plethora of advertising campaigns and promotions offering 'immediate cover' and 'waiver of waiting periods'. These activities had the potential to cause detriment to a significant number of people because the important waiting periods were rarely waived.

One complaint arising from this type of campaign is illustrative.

Case example

Mrs D noticed that a health fund was offering to waive the 2 month waiting period for members joining within the month. She needed some fillings to her teeth so she phoned the fund to check if the offer included this.

The fund staff member confirmed that the 2 month waiting period applying to dental treatment was waived and that the offer included dental fillings. Mrs D joined the health fund immediately.

Mrs D went to the dentist and lodged claims for fillings within the next 2 months, worth $500. The fund rejected the claims on the basis that the dental caries were old and so the 12 months waiting period for pre-existing ailments applied.

When the Ombudsman contacted the fund it said that the offer to waive waiting periods was discretionary. What the fund intended to waive was dental work of a lower amount, say $100.

After some discussion, the fund agreed to pay Mrs D the full amount.

This case also illustrates that people do not appreciate that the pre-existing ailment rule can be used to override any other waiting period. The rule does not merely apply to hospital treatment in some cases - application seems to be discretionary. (Pre-existing ailments are discussed at the end of this chapter.)

It is hard to understand why health funds would want to market their products by offering to waive waiting periods and then complain about hit and run members.
It seems to be inviting consumers to join just to get cover for specific treatment. For those who intend to stay, but are caught by the waiting periods which are not waived, they are turned off health insurance by what they see as trickery.

Problems with promotional material should be fewer now that the Guide to the Trade Practices Act for the promotion of private health insurance has been released.

Private Patient Election in public hospitals

Some health fund members have approached the Ombudsman for help because they believe they have been tricked by public hospitals into incurring unreasonable costs just because they belong to a health fund.

A doctor also lodged a complaint about a health fund. He had treated three patients in a public hospital as private patients and then the health fund had refused to pay the benefits owing to him, the difference between the Medicare benefit payable and the Medicare Benefits Schedule fee. The problem was that the hospital had classified the patients as private when they were admitted as emergencies and then changed the classification when it realised that the patients did not make an informed choice about their status.

Many of these complaints have involved emergency admissions. The crux of the problem is that patients are asked if they have private health insurance rather than being asked if they want to be treated as a private patient. People who tell some public hospitals they have private health insurance are then routinely classified as private patients. Some of these people are getting exactly the same treatment as public patients in the hospitals. They do not have an opportunity to nominate a doctor of their choice and a private room is not offered. The only difference is that these private patients have to pay, sometimes large amounts, towards the treatment they would have got for free if they had been classified as public patients. Bills incurred include: excesses payable under some policies of health insurance, specialist doctors' (includes pathology) fees for amounts charged above the Medicare Benefits Schedule fee and pharmacy items costing more than the Pharmaceutical Benefits Scheme fee.

Case example

Mr E was visiting Sydney on holidays. His daughter became ill and Mr E took her to a public hospital where staff decided to keep her in overnight. Mr E says that the staff asked whether he had private health insurance, and when he replied yes, they said that he had to elect for his daughter to be treated privately or the treatment couldn't continue.

Mr E called the Ombudsman's office the next day to clarify the information that the hospital had given him. Staff advised Mr E that private health insurance provided a choice of being treated as a public or private patient, but that public hospitals were unable to insist that his daughter be treated as a private patient.

After discussions with the NSW Health Care Complaints Commission, the Patient Support Office and the Ombudsman, the hospital wrote to Mr E advising him that there had clearly been a misunderstanding at the time of his daughter's admission. The hospital said that it believed its admissions procedures had been followed, but that to end the matter, his account would be written off.

It seems clear that there is a problem about classification of patients who are emergency admissions. Hospital staff are not always offering patients an informed choice between admission as a public patient and free treatment on the one hand and admission as a private patient on the other hand. Nor do they always follow the procedures agreed to between the State and Federal Governments under the Medicare Agreements of 1993. These procedures are directed at ensuring people make an informed choice.

Besides public hospitals needing to tighten their procedures, health funds should educate their members about their rights to be treated in public hospitals as public patients. This should include the desirability of being a public patient where there is no choice of doctor, no private room and no arrangements in place to ensure health fund members do not pay extra for specialist medical treatment while in hospital.

Electing to be a private patient in a public hospital can have many financial consequences. One extreme example concerns a patient who was transferred to a private hospital because he had health insurance but his insurance was not enough to cover the private hospital's bills.

Case example

Mr F was admitted to a public hospital as a private patient after presenting at the Accident and Emergency Department with a suspected heart attack. He had previously visited his general practitioner who had referred him to the hospital with a letter about his condition. He advised staff that he had the 'highest' possible cover.

During the next few days staff advised him that they were considering transferring him to one of two other large public hospitals. He indicated to them that this did not present any difficulties for him.

Mr F says that while he was in the ambulance en route to one of the hospitals, he asked one of the ambulance attendants about his destination. He was surprised to find that he was being transferred to a nearby private hospital. He had an angiogram at the private hospital and discharged himself after 11 days. Then the bills began arriving.

Mr F did not have the 'highest' possible private health insurance, although he had full cover for treatment in a public hospital.

At first the public hospital said that it may not have been as diligent as it should have been in checking with Mr F's private health fund about his level of cover. However the hospital did not offer any financial solution to the problem.

The Ombudsman and the hospitals entered into protracted negotiations. The private hospital agreed to accept Mr F's health fund payment as full settlement for the considerably larger accommodation account. It refused to write off the theatre fee for the angiogram.

After further discussions between Mr F, the Ombudsman and the hospitals, the Ombudsman recommended that Mr F should not have to pay anything more than his excess ($250) and that the public hospital should pay the outstanding account at the private hospital, which it paid.

This case is another example of the advisability of private and public hospitals thoroughly checking their patients' health insurance cover before transfer and admission.

Jacqui Power, Matthew Blackmore, Roger Gimblett, Jennifer Blyton

Right to transfer between funds

The right to transfer from a policy of one fund to a policy with another fund offering a comparable level of cover, with continuity of entitlements, has been an accepted element of private health insurance for many years. People could shop around for the best price at any time. However, these days this right is not so clear cut in many situations. The reasons are complex.

