Private Health Insurance
OMBUDSMAN

PRIVATE HEALTH INSURANCE OMBUDSMAN ANNUAL REPORT

2000

CONTACT DETAILS

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

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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 Mr Norman Branson, Private Health Insurance Ombudsman, at the above telephone and facsimile numbers.

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Private Health Insurance
OMBUDSMAN

The Hon Dr Michael Wooldridge MP
Minister for Health and Aged Care
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 Ombudsman's operations for each financial year.

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report, for the period 1 July 1999 to 30 June 2000.

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

Yours sincerely

Norman W Branson
OMBUDSMAN

24 August 2000

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OMBUDSMAN'S OVERVIEW

NORMAN BRANSON
PRIVATE HEALTH
INSURANCE
OMBUDSMAN

This year has been one where private health insurance has received considerable public focus. The introduction of lifetime health cover and registered medical gap schemes, combined with the high-income surcharge, has resulted in large numbers of first time entrants into the health insurance market. This is seen as a positive result for insurers, the private health industry and the Government. It has clearly focussed the attention of the consumers on the issue of private health as an adjunct to Medicare.

It is essential now that all private health industry participants provide the high level of commitment to consumers they openly promised during the campaign. Insurers have a task ahead to fill in the information gaps with consumers that were not in evidence during the campaign. Consumers purchased products without full knowledge of the product content or the conditions attached. This has already resulted in a complaint workload increase for my office of around 23% in the final quarter of this financial year as against the corresponding period last year. Private providers have an obligation to ensure patients actually have a right under their particular product cover to participate in the treatment regime they are considering, and if not, inform them of the extent of their costs to enable the patient to make an informed financial decision.

The current issues of concern are covered in more detail in the body of my report. Suffice to say in this overview, that although from a marketing perspective, the results of the campaign have been highly successful, it did result in a significant number of consumers lodging fully warranted complaints about product description, pricing information, service quality and information handling.

It is disappointing to have to report yet again that the perennial problems of informed financial consent, pre existing ailments and portability of membership still remain despite considerable attention being paid to them by this office and industry participants and a Government committed to resolving them.

The issue of informed financial consent, or more correctly the lack of it, has yet again received a considerable level of attention. My Office worked with a reference group of private hospital and health fund executives together with specialist legal advice to address the issue. As a result, it was possible to provide the Department of Health and Aged Care with a more detailed assessment of the problem and some interim solutions. The Department has difficulty mandating a solution and has called

on parties to voluntarily adopt a set of principles and guidelines utilising a paper based information flow. This interim solution has not produced any noticeable reduction in the difficulties faced by consumers.

The major difficulty, apart from apathy, with respect to this issue, is the fact that hospitals and practitioners are often working twenty four hours, seven days a week and the health insurers only have their offices open during a much more restricted timeframe. With the ready availability of electronic commerce based solutions, this problem can and should be solved. The consumer continues to suffer considerable hardship because of the lack of accurate and timely advice, purely because funds and providers cannot agree to commit resources to eliminate the cause of the problem.

In September 1999, the Minister of Health and Aged Care established an expert committee to examine the interpretation and implementation of the current rules associated with pre existing ailments and conditions. My office provided detailed written and oral presentations to the committee. It is somewhat disappointing that the committee is not yet in a position to finalise its report to the Minister and allow for the implementation of industry standard guidelines. It is understood that the report is currently in its final stages of preparation.

Pre existing ailments continue to be of major concern to consumers and other participants in the private health arena. This is one area that is receiving added focus by consumers since the influx of new members through the lifetime health cover campaign. It has always constituted a sizeable portion of the workload of this office in the resolution of individual complaints. Many of these complaints can take months, even years to resolve and involve participants in claims of tens of thousands of dollars. Individual funds and indeed practitioners interpret the rules differently and the consumer is left bewildered. The rule needs to be refined in its interpretation to take away any ambiguity and instill certainty. Only then will new members and existing fund members be protected from aberrant behaviour.

With changes being implemented in health insurance products, particularly as they relate to selective contracting with both hospitals and other providers, consumers see a greater necessity to have the facility to change insurer without compromising their level of cover.

My office has worked with a reference group of health insurance executives to address the complex questions that arise from the variability of health fund products, contracts and arrangements, and how these interfere with the portability arrangements and consumer safeguards as allowed for under paragraphs (la) - (lf) of schedule 1 of the National Health Act.

A comprehensive industry discussion paper has been prepared and reviewed by all segments of the industry, Government and consumer bodies. It is pleasing to note that all major segments of the industry responded to the discussion paper, recognising the need to have principles established which can assist the consumer. Although consensus will be difficult in some areas, the major principles have general agreement. The results of the review once analysed and put to the wider constituency once again will enable progress to be made and recommendations put before Government.

It is pleasing to note the Government has allowed for the introduction of health insurance products which provide a way for insurers and practitioners to dispense with the Medical Gap without the need for ongoing contractual obligations. With the uptake of these arrangements in the private health community, there should be a significant reduction in complaints from consumers. Medical practitioners need to be aware of their responsibility to provide their patients with details sufficient for them to make an informed decision on the price of the service and any out of pocket costs which may be associated.

Products now available to consumers are many and varied. Some are not adequate and yet are sold openly to consumers who are not fully aware of the implications of the limitations inherent in the product. The products of most concern are those marketed as exclusion products and those products which restrict benefits to public hospital admissions for high cost procedures.

Participants who choose private health insurance do so to have access and choice of both practitioners and hospitals.

This office questions the morality of selling a product which purports to offer 100% cover and yet relies on the contributor joining the public hospital waiting lists if they have need to access high cost exclusions. Whilst exclusion products may have had a real place by allowing for a marginal reduction in the cost of health insurance when the industry was facing declining clientele, it is questionable if the same rationale can be used now that the market has stabilised and the cost has been subsidised by the Government's 30% rebate. In the past this office was of the view that as the cost of insurance was paramount in the consumer's mind, price reductions associated with exclusion products outweighed their obvious disadvantage. This is not the contemporary view. This office now regards these products as not being good value and would caution consumers about their appropriateness.

In a similar vein are products which only offer ancillary cover within a list of preferred providers. While this office recognises the overall benefit that can arise from utilising a preferred provider network, it is essential that a comprehensive network is in place before the product is put on sale.

Consumers have already experienced significant problems in accessing preferred providers and yet product descriptions in the advertising literature suggest networks are all embracing and comprehensive. One major fund when recently questioned about the restrictions consumers faced when accessing providers responded to my office "Up to 60% of claims on our new products are now through network providers. There is a wide range and the current focus is on filling gaps, particularly for dental and optical. We have set ambitious 'stretch' targets for network growth over the coming year". The very need to "set ambitious stretch targets" underlies the fact the current network is recognised, even by the fund, as being deficient, and yet the product was (and is) actively promoted.

My office has received complaints from members who have no access to providers in heavily populated areas. As an example, a contributor required to access a psychologist on the Melbourne Mornington Peninsula. At the time there was only one fund recognised provider. On contacting that provider, the contributor was informed that the practice was not taking on any new patients. This product in its current phase of development does not live up to the marketing description.

This year has been one where within this office, we have tried to instill in participants throughout the breadth of private health, that consumer protection is essential for the ongoing growth of their respective segments of the industry.

We have engaged the industry both formally and informally in addressing consumer complaint issues and through the public media have endeavoured to educate the consumer. In most instances the industry has reacted positively, but there is still a way to go.

Complaint numbers have risen this year and although it has been possible for us to resolve around 50% of these with one phone call on the day of the complaint, there are still issues of significance, which continue to be unresolved after 90 days. This is just not good enough and it is apparent that some (though not many) participants use procrastination as a method of complaint resolution or minimisation. Many of the complaints which come to my office could have been resolved within the fund or hospital, if proper complaint handling procedures existed within these organisations.

All is not negative; it is apparent that many major organisations fully recognise their responsibility to all of their participants and are active in developing systems that resolve complaints in house and allow for feedback to executives on complaint issues. I would like to record my appreciation to members of the various industry reference groups I set up, together with officers of the Federal Department of Health and Aged Care and the ACCC who have assisted with advice in an effort to resolve the various intractable issues still confronting consumers.