First, there is an ever increasing divergence of policies and it is harder to be sure about similarity of cover between the old and the new policies. Second, as contracts between hospitals and health funds come and go and vary over time, it is more difficult to conclude that different funds' hospital cover policies are comparable.

A third and related point is that health funds are starting to put up barriers to counter large scale shifts of possibly high claiming members from other funds. In an effort to do this, one fund in the category of large inter state funds has introduced new rules which make it impossible for transferring members to be sure about their entitlements to benefits for hospital treatment provided in the first twelve months of their membership in this fund. Although independent legal advice obtained by the Ombudsman is that the rules are contrary to the conditions of registration set out in the National Health Act 1953, the fund has been allowed to introduce these rules and it has not withdrawn them. (Other funds may well follow the example.) The Ombudsman has written to the Department of Health and Family Services about this but has not received a reply.

Another portability issue giving rise to complaints relates to the growth of arrangements providing some form of loyalty bonus for members. Although variously described, these arrangements increase the benefits members are entitled to for nominated periods of membership, for example for dental cover and funeral benefits. Complaints to the Ombudsman would suggest that some people do not understand that these bonuses cannot be transferred to their new fund. (Others expect to gain the benefit of bonuses offered by the new fund because of their length of membership with the old fund.)

Invariably people do not appreciate their misunderstanding until the time of lodging a claim with their new fund.

Health insurance benefits and workers' compensation and other forms of compensation

Unfortunately, people are still falling between the cracks when it comes to entitlement to health insurance on the one hand and compensation, damages and other forms of treatment cover on the other. Some health funds refuse to pay benefits for treatment where people have claimed compensation, damages or other forms of cover regarding the injury or ailment giving rise to the treatment. These funds can refuse to pay when the fund believes that the member concerned has a right to make these other claims but has not done so.

Workers' compensation

Most complaints to the Ombudsman arise because the health fund member's claim for workers' compensation has been refused and the member wants the fund to pay for treatment associated with the work related injury. Some health funds in these circumstances are prepared to pay benefits for the treatment on

condition that the member pursues the workers' compensation claim and repays the health fund for benefits it pays for the member's treatment, if the workers' compensation claim is successful. It seems that these funds have systems in place to ensure that they are repaid where appropriate.

Unfortunately for some health fund members, some health funds will not assist their members in this way and point blank refuse any assistance. This is blatantly unfair to members who want to be treated privately, especially for those members whose claims for workers' compensation (or other damages) fail. In these situations, unless the member has found other ways of funding treatment in private facilities and can then claim benefits after the other claims have failed, the health fund concerned ultimately avoids legitimate claims.

Case example

At the age of 19, Mr G had a bad accident at work that resulted in him suffering severe spinal injuries. He was initially treated in a public hospital. His parents were unhappy with the care he was receiving there and knowing he had private health insurance as well as an entitlement to workers' compensation, they arranged for him to be transferred to a private hospital on the fifth day of his hospitalisation.

Unbeknown to Mr G and his parents, under the workers' compensation legislation in the state where Mr G lives, he was not entitled to workers' compensation cover for treatment in either the public or the private hospital for longer than 4 days. This is because hospital expenses are payable after 4 days in hospital only if prior approval for continued care is given. No one sought this for Mr G. The private hospital assumed it had been attended to before the transfer on the fifth day.

The treating doctor assumed one of the hospitals would do it. It is unclear whether the compensation authority would have approved the transfer to the private hospital.

Mr G and his parents assumed he would be covered by his private health insurance. However, his fund refused to pay because it has a policy of never paying for treatment related to an injury covered by workers' compensation. It refused to pay although the treatment in question is not covered by the compensation scheme. It said Mr G should have known about its policy on this because it is set out in the fund's brochure.

The fund continues to refuse to pay benefits. This is the case even though the Ombudsman believes it is required to pay under its rules which define all entitlements and bind both the fund and its members. It is also the case that the fund refuses to exercise the discretion it has, under the rules, to pay benefits and seek repayment when Mr G's claims against others are ultimately finalised.

Mr G has no money and no assets. He cannot afford to pay the hospital bill of around $10,000 he owes. He may have to litigate to get his health insurance entitlements and the costs of this will have to come out of other entitlements designated to cover loss of earnings, pain and suffering and future medical expenses.

This case demonstrates three points. First, the need for some health insurers to provide more assistance to their member in extreme circumstances. Second, it demonstrates the need for members to confirm their cover before seeking treatment. Finally, it highlights the need for governments and health insurers to get together to prevent cracks in the system which can leave injured and vulnerable people in such desperate circumstances as Mr G's.

The problems associated with disputed workers' compensation claims may well get worse, if State Governments continue the trend of reducing workers' entitlements under the state based workers' compensation schemes. With some health funds refusing to pay benefits, more and more injured workers are going to be reliant on public facilities.

The problem is even more complicated in situations where the workers' compensation authority accepts liability for the injury but the scheme does not pay for private treatment or has a cap on medical expenses claims. As in Mr G's case, some health funds deny liability for any form of treatment for injuries related to workers' compensation, even where the treatment itself is not covered under the compensation arrangement. Is it fair to limit the entitlements of privately insured people in this way, when private health insurance is supposed to give them peace of mind regarding their health needs?

Common law actions

Difficulties can arise for members when possible causes of action exist in relation to their injuries. One health fund refuses to pay benefits where it believes the member concerned has a legal cause of action. (Most funds have the power to do this written into their rules.) It insists that people who do not want to take legal action do so. This can present big financial and psychological hurdles for injured people attempting to claim their health insurance benefits.

Case example

Miss H has been a member of her health fund for around 70 years. In late 1997 she fell over in the street and broke her pelvis. The local Council paid for some of the medical expenses but refused to pay for all of the treatment she needed, including the surgery she required. Miss H could not understand why her health fund would not pay benefits for that.