ROLE & FUNCTION

Introduction

The Private Health Insurance Ombudsman is an independent statutory corporation established by the Health Legislation (Private Health Insurance Reform) Amendment Act 1995. The Ombudsman was originally established in late 1995 as the Private Health Insurance Complaints Commissioner. Following the passage of legislation through the Parliament in 1998, the Ombudsman replaced the former Complaints Commissioner.

The Ombudsman is an independent body established to resolve problems about private health insurance and to be the umpire in dispute resolution at all levels within the private health industry.

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 1953, are to:

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

In 1998, by Ministerial Determination under Schedule 1 of the National Health Act 1953, the Ombudsman was given jurisdiction to arbitrate disputes between private hospitals and health funds regarding second tier default benefits payable in respect of health fund members.

The Ombudsman has jurisdiction to deal with complaints about the 30% Rebate for private health insurance.

In February 2000, the Minister determined that, in the absence of any agreement between supplier, manufacturer, hospital and health fund, with respect to prices charged for prostheses, the matter should be referred to the Ombudsman.

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; and
- 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; and
- referring the complaint to any other appropriate body.

PRIVATE HEALTH INSURANCE OMBUDSMAN STAFF
(L-R) HILLARY STIRRAT, URSULA SCHAPPI, SASHA ANDREWS, ROGER GIMBLETT, NORMAN BRANSON, HELEN RALLIS, GINETTE BULMER, SAMANTHA GAVEL

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; and
- 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 1953 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 a 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.

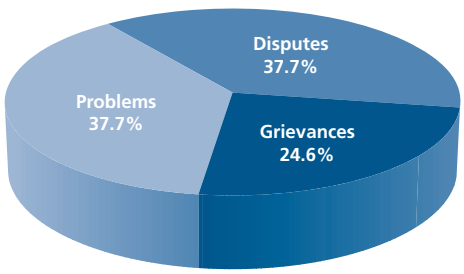
PERFORMANCE

Introduction

The Ombudsman received 1875 complaints in the reporting period 1 July 1999 to 30 June 2000. Although in aggregate this is only 3.5% higher than the figure for last year, there has been a 23% increase in complaint activity during the final quarter of this reporting period when compared with the same period the previous year. This increase in the final quarter is directly associated with the influx of new members to the industry during that period. Indeed one fund alone generated over 50 complaints during the lifetime health cover campaign associated with their advertised introductory price and the content of their product.

The 1875 complaints recorded consisted of 705 disputes, 463 grievances and 707 problems. Figure 1 shows the detail of the complaints received during the financial year.

FIGURE 1: PERCENTAGE OF COMPLAINTS BY CATEGORY



Recording complaints

An approach to the Ombudsman's office is recorded as a complaint when 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; and be
- made about a health fund, hospital, doctor (including some dentists).

Complaints are categorised by the degree of effort needed for their solution. Currently this categorisation is:

Disputes: Highest level of complaint where significant intervention is required

Disputes are dealt with by contacting the health fund, hospital, doctor or dentist about the matter. Issues in this category will have previously been the subject of dispute between the complainant and the respondent and not have been resolved. The Ombudsman attempts resolution through conciliation by telephone or in writing. Common complaints in this category would include pre existing ailments, informed financial consent, benefits available on portability of membership, benefits not in accordance with brochure descriptions and contribution errors.

Grievances: Moderate level of complaint where mediation is required

Grievances are dealt with by staff of the Ombudsman investigating the complainant's grievance directly and providing additional information or a clearer explanation. Complaints within this category generally result from misunderstanding by the consumer of their rights under the product they have purchased, concerns with service levels provided by the fund or provider, price increase, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

Problems: Moderate level of complaint

Problems are 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. Issues within this category can be across the whole complaint range of product description, benefits paid, informed financial consent, pre existing ailments and service quality. The Ombudsman's staff empower the consumer to try and resolve the complaint directly and if they are not successful, they return and reactivate the complaint as a dispute.

The process and timeframes for handling these issues is depicted in Figure 2.

FIGURE 2: STEPS IN HANDLING APPROACHES TO THE OMBUDSMAN

Dispute	Grievance	Problem
TIMEFRAME Depends on the nature and complexity of matter and responses from health fund and provider	**TIMEFRAME** Usually within 24 hours	**TIMEFRAME** Immediate
ACTIONS PHIO contacts health fund or provider to obtain report, mediate dispute or investigate matter	**ACTIONS** Complainant provided with explanation or information to resolve matter, or there is no avenue for the Ombudsman to take up the matter	**ACTIONS** If complainant has not attempted to resolve matter with fund or provider, refer back
OUTCOMES Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal recommendation by Ombudsman	**OUTCOMES** Detailed information	**OUTCOMES** Referral to health fund or provider

The majority of complaints handled are from fund members about their own fund.

Fund members can also lodge complaints about their hospital, doctor or other practitioner but these are small in number.

Hospitals and providers can also lodge complaints about health funds. These are also numerically small but generally of a complex nature. Issues surrounding selective contracting and second tier benefit payments constitute the majority of complaints from this group.

Workload

The office received 1875 complaints (problems, grievances and disputes) in 1999/2000, an average of 156 complaints per month. This figure is marginally higher compared with the average of 151 complaints received per month in the previous year. As previously indicated the influx of new members during the final quarter of the year contributed to the increase.

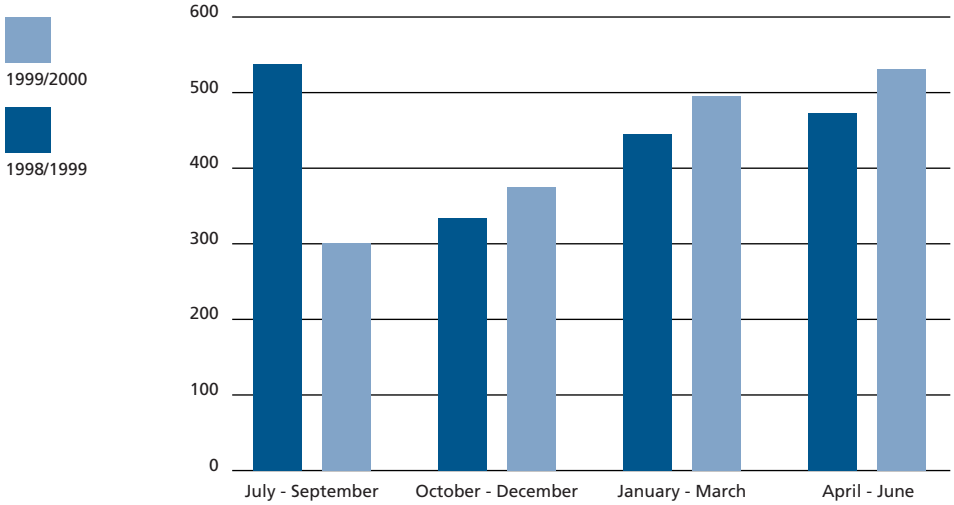
The office finalised 1847 complaints during the year (an average of 154 per month) compared with an average 150 complaints finalised per month in the previous year. Comparative statistics are depicted in Figure 3.

Complaint Issues

The highest number of complaints again this year concerned benefits, accounting for 32.5% of all complaints received. Benefit sub issues include the extent of cover, amount of benefit, gap payments, excess, limits, compensation, payment delays, and out of pocket expenditure.

20% of complaints received by the Ombudsman during the financial year related to the issue of 'Waiting Periods', this is significantly higher than the 14% recorded last year. This category includes complaints about the application of waiting periods for pre existing ailments and obstetric services

FIGURE 3: COMPLAINTS RECEIVED PER QUARTER



and it is significant that in the last quarter of the year, during the height of the lifetime health cover campaign, there is evidence of an escalation in this category of complaint. Waiting periods and the determination of pre existing ailments constitute the single most vexed issue for consumers.