Her health fund refused to pay because it said that the Council was fully liable and should pay for all of the medical and hospital expenses. It said Miss H should sue the Council. Miss H did not want to do this and did not know how to go about it anyway.

The Minister of Miss H's church approached the Ombudsman for assistance. He said that the Council denied liability and he believed that Miss H did not have a good cause of action against the Council.

The Ombudsman approached the health fund. It advised that it believed that the Council was liable for all treatment because it had already paid for some treatment. (This was a reasonable assumption.) The fund said it would pay benefits if Miss H did what was necessary to recover the hospital and related expenses from the Council and then paid the benefits back to the fund, if she succeeded against the Council.

The Ombudsman advised Miss H's Minister that she would have to get independent legal advice on whether the Council was liable - from a legal aid office if she was eligible for it or from a solicitor. This was the only way to resolve the impasse between Miss H and her health fund.

This case raises the issue of what it means to have a cause of action. An arguable but uncertain cause of action could arise in respect of many injuries and illnesses. But many people would find it too risky or not worth their while to pursue the possibility of damages.

Future medical expenses give rise to another difficult issue. Under many health fund rules, a fund can refuse benefits for treatment that it believes to be causally related to a compensible injury. However, a member may disagree about the connection. The nexus between old injuries and illnesses many years later is often unclear.

The Ombudsman believes that health insurers should assist their members to litigate in the circumstances outlined above.

Pre-existing ailments

The principles governing the application of waiting periods for ailments, illnesses and conditions existing at the time a member joins a fund or upgrades their cover continue to cause the type of problems described in previous annual reports.

The test to be applied is set out in the National Health Act 1953 and all health funds have the same one in their rules. Consumers and many doctors do not understand the test. It is this: if a medical practitioner appointed by the health fund is of the opinion that there were signs or symptoms of an ailment, illness or condition in existence at any time in the six months before the member joined or upgraded, then the ailment, etc., is a pre-existing one. Benefits are not payable for treatment in relation to this ailment, illness or condition for the first twelve months after joining or upgrading.

Everyone who has examined the legislation agrees that application of the 'pre-existing ailment test' does not depend on the awareness of the ailment or on the need for treatment but purely on the existence of signs or symptoms.

Differences of view between some health funds and the Ombudsman centre on what constitutes a sign of an ailment or illness. It is a grey area. Some funds believe that if it can be said that an ailment or illness was most likely in existence in the six months before the member joined, then there would have been a sign of it. They say that signs would have been present and detectable by medical tests, such as x-rays, blood tests, endoscopies and the like.

The Ombudsman believes that in the context of the relevant provisions of the National Health Act, before a fund's medical adviser can say there was a sign (or symptom), there must be some manifestation of the ailment, illness or condition at some time in the six months. While it is not necessary for the member to have known they had a medical problem, there must have been something which would have prompted a reasonable person to seek medical advice or a reasonably competent GP to have detected an abnormality during a routine visit.

Potential disagreement about this issue will continue presumably, until the ambiguity is overcome by a court decision or legislative amendment. Fortunately, in most cases involving a dispute about whether an ailment or illness can be classified as 'pre-existing', health funds agree to follow the Ombudsman's recommendations.

General Issues

Establishment of the Private Health Insurance Ombudsman

The Health Legislation Amendment Act (No. 2) 1998 came into effect on 24 April 1998, and contained reforms to private health insurance arrangements. An important change was the renaming of the Private Health Insurance Complaints Commissioner as the Private Health Insurance Ombudsman.

The new role of Ombudsman will increase consumer confidence about the industry and the independence and accessibility of the service provided by the Ombudsman. It also allays earlier concerns expressed by consumer bodies that some health consumers, particularly older ones, were reluctant to complain and were discouraged by the word 'complaints' in the Complaints Commissioner's title. Some health funds were also concerned at the negative connotations of the original name.

The 1998 amendments also:

- gave the Ombudsman power to make recommendations directly to hospitals and doctors
- gave the Ombudsman power to take complaints from partners and dependants of fund contributors
- extended the Ombudsman's powers to decline to take action on complaints in certain situations
- extended the Ombudsman's powers to mediate complaints
- gave people the right to apply to the Minister for the Minister to direct the Ombudsman to investigate or not investigate their complaint and
- made other changes of a practical administrative nature.

Unfortunately, the defects in the legislation governing operation of the Complaints Commissioner's handling of complaints, as outlined in last year's Annual Report at page 42, were not addressed in the Amendment Act. The Private Health Insurance Ombudsman will not be fully effective until these defects are addressed.

Arbitration function

In February 1998, a delegate of the Minister issued a Determination under paragraph (bj) of Schedule 1 of the National Health Act 1953, which established a new rate of hospital benefits payable to private hospitals, in the absence of a purchaser-provider agreement between a fund and a hospital. These benefits, known as second tier default benefits, are higher than the standard default benefits and are payable to private hospitals which meet prescribed criteria.

The Ministerial Determination establishes an arbitration process for disputes between hospitals and funds about whether hospitals meet the criteria. The Ombudsman is the arbitrator. Arbitrations are to be conducted, as far as possible, as if they were conducted under the provisions of the Commercial Arbitration Act (NSW) 1984. There were no arbitrations conducted during the reporting period.

Access and public awareness

Because the Private Health Insurance Ombudsman was established primarily for the benefit of health fund members, it is vital that they know about their right to approach the Ombudsman for assistance. While health funds are now required to publish the contact details for the Ombudsman in their main product brochures, a survey conducted in the latter part of 1997 found that general awareness of the Ombudsman's office is low.

To raise awareness of the service provided by the Ombudsman, the following strategies were employed:

- advertisements outlining the Ombudsman's services were placed in metropolitan and regional newspapers during the year
- the Ombudsman gave radio interviews and appeared on talkback radio
- the Ombudsman developed a World Wide Web site where consumers can access a range of brochures and recent Ombudsman Annual Reports. The site enables consumers to make inquiries, lodge complaints and request printed copies of brochures (including those in community languages). Links to other useful sites are provided. The Ombudsman's website is located at: http://www.phicc.org.au
- the Ombudsman and staff spoke at numerous conferences, public and community meetings during the year.

The re-launch of the Complaints Commissioner as the Ombudsman provides another opportunity to further increase awareness of the service we provide for health insurance members. A formal launch was scheduled for July 1998 and a number of initiatives have been planned around this to raise the profile of the service provided by the Ombudsman.

Relations with stakeholders

Consumers

A national market research company, Reark Research, now merged with ACNielsen Research, was engaged to conduct a customer satisfaction survey on behalf of the Ombudsman.

The survey was conducted in two parts; a telephone survey of health fund members who contacted the Ombudsman with an inquiry or complaint, and health fund staff with whom the Ombudsman's staff had most frequent contact.

The aim of the survey was to find out whether the Ombudsman's office was meeting its clients' needs and to identify any areas where improvements could be made. Regular consultation with stakeholders through such surveys is now an important element of the Federal Government's program of implementing and reporting on service charters for Commonwealth Government departments and statutory authorities.

The survey found a high level of satisfaction, both among fund members and fund staff, with the service provided by the Ombudsman. Among the findings, the study showed that:

- 78% of consumers were satisfied with the service it provided
- 88% of people who contacted the office said they would use it again or recommend it to others
- 50% of complainants surveyed were satisfied with the outcome the Ombudsman achieved for them
- 50% of consumers believed the office could not have done anything more to assist them.

As a result of the survey, the Ombudsman put in place a number of reforms aimed at addressing issues raised by consumers and health fund staff during the survey.

The Ombudsman maintains regular contact with relevant consumer organisations.

Relations with health funds

Staff of private health insurance funds who were interviewed for the Ombudsman's customer satisfaction survey were generally satisfied with the service provided by the Ombudsman.

According to the survey conducted by Reark Research, nearly all of the 26 fund representatives surveyed were satisfied with the time taken by the Ombudsman to resolve complaints (24 of 26), with the information given by the Ombudsman's staff to complainants (21 of 26), with the Ombudsman's assessment of the validity of complaints (21 of 26) and with the information they received from the Ombudsman concerning complaints (25 of 26).

Most respondents were satisfied with the Ombudsman's procedures for dealing with complaints (23 of 26), the overall manner of the Dispute Resolution Officers (24 of 26), the feedback they received (24 of 26) and the outcomes achieved by the Ombudsman (21 of 26).

Nearly all respondents agreed that the Ombudsman looked after the interests of consumers (25 of 26), with four respondents believing the Ombudsman should be less biased towards the interests of consumers. Most felt that the Ombudsman provided an efficient (21 of 26) and independent (23 of 26) service and nearly all respondents (24 out of 26) were satisfied or very satisfied with the overall service provided by the Ombudsman.

While relations with the majority of health funds have continued to be cordial during the year, there have been problems in recent months with the time taken to respond to the Ombudsman's requests for information, particularly among the larger funds. Some funds now regularly take months to respond to the initial referral as well as subsequent letters about difficult cases. (The Ombudsman has no power to direct that a health fund responds to requests within a specified timeframe.)

Since the Commonwealth is reimbursed for the running costs of the Ombudsman's office by a levy on all funds, all fund members should be able to benefit equally from the Ombudsman's services. The Ombudsman may have difficulty in providing a fair dispute resolution service for members of several funds, unless complaints and requests for information directed to those funds are dealt with in a more timely manner.

Relations with medical practitioners and private hospitals

The industry and professional associations are co-operative and cordial. Most of the hospitals involved in health fund members' complaints are co-operative and helpful. While some medical practitioners have been willing to negotiate regarding members' problems with bills, many have refused to enter into any dialogue with the Ombudsman's office.

Information technology

Until June 1998, a temporary complaints data base was used to manage and report on approaches to the office. After eighteen months of rising complaint numbers it became clear that a more sophisticated complaints management and reporting system was required and detailed specifications were prepared during the year with the assistance of a specialist consultant. The Ombudsman sought tenders for the provision of the new system and installation began at the end of the reporting year.

This facilitated the generation of more detailed reports about complaints and inquiries, including a more detailed classification of approaches to the office, into inquiries, problems, grievances and disputes, rather than simply inquiries or complaints, as has been the case in the past.

Staff of the Private Health Insurance Ombudsman

Statutory Reporting Information

Staffing

As at 30 June 1998, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman	1	-
Director, Policy & Customer Service	-	1
Director, Corporate Services	1	-
Dispute Resolution Officers	2	1
Policy & Project Officer	1	-
Administrative Assistant	2*	-
Total	**7**	**2**

*1 staff member on maternity leave

Statutory positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry Date
Ms M Perrett	Ombudsman	3 years	1 Nov 1998

Staff development and training

During the 1997-98 financial year $16,057 was spent on PHIO staff attending training courses, conferences and seminars.

The Ombudsman undertook a staff skills audit during the 1997/98 financial year and is implementing a tailored staff development and training program which will be conducted over the 1998/99 financial year.

The training undertaken by staff during the year is summarised below.

Topic	Provider	Attending
Health & Health Insurance		
'Quality of Care' Conference	NSW Health Funds Association	1 staff
Health Summit '98	AIC Conferences	1 staff
Simplified Billing Seminar	Private Hospitals Association of NSW	1 staff
98 Post Budget Health Breakfast	AIPS	2 staff
General Business Related		
Application of State Laws to the Commonwealth	Australian Government Solicitor	1 staff
Professional Excellence Training	Prime Learning	1 staff
Recent Developments in Commonwealth Law	Institute of Public Administration	1 staff
Commonwealth Authorities and		
Companies Act Information Session	Department of Finance and Administration	1 staff
Dealing with Difficult People	IIR Pty Ltd	2 staff
Consumer Affairs Conference	Society of Consumer Affairs Professionals	2 staff
Outsourcing Government IT	AIC Conferences	1 staff
Customer Service Forum	Society of Consumer Affairs Professionals	1 staff
98 National Administrative Law Forum	Australian Institute of Admin Law	1 staff

Some staff also participated in part-time studies at formal educational institutions.