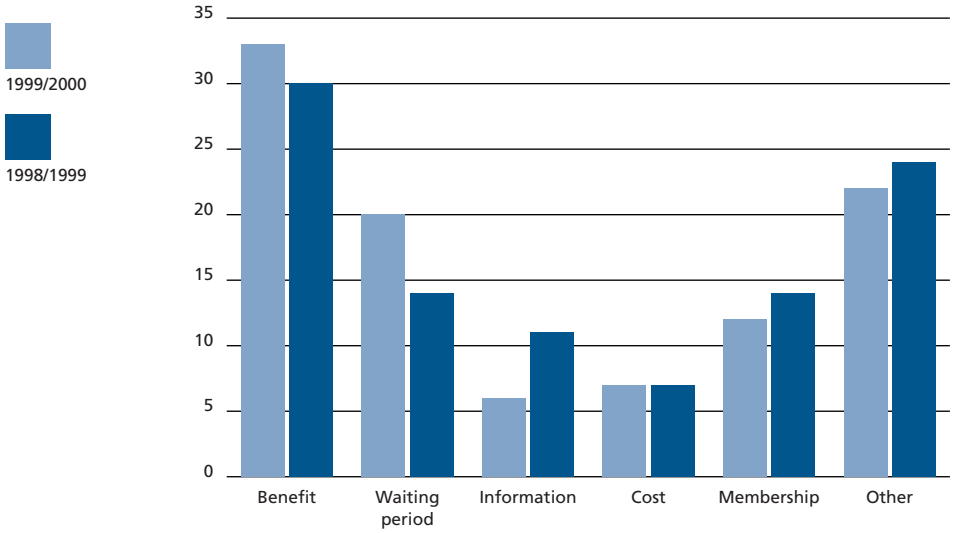
It is evident there is a need for funds to be more explicit in explaining to members what waivers of waiting periods mean when these are routinely offered, particularly as it relates to pre existing ailments. Far too many consumers are confused about their rights when offered waivers of waiting periods and the result is they have procedures performed that are not covered under the waiver.

There are still inconsistencies between funds on the interpretation and application of the pre existing ailment rule which makes it difficult to apply a standard approach to consumer complaints in this area. A level of consistency is required both in the interpretation of the rule, and in the dissemination of information to members. It is to be hoped the release of the Minister's report into pre existing ailments will alleviate this problem in the future.

Complaints about 'Membership' accounted for 12.5% of complaints received and included concerns about the cancellation or suspension of a health fund membership and more importantly, difficulties reconciling contributions paid with authorities to deduct through electronic processing.

Complaints about 'Information' accounted for 6% of all complaints received and these complaints concerned issues such as mis-leading information, inadequate information and the lack of appropriate information.

FIGURE 4: COMPLAINT ISSUES



Complaints in which 'Cost' was the issue were marginally higher this year than last year's all time low, reflecting the relatively low rate of contribution rate increases this year as compared with previous years. The comparison of complaints in this category with previous years has been 23% in 1997/98, 7% in 1998/99 and 7.5% in 1999/2000. Complaints relating to cost not only concern the price of health fund premiums, but also differential charging of privately insured patients by some health providers and alleged lack of informed financial consent to health providers' fees and charges.

The remaining 21.5% of complaints dealt with a wide variety of other issues including health fund rule changes, the quality of customer service from a health fund, premium payment difficulties, private patient elections in public hospitals, health fund and hospital contracting arrangements.

Figure 4 depicts the ratio of the different complaint issues.

Complaints by State/Territory

Figure 5 identifies, on a state by state basis, where complaints originate. This data is shown by State, against the percentage of people who have private health insurance coverage.

Time taken to resolve Complaints

Figures 6 and 7 provide information on the time taken to resolve complaints and shows a marginal increase in resolution time.

Response from funds on complaint handling is continuing to improve and most health funds respond to informal telephone requests for information by the Ombudsman's staff and this explains why many complaints are resolved in less than one week.

FIGURE 5: COMPLAINTS BY POPULATION COVERED BY STATE AND TERRITORY

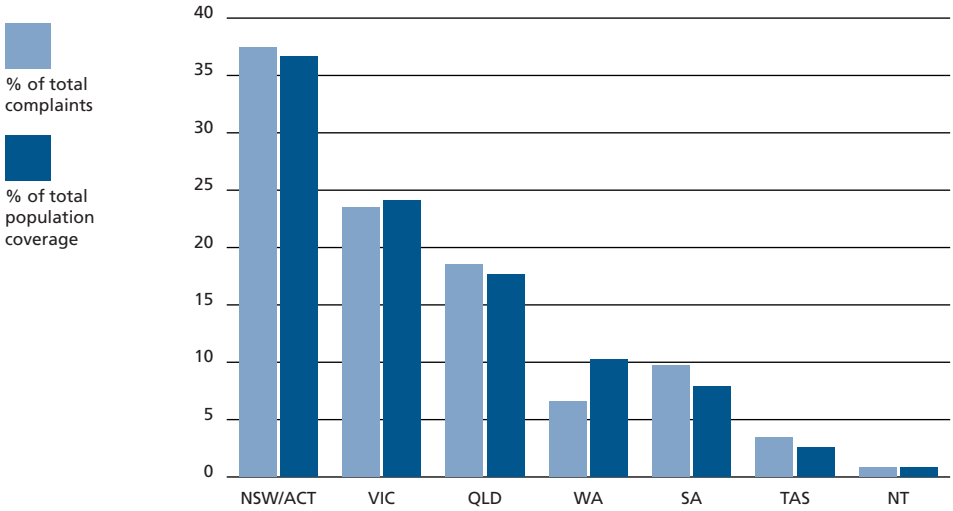


FIGURE 6: TIME TAKEN TO FINALISE COMPLAINTS

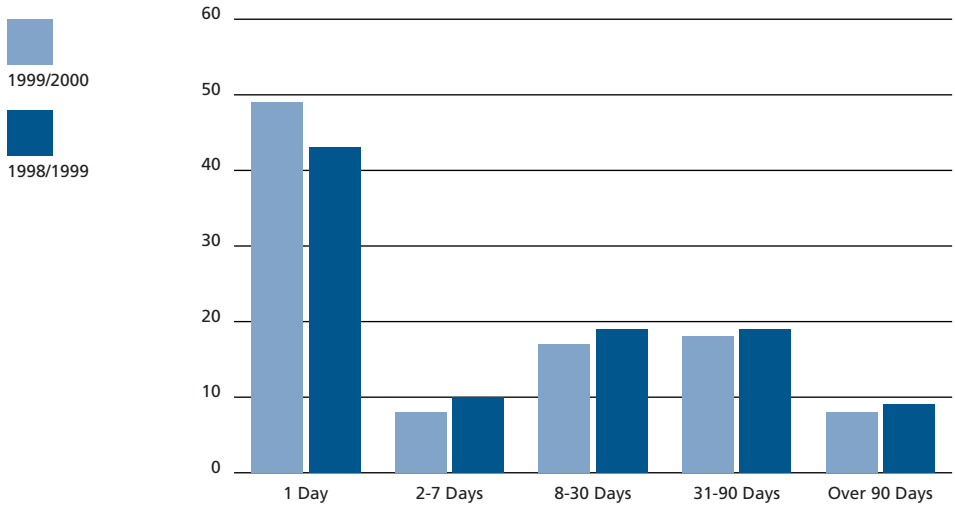
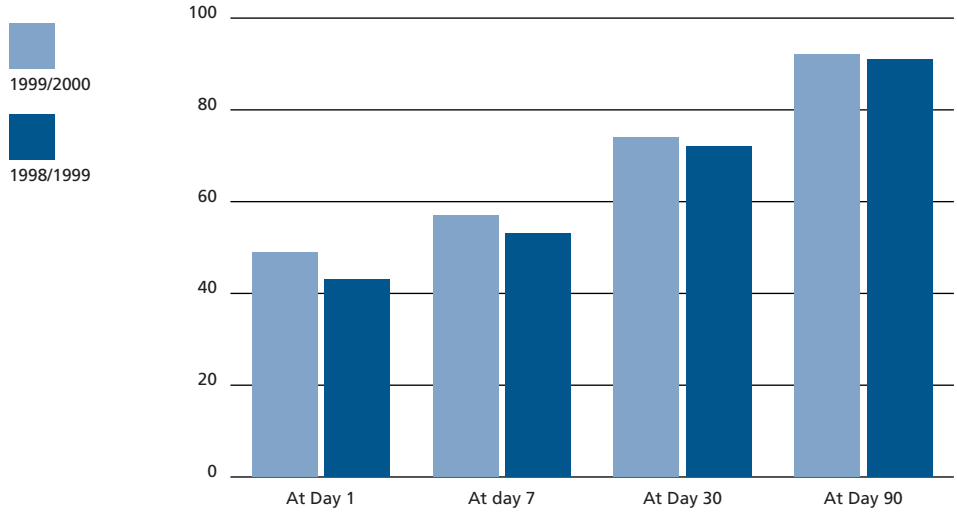


FIGURE 7: COMPLAINTS COMPLETED SINCE DAY OF LODGEMENT



Who was complained about
Most complaints were made about health funds (1737), followed by practitioners, doctors and dentists (97) and hospitals (70). 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 (1912) adds up to more than the total number of complaints (1875).

Complaints about health funds
Figure 8 provides a summary of all complaints (problems, grievances and disputes) for individual health funds compared with their market share. This data is further dissected with respect to the higher category 'disputes', again by market share. Analysing the information at this further level of detail provides a more realistic picture of the way funds respond to their members' complaints in general and to the higher level issues included in the dispute category. Higher dispute to market share ratios, are a pointer to a less than adequate internal disputes resolution process for complex issues within the fund.

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. The National Health Act 1953 requires a hospital which has an agreement with a health fund to inform a potential patient of any out of pocket expense associated with a hospital episode. In quite a number of instances this is not occurring.

There is insufficient data to enable analysis of the complaints with respect to their geographic distribution, hospital speciality or ownership.

Complaints about doctors
Most complaints about doctors concern the lack of informed financial consent. As with the hospitals, there is insufficient data available to enable analysis with respect to their geographic distribution or medical speciality.

Resolving complaints
39% of complaints are resolved by the Ombudsman's office providing an independent and impartial explanation of the health fund member's problem, or by providing additional information.

32% of complaints were referred directly back to the health fund, generally through the complainant. In these circumstances the Ombudsman was able to suggest ways for the complainant to pursue the matter with the health fund. Only in a relatively small number of instances was it subsequently necessary for the complaint to be re-opened as a dispute and actioned by the office direct with the fund on behalf of the contributor.

Payments made by health funds or accounts written off by hospitals resolved a further 9% of complaints. 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 was made on an ex gratia basis to a loyal member.

FIGURE 8: COMPLAINTS BY HEALTH FUND, BY MARKET SHARE

Name of Fund	Total number complaints (Note 1)	% of total complaints	Total number of disputes (Note 2)	% of total disputes	% Health fund of market share (Note 3)
ACA Health Benefits Fund	0	0.0	0	0.0	0.1
AMA Health Fund Ltd	1	0.1	1	0.1	0.1
Australian Health Management Group	52	2.9	16	2.3	2.5
Australian Unity Health Fund	40	2.3	20	2.9	2.8
AXA Australia Health Fund	270	15.2	144	20.7	10.5
CBHS Friendly Society	10	0.6	2	0.3	0.9
CDH Benefits Fund	0	0.0	0	0.0	0
CUA Members Benefit Friendly Society	9	0.5	3	0.4	0.5
Defence Health Benefits Society	21	1.2	5	0.7	1.2
Geelong Medical & Hospital Benefits Association	8	0.5	4	0.6	1
Goldfields Medical Fund Inc.	1	0.1	0	0.0	0.2
Grand United Corporate Health Ltd	11	0.6	4	0.6	0.3
Grand United Friendly Society	34	1.9	12	1.7	0.5
Health Care Insurance Ltd	7	0.4	2	0.3	0.1
Health Insurance Fund of WA	11	0.6	1	0.1	0.3
Health-Partners	17	1.0	13	1.9	0.6
Healthguard Health Benefits Fund Ltd	1	0.1	0	0.0	0.1
Hospital Benefit Fund of WA (inc)	48	2.7	21	3.0	11.4
Hospital Contributions Fund of Australia Ltd	128	7.2	53	7.6	8.4
IOOF Friendly Society of Victoria	3	0.2	2	0.3	0.2
IOR Australia Pty Ltd	21	1.2	8	1.2	0.7
Latrobe Health Services (VIC)	5	0.3	2	0.3	0.4
Lysaght	0	0.0	0	0.0	0.2
Manchester Unity Friendly Society in NSW	49	2.8	20	2.9	1
Medibank Private	432	24.3	167	24.0	27.1
Medical Benefits Fund of Australia Ltd	396	22.3	111	16.0	18.2
Mildura District Hospital Fund	2	0.1	0	0.0	0.3
Naval Health Benefits Society	1	0.1	0	0.0	0.3
NIB Health Funds Ltd	106	6.0	49	7.0	4.6
NSW Teachers Federation Health Society	17	1.0	6	0.9	1.5
Phoenix Welfare Association Ltd	1	0.1	0	0.0	0.2
Railway & Transport Employees Friendly Society	8	0.5	2	0.3	0.4
Reserve Bank Health Fund Friendly Society	1	0.1	0	0.0	0.1
SA Police Employees Health Fund Inc	0	0.0	0	0.0	0.1
NRMA Health Pty Ltd	18	1.0	4	0.6	1.2
St Lukes Medical & Hospital Benefits Association	9	0.5	4	0.6	0.5
Teachers Union Health	11	0.6	7	1.0	0.4
Transition Benefits Fund	1	0.1	0	0.0	0.2
Transport Friendly Society	4	0.2	1	0.1	0.1
United Ancient Order of Druids Victoria	6	0.3	4	0.6	0.1
United Ancient Order of Druids Grand Lodge of NSW	0	0.0	0	0.0	0.1
Western District Health Fund Ltd	20	1.1	8	1.2	0.4
Federation Health	0	0.0	0	0.0	0.1

Note 1. Complaints = problems, grievances and disputes
Note 2. Disputes require intervention by the Ombudsman with the fund
Note 3. Derived using 1999 PHIAC Annual Report

An additional 7% of complaints were resolved by taking other remedial action, such as re-instating a membership or allowing the back payment of contributions where a membership had lapsed.

3% of complaints were withdrawn or required no further action.

Finally, 2.5% of complaints which met the criteria for complaint contained in the National Health Act were referred to another agency.

Information about the resolution of complaints is provided in Figure 9.

Type of complainant

The law provides that health fund members, hospitals; doctors, some dentists, health funds or persons acting on their behalf can lodge complaints. Overwhelmingly, complaints were made by health fund members (91%), followed by practitioners (5%), hospitals/day hospitals (3.66%), and health funds (0.4%).

How complaints were made

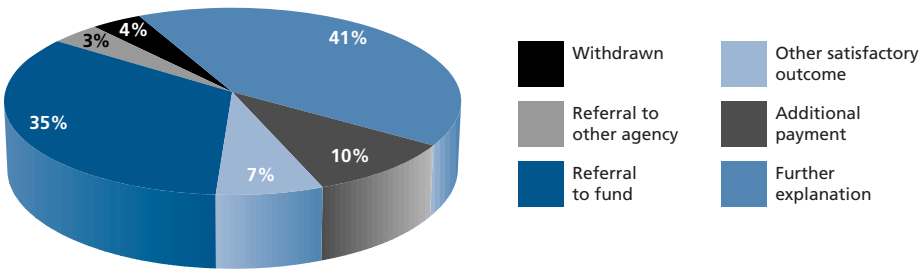
91% of all problems, grievances and disputes were made by telephone. 7% were received by letter. The remaining 2% were made by fax, personal visit, e-mail or by Parliamentary Representation.

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 Section 82ZTA of the National Health Act 1953.

FIGURE 9: OUTCOME OF FINALISED COMPLAINTS



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 deemed an inquiry.

Examples of inquiries include calls and letters seeking general information about private health insurance, requests for brochures and explanations about waiting periods. The Ombudsman provides a brochure entitled The Ten Golden Rules of Private Health Insurance to assist some callers and others were dealt with by providing telephone advice and a copy of the Private Patient's Hospital Charter.

Some inquiries received by the Ombudsman were more appropriately dealt with by other organisations and were referred elsewhere.

COMPLAINT ISSUES

Introduction

Complaints to the Ombudsman must first meet the requirements of the Section 82Z of the National Health Act. Embodied in that section is the requirement that a complaint be about a health insurance arrangement. Given this criteria, it is not surprising the great majority of complaints are from consumers about their health insurer. From a consumer's perspective, matters involving hospitals and doctors are generally about fees and accounts that fund members have been asked to pay. On the other hand, there are quite a number of complaints registered by practitioners and hospitals with respect to preferred provider conditions and conditions of contract. Complaints about the service that doctors or hospitals provide to health fund members do not come within the bailiwick of this office and are referred to the various state-based health complaints bodies.