Equal employment opportunity

The Private Health Insurance Ombudsman is committed to providing a safe working environment that supports the rights, responsibilities and legitimate needs of all staff. Further, the Ombudsman is committed to best practice in selection, recruitment and promotion of staff in line with the merit principle. EEO is incorporated into all strategic and management planning.

The following table sets out the number of staff in the EEO target groups who were employed or separated in 1997-98.

Workplace diversity

The Ombudsman is in the final stages of developing its workplace diversity program that will be implemented by 31 August 1998. This program will meet all the requirements set out in the Public Service Commissioner Guidelines on Managing Workplace Diversity. The program will be accessible to all Ombudsman employees, it will encourage all employees to develop their work skills and contribute to their maximum potential. It will recognise the diverse skills, cultural values and backgrounds of employees and ensure that the Ombudsman uses these effectively. Workplace structures, systems and procedures that will assist employees balance their work and family responsibilities effectively will be implemented.

Performance appraisal

The Ombudsman has developed a performance appraisal system that is used to measure staff performance and as a tool to assist the Ombudsman with annual salary reviews. All staff are subject to an annual performance appraisal.

Occupational Group	NESB1	NESB2	ATSI	PWD	Women	Total Staff
SES	-	-	-	-	1	1
Other	-	-	-	-	6	8
Total	**-**	**-**	**-**	**-**	**7**	**9**

Note: SES Senior Executive Service
Other All other staff - temporary and permanent
NESB1 Non-English speaking background, 1st Generation
NESB2 Non-English speaking background, 2nd Generation
ATSI Aboriginal and Torres Strait Islander
PWD People with a disability

Occupational health & safety

Responsibility for the safety and health of all staff rests with the Ombudsman, who is required to be aware of all dangers to health and safety in the workplace. The Ombudsman, being a trained nurse, is the First Aid and Occupational Health and Safety Officer.

The Ombudsman complies with all provisions of the Occupational Health and Safety (Commonwealth Employment) Act 1991.

Industrial democracy

Staff are involved in decisions that affect their working lives and the Ombudsman's functions through regular staff meetings and dissemination of relevant written material.

Consultants engaged

The Ombudsman engaged specialist consultants to provide expertise in the areas of legal advice, information technology and recruitment.

During the financial year 9 consultants were engaged for a total cost of $59,057.08. Details of consultants who were paid more than $2000 are set out below.

The services of consultants were required to provide assistance and expertise not available within the current skills mix of staff within the office.

Consultant	Project	Total Cost of Consultancy $	1997/98 Payments $
S Meadows	CMRS Implementation & Testing	4326.40	4326.40
Love & Rodgers Hall Chadwick	Accountancy	3420.00	3420.00
PA Management	Recruitment	17897.80	17897.80
The Kerridge Consulting Group	Strategic Planning Communications	7000.00	7000.00

Information systems

The Ombudsman's information system is based on a Windows NT network using ASI personal computers. Software used consists of the Microsoft Office 97 suite, which includes word processing, spreadsheet, desktop publishing, mail and database facilities. Accounting software used is Mind Your Own Business, and a new Complaints Management and Reporting system was installed at the end of the Financial Year.

Advertising and market research

The Ombudsman expended the following monies during the 1997/98 financial year on advertising and market research.

Accounting services

The Ombudsman has engaged Love & Rodgers Hall Chadwick Chartered Accountants to assist it with its accounting functions.

Payroll services

The Ombudsman has engaged Australian Payroll Management Services to provide a payroll processing service.

Fraud control

The Ombudsman is updating its fraud control policy. Staff are trained in fraud awareness and procedures are in place to notify the Australian Federal Police and/or the Director of Public Prosecutions if loss occurs as a result of fraud. No cases of fraud were detected during the 1997/98 financial year.

Provider	Service	Amount
		$
TMP Worldwide Advertising	Advertising - print media	6114.39
Reark Research	Market Research	23000.00

Social justice, access and equity

The Private Health Insurance Ombudsman is committed to the principles of access, equity, communication, responsiveness, effectiveness, efficiency, and accountability as set out in the Government's Charter of Public Service in a Culturally Diverse Society.

Access and equity policies aim to ensure that government services meet the needs of people from diverse linguistic and cultural backgrounds so that they can participate fully in economic, social and cultural life.

To this end, the Ombudsman provides a speedy and informal complaints and inquiry service which is free of charge. Complaints and inquiries can be made from anywhere in Australia on the freecall Hotline 1800 640 695. Complaints may be lodged by telephone, fax and E-mail.

People who are deaf, hearing or speech impaired can contact us through the National Relay Service by telephoning 13 25 44.

People unable to speak English can contact us through the Translating and Interpreting Service by telephoning 13 14 50.

The Ombudsman has also produced a web site on the Internet, which enables people to access information about us via computer.

Access and equity goals underpin the decision making process of the Ombudsman's office. A primary goal is to raise community awareness about the Ombudsman through advertising and through the wide distribution of pamphlets and our annual report to community groups, private hospitals, doctors' surgeries, health funds, Ombudsmans' offices, consumer affairs organisations and Members of Parliament.

Another key goal is to ensure that information about the Ombudsman's role and functions is available to the wider community through the publication of our brochures in six community languages, Arabic, Greek, Italian, Spanish, Chinese and Vietnamese.

Service charter

The Ombudsman's Service Charter has been in operation since November 1997 and provides a framework against which the effectiveness of our service delivery can be monitored.

The Service Charter sets out what we do, the service standards our customers can expect and the steps they can take if these standards are not met. The Charter was developed in consultation with staff and customers.

Copies of the Charter are sent to people who contact the Ombudsman's office with a complaint or inquiry. Copies have also been sent to consumer groups and other stakeholders. The Charter will be reviewed in June 1999.

Freedom of information statement

This statement is published to meet the requirements of Section 8 of the Freedom of Information Act 1982 (FOI Act). It is correct as at 30 June 1998.

Establishment

The Private Health Insurance Ombudsman (the Ombudsman) is established under the National Health Act 1953 to resolve complaints about any matter arising out of or connected with a private health insurance arrangement. The Ombudsman is an independent statutory corporation.

Legislation enabling the Private Health Insurance Complaints Commissioner (now Ombudsman) commenced on 1 October 1995.

The Health Legislation Amendment Act (No. 2) 1998 came into effect on 24 April 1998, and provided for the renaming of the Private Health Insurance Complaints Commissioner as the Private Health Insurance Ombudsman.

Public information

The FOI Act requires the Ombudsman to publish certain information in its annual report. Information about its organisation, functions, decision making powers and about public participation in the work of the Ombudsman is contained under the headings 'Role and Function', 'Service Charter' and 'General Issues'. The other information required by the FOI Act is set out below.

Requests

The Ombudsman received many requests for information about its activities during the reporting year and received one request for information under the FOI Act. The request was granted in full.

The Ombudsman has a policy of openness with the information it holds, subject to necessary qualifications, for example, documents relating to the business affairs of an organisation or material of a personal nature that does not relate to the person making the request.

Documents held by the Ombudsman

The FOI Act requires publication of a statement of the categories of document the Ombudsman holds. They are as follows:

- a brochure 'Who We Are'
- a brochure 'Making a Complaint'
- a brochure 'The Ten Golden Rules of Private Health Insurance'
- a brochure 'Service Charter'
- a brochure 'When the Doctor's Bill Makes You Ill'
- a booklet and brochure 'Private Patients' Hospital Charter'
- a booklet 'Insure, Not Sure?'
- Complaints Register and Complaints files
- Guidelines for staff 'Dealing with Complaints and Inquiries - Policies and Procedures'
- Guideline for staff 'Complaints Management and Reporting System - User Guide'
- Correspondence and working papers relating to the administration of the Ombudsman, including personnel and financial papers
- other guidelines for staff of an administrative nature to assist in the efficient and effective operation of the office.

Documents available free of charge

The following categories of documents are available free of charge upon request:

- a brochure 'Who We Are'
- a brochure 'Making a Complaint'
- a brochure 'The Ten Golden Rules of Private Health Insurance'
- a brochure 'Service Charter'
- a brochure 'When the Doctor's Bill Makes You Ill'
- a booklet and brochure 'Private Patients' Hospital Charter'
- a booklet 'Insure, Not Sure?'

Complainants can have access to material held on the complaints register and complaint files relating to them. (Material that would be exempt from disclosure under the FOI Act may be withheld if necessary.)

Access to documents

People may obtain documents:

- from the office of the Ombudsman located at
  Suite 1201, Level 12
  St Martins Tower
  31 Market Street
  Sydney NSW 2000
- by telephoning (02) 9261 5855
  or 1800 640 695 (freecall)
- by fax on (02) 9261 5937
- by e-mail to info@phicc.org.au
- from the web site http://www.phicc.org.au.

Information and procedures for Freedom of Information Act requests

Requests under the FOI Act should be made in writing and accompanied by a $35 application fee, as required by the Act, and directed to:

Director, Policy and Customer Service
Private Health Insurance Ombudsman
Suite 1201, Level 12
St Martins Tower
31 Market Street
Sydney NSW 2000.

Initial enquires about access to documents may be made in person or by telephone. The office is open for business between 8:30am and 5:00pm on weekdays.

External review and scrutiny

Courts

In June 1998, the Ombudsman was advised that proceedings had been lodged with the Federal Court seeking a review under the Administrative Decisions (Judicial Review) Act 1974, of a decision made by the Ombudsman. At the end of the reporting period, the Ombudsman had not been served with proceedings.

Ombudsman

During the year, no complaints about the Private Health Insurance Ombudsman were made to the Commonwealth Ombudsman or investigations notified.

Other

There were no other reviews conducted of the Private Health Insurance Ombudsman's office.

A national market research company, Reark Research, was engaged to conduct a client satisfaction survey of health fund members who have contacted the Private Health Insurance Ombudsman with an inquiry or complaint, and health fund staff with whom the customer service staff of the Ombudsman have dealt during the past year.

The aim of the survey was to find out whether we were meeting our clients' needs and identify any areas where improvements could be made. Regular consultation with stakeholders through such surveys is now an important element of the Federal Government's program of implementing and reporting on service charters for Commonwealth Government departments and Statutory Authorities.

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Family Services

Scope

I have audited the financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 1998. The financial statements comprise:

- Statement by the Ombudsman;
- Statement of Assets and Liabilities;
- Operating Statement;
- Statement of Cash Flows;
- Schedule of Commitments;
- Schedule of Contingencies; and
- Notes to and forming part of the Financial Statements.

The Ombudsman is responsible for the preparation and presentation of the financial statements and the information they contain. I have conducted an independent audit of the financial statements in order to express an opinion on them to you, the Minister for Health and Family Services.

The audit has been conducted in accordance with Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards, to provide reasonable assurance as to whether the financial statements are free of material misstatement. Audit procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Australian Accounting Standards, other mandatory professional reporting requirements (Urgent Issues Group Consensus Views) and statutory requirements so as to present a view of the entity which is consistent with my understanding of its financial position, the results of its operations and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

PO Box A456 Sydney South NSW 1235
130 Elizabeth Street
SYDNEY NSW
Phone (02) 9367 7100 Fax (02) 9367 7102

Audit Opinion

In my opinion:

(i) the financial statements have been prepared in accordance with the Guidelines for Financial Statements of Commonwealth Authorities; and

(ii) the financial statements give a true and fair view, in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and the Guidelines for Financial Statements of Commonwealth Authorities, of the financial position of the Private Health Insurance Ombudsman as at 30 June 1998 and the results its operations and its cash flows for the year then ended.

Australian National Audit Office

Russ Chantler

For the Auditor-General

Sydney

28 July 1998

PRIVATE HEALTH INSURANCE OMBUDSMAN

STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements present fairly the information required by the Minister for Finance and Administration's Guidelines for Financial Statements of Commonwealth Authorities.