The single issue which attracted the largest number of complaints this year, was that of introductory price offers during the lifetime health cover campaign. One fund in particular failed to identify at all times in its promotion and through its sales offices that the introductory offer was only available until 30 June 2000. People who purchased the product, particularly through the fund's Tele-marketing company, understood they would have access to the reduced fee for the whole year. At the time of reporting approximately 50 complaints had been registered officially about this issue. It is anticipated this number will rise as consumers receive their post 30 June invoices at the regular product price.

As in past years the more complex complaints still concerned the vexed questions of pre existing ailments, informed financial consent and transfers between health funds. Although a lot of effort has been put into finding enduring solutions to these fundamental questions, they are still unresolved and consumers face difficulties as a consequence.

Pre existing ailments

The Minister for Health and Aged Care set up an expert committee to look into the principles governing the interpretation and implementation of the pre-existing ailment rules as they are currently defined in the National Health Act. The need for such an enquiry is very apparent when account is taken of the number and complexity of complaints lodged with this office since its inception. It is apparent that a minority of funds interpret the Act differently to the vast majority. The impact on the consumer is significant and sometimes severe. Some medical practitioners who advise patients as to their rights are often not aware of the scope of the Act and consequently provide erroneous advice.

The Act provides for a medical practitioner appointed by the health fund, to determine that signs or symptoms of the ailment or condition were in existence in the six months prior to the member joining the health fund or upgrading their cover. The pre existing ailment provisions remain in force for a twelve month period after joining or upgrading cover. It is only the fund appointed medical practitioner who is legally able to determine if signs or symptoms existed, not the patient's treating practitioner.

The difficulty faced by consumers and practitioners is that the condition does not need to be diagnosed, but simply that signs or symptoms need to have been in existence.

The Ombudsman believes that in the context of the relevant provisions of the National Health Act 1953, 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 preceding 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 General Practitioner to have detected an abnormality during a routine visit.

Mr Bronze, a 52 year old, joined his health fund in March. On the 17th of November, he suffered a myocardial infarction and had three stents placed in his right coronary artery.

The health fund rejected his claim on the basis "the condition was in existence prior to taking out Health Insurance with us".

Mr Bronze requested his local GP inform the fund if at any time he had presented with signs or symptoms that would indicate potential heart problems.

His GP responded to the fund that "up to the time he had a myocardial infarct on 11 November, he had no prior cardiac problems".

Mr Bronze sought a reassessment of his claim after presenting similar evidence from his treating surgeon. The fund carried out further enquiries with the treating surgeon but still rejected the claim on the basis that "he must have had signs otherwise he would not have had a heart attack".

The Ombudsman's office was contacted in July and asked the treating practitioner for further details. The practitioner, a clinical associate professor of medicine responded he was "dumbfounded regarding his (the fund medical officer) interpretation. I explained that at least 30% of patients who first present with heart disease do so out of the blue with absolutely no evidence of heart disease prior to the presentation".

The fund medical officer stated that had Mr Bronze had a coronary angiogram at the time coronary disease would have been found. The professor responded, "this is likely to be the case, as more than 95% of patients who have a heart attack have evidence of coronary disease. The evidence demanded was whether there was evidence clinically of signs or symptoms, NOT evidence on sophisticated and expensive tests".

In early November the Ombudsman compiled all the enormous amount of correspondence and associated data, (including the patient Medicare records showing no treatment at all for any purpose in the six months prior to joining the fund) and recommended on the evidence, that the fund reverse its decision. The fund was not of a mind to do so.

On 30 November the Ombudsman advised the fund that unless a satisfactory response was forthcoming within 48 hours, the office would be in no position other than to recommend to Mr Bronze that he seek a remedy in the courts for recovery of the $22,000 in fees for service.

On the 7th December, 12 months and 12 days after the surgery, the fund agreed to settle the amount.

Transfers between health funds

With the significant influx of new members into health insurance as a consequence of the success of the lifetime health cover campaign, the question of transfers between health funds becomes even more important.

The new members do not have the same allegiances as existing members and it is already apparent some are discontent with the original product they purchased, once they have had time to examine the fine detail. These consumers, along with those who wish to transfer for other reasons, need to have certainty in being able to maintain their rights of continuity when they do transfer either to another fund, or within their existing fund.

The right to transfer between health funds without having to re-serve waiting periods is a basic consumer protection measure which has been available to health fund members for many years. However, the issue has become increasingly complex due to a number of factors, including the difficulties of comparing different tables of cover and the introduction of selective contracting with hospitals and medical practitioner arrangements.

The following case illustrates the difficulties faced by consumers who feel a need to transfer funds.

Mrs Silver was a 76 year old who had private health insurance for over 40 years. She was disappointed when her fund did not have a contract with her preferred hospital and reluctantly joined another in Mid August. She understood she had 100% cover, the same as her old fund, except for inter hospital ambulance and obstetrics. At 76, this didn't present as a problem.

She had, 21 years previously, had heart surgery and wouldn't have knowingly taken a product without heart cover as 3 years ago she also needed a pacemaker. She had indicated her heart condition at the time of transfer.

Subsequently Mrs Silver had to undergo minor surgery and the private hospital informed her the fund would not pay benefits as the product she had transferred to, although being 100% cover, had benefit limitations for 12 months for cardiac procedures. She had to be transported by ambulance from the private to the public hospital.

On intervention by the Ombudsman's office, the fund resolved the issue to the satisfaction of Mrs Silver.

Automatic Premium Deduction from Payroll, Credit Card or Bank Account

Health insurers have encouraged contributors to use automated premium payments either through payroll deductions or through continuing authorities with their credit cards or bank accounts. Premium discounts are often associated with this type of payment method. It is apparent that while automatic payments offer members a convenient method of payment, there is a need for contributors to check their accounts regularly, to ensure that payments have been made. Far too often the consumer gets caught out with unpaid contributions, either due to changes in the workplace, changes in banking arrangements, or just insufficient funds being available at the time the automatic payment is due.

Another consequence of the automated payments is the difficulty faced by some consumers when they discover an error has been made. This office receives many complaints about incorrect deductions and the effort and time taken to rectify the error. In one instance a contributor had ten times the authorised deduction taken from a bank account. An error of three thousand dollars. Yes just a simple mistake. An additional zero incorrectly inserted in the system. After finally being able to contact the fund on their 'hot line' they were informed they would need to apply in writing and the reversal would take around four weeks. The Ombudsman's office intervened and fixed this transaction, but during the investigation the office was informed it was normal practice for refunds or reversals to take from four to six weeks.

If this was a one off problem it would be less worthy of reporting; unfortunately it is not. Errors in bank transactions are common place and the response from some funds less than acceptable. The error is of their making, and the rectification should be immediate. Consumers should not suffer because fund internal administrative arrangements are inadequate.

Informed Financial Consent

This is one of the perennial issues which just refuses to go away. The lack of information provided to a patient on which they can base an informed decision can come about for a myriad of reasons. It is incumbent on all segments of the industry to not only be aware of the factors that can lead to the problem, but also the difficulty faced by all participants if the patient does not make an informed decision.

Patients can be uninformed about;

- Their level of cover
- Any exclusions or benefit limitations applying to their particular product
- Whether the procedure falls within the provisions of the pre-existing ailment rules
- Whether or not the hospital and health fund have an agreement
- The level of cover provided for the particular procedure within the hospital/ health fund agreement
- Whether the doctor and the health fund are covered by a scheme of arrangement
- Whether or not their contributions are up to date.

Given that the health fund advises members to always check with them prior to going to hospital, and the hospital/fund agreement complies with section 73BD(2)(d) of the National Health Act requiring a hospital "to inform eligible contributors... of the amounts the eligible contributor will be liable to pay to the hospital", it is difficult to understand why we still receive so many complaints concerning lack of informed financial consent.

Mr and Mrs Gold (both in their eighties) were on a bus excursion in rural New South Wales when Mrs Gold suffered an injury to her hip when alighting from the bus and sustained a broken hip.

The patient and her husband were subsequently transported to a regional public hospital. Mr Gold was asked if they had private health insurance and he responded yes and Mrs Gold was then on-carried and admitted to the local private hospital.

Her significantly distressed 84 year old husband was asked at the hospital if they had private health insurance and he produced his card and said his wife's was the same.

Mrs Gold remained a patient for 14 days, having undergone a hip replacement. At no stage during the whole of the 14 days, did the hospital seek confirmation from the fund of her insurance status, instead relying on the initial word of her aged and distressed husband.