Mary Perrett

Mary Perrett
Private Health Insurance Ombudsman

Dated: 27/7/1998

Operating Statement

For the year ended 30th June 1998

	Note	1998 $	1997 $
NET COST OF SERVICES			
Operating expenses			
Suppliers	**2A**	**291,254**	318,468
Employees	**2B**	**472,343**	427,912
Depreciation and Amortisation	**2C**	**66,736**	50,903
Total operating expenses		**830,333**	797,283
Operating revenue from independent sources			
Interest	**3**	**15,456**	23,189
Total operating revenue from independent sources		**15,456**	23,189
Net cost of services		**814,877**	774,094
REVENUES FROM GOVERNMENT			
Parliamentary Appropriations Received	**4A**	**700,000**	705,000
Grant	**4B**	**-**	50,000
Total revenues from government		**700,000**	755,000
Surplus (deficit) of revenues from government over net costs of services		**(114,877)**	(19,094)
Surplus (deficit)		**(114,877)**	(19,094)
Accumulated surpluses at beginning of reporting period		**323,741**	342,835
Accumulated surpluses at end of reporting period		**208,864**	323,741

The accompanying notes form part of these financial statements

Statement of Assets and Liabilities

For the year ended 30th June 1998

	Note	1998 $	1997 $
PROVISIONS AND PAYABLES			
Suppliers	5A	**91,086**	91,428
Employees	5B	**90,852**	92,858
Total provisions and payables		**181,938**	184,286
Total liabilities		**181,938**	184,286
EQUITY			
Accumulated Surpluses		**208,864**	323,741
Total liabilities and equity		**390,802**	508,027
FINANCIAL ASSETS			
Cash	6A	**147,664**	291,652
Receivable	6B	**-**	4,803
Total financial assets		**147,664**	296,455
NON FINANCIAL ASSETS			
Infrastructure, plant and equipment	7A	**173,387**	190,313
Other	7B	**69,751**	21,259
Total non-financial assets		**243,138**	211,572
Total assets		**390,802**	508,027
CURRENT LIABILITIES		**128,738**	134,892
NON-CURRENT LIABILITIES		**53,200**	49,394
CURRENT ASSETS		**217,415**	317,714
NON-CURRENT ASSETS		**173,387**	190,313

The accompanying notes form part of these financial statements

Statement of Cashflows

For the year ended 30th June 1998

	Note	1998 $	1997 $
OPERATING ACTIVITIES			
Cash received			
Appropriations		**700,000**	705,000
Interest		**15,456**	23,189
Other		**-**	50,000
Total cash received		**715,456**	778,189
Cash used			
Suppliers		**(364,976)**	(243,330)
Employees		**(444,658)**	(431,857)
		(809,634)	(675,187)
Net cash from operating activities	**14**	**(94,178)**	103,002
INVESTING ACTIVITIES			
Cash used			
Purchase of Infrastructure, Plant & Equipment		**(49,810)**	(53,684)
Net cash from investment activities		**(49,810)**	(53,684)
Net increase/(decrease) in cash held		**(143,988)**	49,318
add cash at 1 July		**291,652**	242,334
Cash at 30 June		**147,664**	291,652

The accompanying notes form part of these financial statements

Schedule of Commitments

For the year ended 30th June 1998

	1998 $	1997 $
BY TYPE		
OTHER COMMITMENTS		
Operating Lease Commitments	**64,003**	122,533
Project commitments	**-**	60,000
	64,003	182,533
BY MATURITY		
One Year or Less	**64,003**	123,930
From one to two years	**-**	58,603
From two to five years	**64,003**	182,533

Schedule of Contingencies

For the year ended 30th June 1998

CONTINGENT LOSSES	**-**	-
CONTINGENT GAINS	**-**	-
Net Contingencies	**0**	0

Notes to and forming part of the Financial Statements

For the year ended 30th June 1998

1.STATEMENT OF ACCOUNTING POLICIES

The financial statements are a general purpose financial report. They have been prepared on an accrual basis from the records of the entity for the year ended 30th June 1998. They are based on historical costs and do not take into account the changing values of money. Cost is based on the fair values of the consideration given in exchange for assets.

The accounts have been prepared in accordance with the Guidelines on Financial Statements of Commonwealth Authorities issued by the Minister of Finance which require compliance with relevant Australian Accounting Standards and related Guidance Releases and have regard to Australian Statements of Accounting Concepts and have been prepared in accordance with Urgent Issues Group consensus views.

The following is a summary of the significant accounting policies adopted in the preparation of the financial statements.

INFRASTRUCTURE, PLANT & EQUIPMENT

All assets with a cost of less than $500.00 are expensed in the year of acquisition except where they form a group of similar items which are significant in total.

Infrastructure, plant & equipment are brought to account at cost less, where applicable, any accumulated depreciation or amortisation.

The depreciable amount of fixed assets is depreciated over their useful lives commencing from the time the asset is held ready for use. Leasehold improvements are amortised over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

LEASES

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

EMPLOYEE ENTITLEMENTS

The provision for employee entitlements encompasses annual leave and long service leave and the on costs for these provisions. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken by employees is less than the annual entitlement for sick leave.

The provision for annual leave reflects the value of total annual leave entitlements of all employees at 30 June 1998 and is recognised at its nominal value.

The liability for long service leave is recognised and measured at present value of the estimated future cash flows to be made in respect of all employees at 30 June 1998.

Contributions are made by the economic entity to employee superannuation funds and are charged as expenses when incurred.

TAXATION

The Ombudsman is exempt from all forms of income tax except fringe benefits tax.

CASH

For the purpose of statement of cash flows, cash includes cash on hand and in at call deposits with banks.

COMPARATIVE FIGURES

Where necessary, comparative figures have been adjusted to conform with changes in presentation in these financial statements.

Notes Continued

For the year ended 30th June 1998

FINANCIAL INSTRUMENTS

(a) Interest rate risk

The Ombudsman's exposure to interest rate risk, which is the risk that a financial instrument's value will fluctuate as a result of changes in the market interest rates and the effective weighted average interest rates on classes of financial assets and financial liabilities, is as follows:

	Weighted average effective interest rate		Floating interest rate	
	1998	**1997**	**1998**	**1997**
Financial Assets	**%**	**%**	**$**	**$**
Cash	4.4	5.9	147,664	291,652
Debtors			-	4,803
Total Financial Assets			147,664	296,455

(b) Credit Risk

The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date to recognised financial assets is the carrying amount, net any provisions for doubtful debts, as disclosed in the balance sheet and notes to the financial statements.