Six months prior to the incident, the couple had gone to the local fund office seeking ways to reduce the cost of their full cover family insurance. They were advised they could do this by taking out two single memberships with some exclusions. As it transpired the benefit limitations were much more extensive than the maternity they laughingly spoke about and actually had restrictions on joint replacements, lens procedures, cardiac procedures and obstetrics.

The fund denied full benefits on the basis that the policy held by Mrs Gold did not cover joint replacement in a private hospital. The fund paid $14,000 of the total $20,000 account and the hospital sought to recover the remaining $6000.

It took a considerable amount of persuasion by the Ombudsman for the hospital to admit they had not fulfilled their obligations under contract nor the spirit of the legislation requiring hospitals to inform eligible contributors, even though Mrs Gold had been a patient for 14 days.

The other sleeper issue surrounding this particular episode, is that of supplying a product fit for purpose. Section 71(2) of the Trade Practices Act requires

"Where a Corporation supplies goods to a consumer in the course of business and the consumer, expressly or by implication makes known to the corporation... any particular purpose for which the goods are being acquired, there is an implied condition that the goods supplied... are reasonably fit for purpose, whether or not that is the purpose for which the goods are commonly supplied".

It is highly questionable if this product, designed for young singles, is a product fit for purpose. Surely, by presenting in person as an 80s plus couple, the Golds by implication made known the particular purpose for which the goods are being purchased.

Insurers need to be aware, that if they continue to sell products which deny the very fundamentals on which the private product is sold, they risk being held to account on the question of product fit for purpose. Exclusion products face the possibility of being tested against the Section 72 Trade Practices Act provisions unless those to whom they are sold are appropriate customers, and full and accurate disclosure of the extent of the exclusions is provided. The current extent and accuracy of exclusion products is a constant subject of dispute not only from the consumer, but also from the practitioners.

Significant Service Issues

In the past, service issues did not warrant inclusion in this report. Unfortunately in this instance this is not the case.

With the emphasis insurers placed on attracting new members during the recent lifetime health cover campaign, existing consumers were relegated to a lesser position of importance. Fund branches suspended cash claims settlements without prior advice to customers, telephone hot lines became hopelessly congested, and queues at branch offices were so large that existing consumers were again given lesser access than new membership enquiries. The service provided by many funds to their loyal existing customers was poor.

Unfortunately with the conclusion of the campaign the service component did not improve. Funds have underestimated the service needs of the new customers and the additional administrative infrastructure essential to cater for the needs of a larger customer base.

Telephone hot lines continue to be congested, to the point where the Ombudsman's office has to respond to complaints from long suffering consumers who cannot gain access through the network. Days, not hours are spent by consumers trying to gain a satisfactory response to simple enquiries.

Insurers will need to shift their focus from the campaign of gaining new members, to one of offering high quality service to both new and existing consumers. This needs to be a priority.

GENERAL ISSUES

Access and public awareness

Because the Private Health Insurance Ombudsman was established primarily for the benefit of health fund members, it is important that they know about their right to approach the Ombudsman for assistance. Health funds are required to publish the contact details for the Ombudsman in their main product brochures, and many members are being made aware of the Ombudsman's services through this avenue.

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

- advertisements outlining the Ombudsman's services were placed in metropolitan newspapers during the year, particularly during the media campaigns for lifetime health cover;
- the Ombudsman gave radio and television interviews and participated in talkback radio in all mainland States. A similar campaign will be conducted in Tasmania later in the year.
- the Ombudsman hosts a World Wide Web site where consumers can access a range of brochures and recent Ombudsman Quarterly Bulletins and Annual Reports. The site enables consumers to make inquiries; lodge complaints and request printed copies of brochures (including community language). It also provides consumers with links to other useful sites. The Ombudsman's website is located at: www.phio.org.au.

  During the 99/00 financial year the Ombudsman's website was visited by 12,354 unique users who viewed a total of 59,918 pages.

  There were 471 complaints and enquiries lodged via the website and 6416 PDF files downloaded. These included PHIO's quarterly Bulletins, Annual Reports and discussion papers;
- the Ombudsman and staff spoke at numerous conferences and community meetings during the year.

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 inquires can be made from anywhere in Australia on the free-call Hotline 1800 640 695. Complaints may be lodged by mail, telephone, fax and e-mail.

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

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

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, bulletins 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.

Relations with Stakeholders

The Ombudsman produces a Quarterly Bulletin containing general information about current problem areas and health insurance complaint statistics which is sent to members of Parliament, consumer groups, libraries, health funds and hospitals.

The Ombudsman maintains regular contact with relevant health fund, hospital and consumer organisations.

In February, the Office conducted a seminar in Wollongong, inviting participation from all Health Funds. Feedback from participants was excellent and it is intended to conduct further seminars to assist in maintaining an awareness by fund contact personnel and executives of the issues which come before the office and the means adopted to resolve complaints.

In March 2000, the office carried out a mail survey of all complainants who had lodged complaints during the period 1 September to 31 December, 1999. 174 complainants responded. In May 2000, the Office surveyed all health funds, including fund/PHIO contact personnel and chief executives. Four funds did not respond.

The aim of both surveys was to gauge the degree to which PHIO 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 complainant survey found a similar high level of satisfaction among consumers with the Ombudsman's services as was found previously. Among the findings, the study showed that:

- 92% reported that staff listened to their concerns.
- 83% of respondents said they were satisfied or mostly satisfied with the way staff handled the complaint.
- 70% were satisfied with the time it took to finalise the complaint.
- 85% were of the view that the Ombudsman's staff were independent in dealing with their complaint.
- 82% reported they were satisfied with the Ombudsman's service overall.

The Health Fund survey looked at both the processes for handling complaints and the personnel issues. All respondents agreed that the categories of complaint were adequate for delineating the complexity of complaint, and the approach used for communicating issues between the parties. There was also overwhelming agreement that the 21-day response period was in most cases over generous. As a consequence, this has now been revised to 14 days.

- 75% of respondents considered the professionalism exhibited by PHIO staff to be fully professional and 25% considered it to be adequate.
- 36% of respondents considered the industry knowledge of the PHIO staff, in all cases to be adequate, with 61% saying in most cases it was adequate. 3% considered that in some individuals the level of knowledge was inadequate.
- 35% of health fund respondents considered PHIO staff adopted an impartial approach on all occasions and 61% reporting they were impartial on most occasions. 4% reported the staff were not impartial.

Health Policy Liaison with other bodies

The Ombudsman's office has a role in assisting with the broader issues associated with health policy. During the year, the Office presented information to various bodies assisting in the formulation of health policy and the compliance with established rules and laws. Some of the issues of significance were:

- Provision of evidence to the Australian Competition and Consumer Commission with respect to an application for authorisation on certain issues by the Australian Association of Anaesthetists.
- Provision of detailed information to the Australian Competition and Consumer Commission to allow it to comply with the provisions of an order from the Australian Senate for six monthly reporting on "any anti competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses".
- The establishment of industry reference groups to assist the Ombudsman in determining a position with respect to legislative change. In particular this year the reference groups, made up of private hospital and health insurance executives, provided guidance on portability of health insurance, and informed financial consent.
- Provision of detailed information to assist the Ministerial body set up to look at the current provisions relating to pre-existing ailments and conditions.

APPENDICES

STATUTORY REPORTING INFORMATION

CORPORATE GOVERNANCE

Being a small office with duties specified by the National Health Act, the business of the office is well defined. In accomplishing the tasks envisaged under the Act, there is a need for procedures to be in place to monitor both performance and process, together with the appropriate management and staff policies. In providing for this, the Ombudsman works with the Director of Policy and Customer Service to define the operational procedures and includes the Director of Corporate Services in determining administrative processes.

Within this environment, staffing and accounting practices provide the following framework of the Office's management activities:

MANAGEMENT OF HUMAN RESOURCES

The core function of the office is to resolve complaints from consumers, practitioners, hospitals and health funds with respect to health insurance arrangements. This involves the resolution of individual complaints and development of strategies to assist in identifying and resolving the underlying principles, which lead to complaints.

The ability within a small organisation to accomplish these task places a significant reliance on all staff to work as a team and to fully understand the fundamentals associated with the whole private health industry. Dispute resolution staff are responsible for the day to day management of individual complaints and to bring to the attention of the Ombudsman and the Director of Policy and Customer Service, potential and actual issues, which require broader attention. Disputes resolution staff need to be highly trained and sourced from such disciplines as Law, Commerce or Nursing. The activity of the office is very intense and staff retention as a consequence is a significant problem.