The Ombudsman does not have any material credit risk exposure to any single debtor or group of debtors under financial instruments entered into by the Ombudsman.

(c) Net Fair Values

For the assets and liabilities the net fair value approximates their carrying value.

Notes Continued

For the year ended 30th June 1998

	1998 $	1997 $
2. GOODS AND SERVICES EXPENSES		
2A. Suppliers expenses		
Supply of Goods and Services	**225,186**	254,905
Operating Lease Rentals	**66,068**	63,563
	291,254	318,468
2B. Employee expenses		
Remuneration for Services Provided	**472,343**	427,912
	472,343	427,912
2C. Depreciation and amortisation		
Depreciation	**52,664**	38,706
Amortisation - Lease Fitout	**14,072**	12,197
	66,736	50,903
3. REVENUES FROM INDEPENDENT SOURCES		
Interest		
Deposits	**15,456**	23,189
4. REVENUES FROM GOVERNMENT		
4A. Parliamentary appropriations		
Appropriation Act No. 1	**700,284**	705,000
Offset against receivables as it related to amount owed by Department of Health and Family Services that was taken up as revenue in a prior year.	**(284)**	-
	700,000	705,000
4B. Grant		
Grant from Department of Health	**-**	50,000

Notes Continued

For the year ended 30th June 1998

	1998 $	1997 $
5. PROVISIONS AND PAYABLES		
5A. Suppliers		
Trade Creditors	**87,686**	85,108
Accruals	**3,400**	6,320
	91,086	91,428
5B. Employees		
Salaries and Wages	**5,981**	4,837
Annual Leave	**31,671**	38,627
Long Service Leave	**53,200**	49,394
	90,852	92,858
6. FINANCIAL ASSETS		
6A. Cash		
Cash on Hand	**250**	250
Cash at Bank	**147,414**	291,402
	147,664	291,652
6B. Receivables		
Other Debtors	**-**	4,803
7. NON FINANCIAL ASSETS		
7A. Infrastructure, plant & equipment		
Leasehold Fitout - at Cost	**82,420**	71,745
Less: Accumulated Amortisation	**29,379**	15,307
	53,041	56,438
Plant & Equipment - at cost	**218,599**	179,464
Less: Accumulated Depreciation	**98,253**	45,589
	120,346	133,875
Total Property, Plant & Equipment at Written Down Value	**173,387**	190,313
7B. Other assets		
Other Prepayments	**69,751**	21,259
	69,751	21,259

Notes Continued

For the year ended 30th June 1998

Movement summary 1997-98 for all assets irrespective of valuation base

Item	Leasehold Fitout $	Plant & Equipment $	Total $
Gross value as at 1 July 1997	**71,745**	**179,464**	**251,209**
Additions:	10,675	39,135	49,810
Revaluations	-	-	-
Disposals	-	-	-
Other movements	-	-	-
Gross Value as at 30 June 1998	**82,420**	**218,599**	**301,019**
Accumulated depreciation / amortisation as at 1 July 1997	**15,307**	**45,589**	**60,896**
Depreciation / amortisation charge for assets held 1 July 1997	12,586	48,955	61,541
Depreciation / amortisation charge for additions	1,486	3,709	5,195
Adjustment for revaluations	-	-	-
Adjustment for disposals	-	-	-
Adjustment for other movements	-	-	-
Accumulated depreciation / amortisation as at 30 June 1998	**29,379**	**98,253**	**127,632**
Net book value as at 30 June 1998	**53,041**	**120,346**	**173,387**
Net book value as at 1 July 1997	**56,438**	**133,875**	**190,313**

Notes Continued

For the year ended 30th June 1998

	1998 $	1997 $
8. REMUNERATION OF OFFICERS		
Total income received or due and receivable by the Ombudsman:	**126,300**	121,639
Number of Officers whose total income falls within the following bands:		
$120,000 - $129,999	**1**	1
9. REMUNERATION OF AUDITORS		
Remuneration to the Auditor-General for Auditing the Financial Statements.	**2,900**	2,900

No other services were provided by the Auditor-General during the reporting period.

10. SUPERANNUATION

The Ombudsman's office contributes to the Commonwealth Superannuation (CSS) and the Public Sector (PSS) superannuation schemes which provide retirement, death and disability benefits to employees. Contributions to the scheme are at rates calculated to cover existing and emerging obligations. Current contribution rates are 20.1% of salary (CSS) and 11.0% of salary (PSS). An additional amount of up to 3% is contributed for employer productivity benefits.

11. ECONOMIC DEPENDENCY

The Ombudsman is dependent on appropriations from Parliament to carry out its normal activities.

12. SEGMENT REPORTING

The Ombudsman operates in a single industry and geographic segment, being provision of complaint resolution services in Australia.

13. CASH

Cash on Hand	**250**	250
Cash at Bank	**147,414**	291,402
	147,664	291,652

Notes Continued

For the year ended 30th June 1998

	1998 $	1997 $
14. CASH FLOW RECONCILIATION		
Reconciliation of net cash flows from operating activities to Net Cost of Services		
Net cost of services	**(814,877)**	(774,094)
Parliamentary Appropriation	**700,000**	705,000
Grant	**-**	50,000
Operating surplus	**(114,877)**	(19,094)
Amortisation - Lease Fitout	**14,072**	12,197
Annual Leave Provision	**(6,956)**	11,185
Depreciation	**52,664**	38,706
Long Service Leave	**3,807**	2,056
Decrease/(Increase) in Other Debtors	**4,803**	(3,007)
Increase in Trade Creditors	**2,578**	67,420
(Decrease)/Increase in Accruals	**(1,776)**	5,091
Increase in Other Prepayments	**(48,493)**	(11,552)
Net cash provided by operating activities	**(94,178)**	103,002

Index