Staff Details

As at 30 June 1999, 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	
Senior Dispute Resolution Officers		1
Dispute Resolution Officers	3	
Administrative Assistant	1	
Total	6	2

Statutory Positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry date
Mr N Branson	Ombudsman	3 years	1 August 2002

Staff development and training

During the 1999-2000 financial year $12,421 was spent on PHIO staff attending training courses, conferences and seminars. The Ombudsman designed and implemented a staff development and training program for its Dispute Resolution staff.

The Ombudsman's Office conducted a significant training event attended by disputes staff associated with the private health insurance funds in February 2000 which was self funding.

With the assistance of the Office, staff also participated in part-time studies at formal educational institutions.

Staff Employment Status

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.

The following table shows the numbers and status of staff who are employed on 30 June 2000:

Occupational group	Female	Male	NESB1	Total Staff
SES		1	-	1
Other	6	1	2	7
Total	6	2	2	8

SES = Senior Executive Service
Other = All other staff - temporary and permanent
NESB1 = Non-English speaking background, 1st Generation

Workplace structures, systems and procedures are in place to assist employees balance their work and family responsibilities effectively.

Performance Appraisal

The Ombudsman has a performance appraisal system in place that is used to measure staff performance. This tool assists the Ombudsman with annual salary reviews. All staff are subject to an annual performance appraisal and salary and promotion advancement is based solely on performance.

INDUSTRIAL DEMOCRACY

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

ACCOUNTING SERVICES

The Ombudsman has engaged Hall Chadwick Chartered Accountants to assist it with its accounting functions. The office utilises the MYOB suite of accounting programs internally.

CONSULTANTS ENGAGED

During the financial the Ombudsman engaged specialist consultants to provide expertise in the areas of legal advice, medical opinions, especially as it relates to pre-existing ailments and conditions and information technology.

Ten consultancies were let at a total cost of $11,734. Consultants were appointed using the Ombudsman's purchasing and contracting guidelines, which have regard to value for money, open and effective competition, the promotion of ANZ industry development, ethics and fair dealing. Consultants were engaged to supplement the office's in-house resources and gave access to the latest experience in application.

There were no consultancies paid more than $2000.00 during the financial year.

ADVERTISING AND MARKET RESEARCH

The Ombudsman expended the following monies during the 1998/99 financial year on advertising and market research.

Provider	Service	Amount $
TMP Worldwide	Advertising - print media	12167.40
David Syme & Co.	Advertising - print media	334.40
Public Information Services	Advertising - print media	1345.00
		$13846.40

INFORMATION SYSTEMS

The Ombudsman's information system is based upon 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 Accounting and Asset Manager. Additionally the Ombudsman has a purpose built Complaints Management and Reporting system on-site.

PAYROLL SERVICES

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

FRAUD CONTROL

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. A formal fraud procedure manual was introduced during the year. No cases of fraud were detected during the year.

SERVICE CHARTER

The Ombudsman's Service Charter has been in operation since June 1998 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.

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 Director, Policy and Customer Service is the Ombudsman's First Aid and Occupational Health and Safety Officer.

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

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 2000.

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, but no requests were received for information under the FOI Act during the reporting period.

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'
- Complaints Register and Complaints files
- Guidelines for staff - 'Dealing with complaints and Inquiries - Policies and Procedures'
- Guidelines 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'

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) 92615855 or 1800 640 695 (freecall)
- by fax on (02) 9261 5937
- by e-mail to info@phio.org.au
- from the website www.phio.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 9.00am and 4.30pm on weekdays.

EXTERNAL REVIEW & SCRUTINY

The Office subjects itself to regular review of its performance by way of the conduct of a survey of complainants and health insurance funds. The review of complainants is extensive and is offered on a whole of population basis of complainants during a full quarter of activity and not by sample. The review with respect to health insurance funds is for all registered health benefits organisations.

Details of both of these reviews are available in the body of this report.

Courts

There was no action by the Courts which directly affected the office during the year.

Commonwealth 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.

Service Charter

In line with requirements for all Commonwealth Government agencies, the Ombudsman introduced a Service Charter in June 1998.

The Service Charter covers all of PHIO's customers and sets out the service delivery standards which they can expect from the office. The Charter was developed in consultation with staff and customers and copies of the charter are routinely sent out to people who contact the office.

The Charter includes 15 service standards and provides for a tiered system for handling complaints specifically about our service (as distinct from our work as a complaints body). The Ombudsman has in place a system for recording complaints, compliments and feedback about our service.

During the reporting period, one formal complaint about our service was recorded, 30 formal compliments about our service were also recorded.

The key performance standards listed in the Service Charter are: Accessibility, Timeliness, Courtesy and Sensitivity and High Quality Advice.

FINANCIALS

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Aged Care

Scope

I have audited the financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2000. The financial statements comprise:

- Statement by Ombudsman;
- Operating Statement;
- Balance Sheet;
- 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 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 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 Schedule 2 of the Finance Minister's Orders; and

(ii) the financial statements give a true and fair view, in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and Schedule 2 of the Finance Minister's Orders, of the financial position of the Private Health Insurance Ombudsman as at 30 June 2000 and the results of its operations and its cash flows for the year then ended.

Australian National Audit Office

Paul Hinchey
Senior Director

Delegate of the Auditor-General

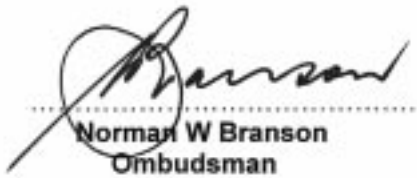
Sydney
11 September 2000

Private Health Insurance
OMBUDSMAN

Private Health Insurance Ombudsman

Statement by the Ombudsman

In my opinion, the attached financial statements give a true and fair view of the matters required by the Finance Minister's Orders made under the Commonwealth Authorities and Companies Act 1997 for the year ended 30 June 2000.



Norman W Branson
Ombudsman

11 Sept 2000

Dated

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

OPERATING STATEMENT

FOR THE YEAR ENDED 30 JUNE 2000

	Note	2000 $	1999 $
Operating Revenues			
Revenues from Government	2A	**950,000**	700,000
Interest	3A	**11,328**	7,413
Other Income	3B	**1,933**	10,224
Total Operating Revenues		**963,260**	717,637
Operating expenses			
Suppliers	4A	**308,060**	409,009
Employees	4B	**443,666**	344,160
Depreciation and Amortisation	4C	**57,057**	74,340
Total operating expenses		**808,783**	827,509
Operating Surplus (Deficit)		**154,478**	(109,872)
Accumulated surpluses at beginning of reporting period		**98,992**	208,864
Accumulated surpluses at end of reporting period		**253,470**	98,992

BALANCE SHEET

AS AT 30 JUNE 2000

	Note	2000 $	1999 $
ASSETS			
Financial Assets			
Cash	5A	**191,336**	52,788
Receivable	5B	**477**	8,466
Total Financial Assets		**191,813**	61,254
Non Financial Assets			
Infrastructure, plant and equipment	6B	**109,137**	112,272
Other	6C	**-**	9,018
Total Non Financial Assets		**109,137**	121,290
Total Assets		**300,950**	182,544
LIABILITIES			
Suppliers	7A	**9,185**	38,395
Employees	7B	**38,296**	45,157
Total Liabilities		**47,481**	83,552
EQUITY			
Accumulated Surpluses		**253,470**	98,992
Total Liabilities and Equity		**300,950**	182,544
CURRENT LIABILITIES		**47,481**	68,564
NON CURRENT LIABILITIES		**-**	14,988
CURRENT ASSETS		**191,813**	70,272
NON CURRENT ASSETS		**111,913**	112,272

STATEMENT OF CASHFLOWS

FOR THE YEAR ENDED 30 JUNE 2000

	Note	2000 $	1999 $
OPERATING ACTIVITIES			
Cash Received			
Appropriations		**950,000**	700,000
Interest		**11,328**	7,413
Other		**1,933**	3,174
Total cash received		**963,260**	710,587
Cash Used			
Suppliers		**(301,400)**	(412,031)
Employees		**(469,391)**	(378,150)
Total cash used		**(770,791)**	(790,181)
Net cash from operating activities	13	**192,470**	(79,595)
INVESTING ACTIVITIES			
Cash used			
Purchase of Property, Plant and Equipment		**(53,922)**	(15,281)
Net cash from investing activities		**(53,922)**	(15,281)
Net increase/(decrease) in cash held		**138,548**	(94,876)
Cash at the Beginning of Reporting Period		**52,788**	147,664
Cash at the end of reporting period		**191,336**	52,788

SCHEDULE OF COMMITMENTS

AS AT 30 JUNE 2000

	Note	2000 $	1999 $
BY TYPE			
Capital Commitments		-	-
Other Commitments			
Operating Lease Commitments		**150,981**	-
Total other commitments		**150,981**	-
BY MATURITY			
Operating Leases			
One Year or Less		**84,835**	
From one to two years		**66,146**	
		150,981	-

SCHEDULE OF CONTINGENCIES

AS AT 30 JUNE 2000

	Note	2000 $	1999 $
CONTINGENT LOSSES		**0**	0
CONTINGENT GAINS		**0**	0
Net Contingencies		**0**	0

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2000

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Basis of Accounting

The financial statements are required by clause 1(b) of Schedule 1 to the Commonwealth Authorities and Companies Act 1997 and are a general purpose financial report.

The statements have been prepared in accordance with:

- Requirements for the Preparation of Financial Statements of Commonwealth Agencies and Authorities made by the Minister for Finance and Administration in August 1999 (Schedule 2 to the Commonwealth Authorities and Companies (CAC) Orders);
- Australian Accounting Standards;
- Other authoritative pronouncements of the Australian Accounting Standards Boards; and
- The Consensus Views of the Urgent Issues Group.

The statements have been prepared having regard to:

- Statement of Accounting Concepts; and
- The Explanatory Notes in Schedule 2 issued by the Department of Finance and Administration.

The financial statements have been prepared on an accrual basis and are in accordance with historical cost convention. Except where stated, no allowance is made for the effects of changing prices on the results or the financial position of the Authority.

1.2 Changes in Accounting Policy

Changes in accounting policy have been identified in this note under their appropriate headings.

1.3 Property, Plant & Equipment

Asset recognition threshold

Purchases of property, plant and equipment are recognised initially at cost in the Balance Sheet, except for purchases costing less than $500, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

Revaluations

Schedule 2 requires that buildings, infrastructure, plant and equipment be revalued progressively in accordance with the 'deprival' method of valuation in successive 3-year cycles.

The Ombudsman completed a management asset revaluation at 30 June 2000, no adjustment was considered necessary.

Recoverable amount test
The carrying amount of each item of non-current property plant and equipment assets is reviewed to determine whether it is in excess of the asset's recoverable amount. If an excess exists at the reporting date, the asset is written down to its recoverable amount immediately. In assessing recoverable amounts, the relevant cash inflows have been discounted to their present value.

The application of the recoverable amount test to the not-for-profit departmental non-current assets of the Ombudsman is a change of accounting policy required by the Finance Minister's Orders in 1999-2000. The new policy is being applied from the beginning of 1999-2000. No write-down to recoverable amount has been made in 1999-2000 as a result of this change in policy.

Depreciation and Amortisation
Depreciable property plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Ombudsman using, in all cases, the straight line method of depreciation. Leasehold improvements are amortised on a straight line basis over the lesser of the estimated useful life of the improvements or the unexpired period of the lease.

Depreciation/amortisation rates (useful lives) and methods are reviewed at each balance date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate. Residual values are re-estimated for a change in prices only when assets are re-valued.

Depreciation and amortisation rates applying to each class of depreciable asset are based on the following useful lives:

Leasehold Fitout	3 years.
Plant and Equipment	3 to 5 years.

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 2C.

1.4 Leases
A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of leased non-current assets and operating leases under which the lessor effectively retains substantially all such risks and benefits.

Lease payments for operating leases are charged as expenses in the periods in which they are incurred.

The Ombudsman has no finance leases.

1.5 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 2000 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 2000. In determining the present value of the liability, attrition rates and pay increases through promotion and inflation have been taken into account.

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

1.6 Taxation

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

1.7 Cash

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

1.8 Comparative Figures

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

	2000 $	1999 $
2 REVENUES FROM GOVERNMENT		
2A Parliamentary appropriations		
Appropriations Act No. 1	**950,000**	700,000
	950,000	700,000
3 REVENUES FROM INDEPENDENT SOURCES		
3A Interest		
Deposits	**11,328**	7,413
	11,328	7,413
3B Other Income		
Workers compensation insurance		9,780
Proceeds from sale of plant and equipment		444
Employee Reimbursements	**1,933**	0
	1,933	10,224
4 GOODS AND SERVICES EXPENSES		
4A Suppliers expenses		
Supply of Goods and Services	**210,878**	337,428
Operating Lease Rentals	**97,182**	71,581
	308,060	409,009
4B Employee expenses		
Remuneration for Services Provided	**443,666**	344,160
	443,666	344,160
4C Depreciation and Amortisation		
Depreciation	**43,352**	59,984
Amortisation - Lease Fitout	**13,705**	14,356
	57,057	74,340

	2000 $	1999 $
5 FINANCIAL ASSETS		
5A Cash		
Cash on Hand	**250**	250
Cash at Bank	**191,086**	52,538
	191,336	52,788
5B Receivables		
Other Debtors	**477**	8,466
	477	8,466
6 NON FINANCIAL ASSETS		
6A Land and Buildings		
Leasehold Fitout - at valuation	**80,620**	80,620
Less: Accumulated Amortisation	**55,641**	41,935
Total Land and Buildings	**24,979**	38,685
6B Plant and Equipment		
Plant and Equipment - at valuation	**265,019**	211,096
Less: Accumulated Depreciation	**180,861**	137,509
Total Plant and Equipment	**84,158**	73,587
Total Property, Plant and Equipment at Written Down Value	**109,137**	112,272
6C Other Assets		
Other Prepayments	**-**	9,018
	-	9,018

6D Movement Summary 1999-00 for all assets

Item	Leasehold Fitout $	Plant & Equipment $	Total $
Gross value as at 1 July 1999	80,620	211,097	291,717
Additions - New		25,789	25,789
Additions - Replacement		28,133	28,133
Gross value as at 30 June 2000	80,620	265,019	345,639
Accumulated depreciation/amortisation as at 1 July 1999	41,935	137,509	179,444
Depreciation / amortisation charge for assets held at 1 July 1999	13,705	38,854	52,559
Depreciation / amortisation charge for additions		4,499	4,499
Accumulated depreciation/amortisation as at 30 June 2000	55,640	180,862	236,502
Net book value as at 30 June 2000	24,980	84,157	109,137
Net book value as at 1 July 1999	38,685	73,588	112,272

	2000 $	1999 $
7 PROVISIONS AND PAYABLES		
7A Suppliers		
Trade creditors	**-**	28,179
Accruals	**9,185**	10,216
	9,185	38,395
7B Employees		
Salaries and Wages	**13,300**	5,974
Annual Leave	**24,996**	24,195
Long Service Leave		14,988
Aggregate employee entitlement liabilities	**38,296**	45,157

	2000 $	1999 $

8 REMUNERATION OF OFFICERS

The position of Ombudsman was filled by 2 people during the reporting period. Neither received over $100,000 in remuneration.

9 REMUNERATION OF AUDITORS

Remuneration to the Auditor-General for Auditing the Financial Statements	**3,200**	3,200

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 10.5% of salary (PSS). An additional amount of up to 3% is contributed for employer productivity benefits. Casual staff can choose to be a member of any approved superannuation fund and receive employer benefits at the Superannuation Guarantee Charge rate, currently 7%.

11 ECONOMIC DEPENDENCY

The Ombudsman is dependent on appropriations from the Parliament of the Commonwealth for its continued existence and ability to carry out its normal activities.

12 SEGMENT REPORTING

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

	2000 $	1999 $
13 CASH FLOW RECONCILIATION		
Reconciliation of net cash flows from operating activities to Net Cost of Services		
Net Cost of Services	**(795,523)**	**(809,872)**
Parliamentary Appropriation	**950,000**	700,000
Operating Surplus	**154,477**	**(109,872)**
Amortisation - Lease fitout	**13,705**	14,356
Annual Leave Provision	**801**	(7,476)
Depreciation	**43,352**	59,984
Long Service Leave	**(14,988)**	(36,156)
Decrease/(Increase) in Other Debtors	**7,989**	(8,466)
(Decrease)/Increase in Trade Creditors	**(28,179)**	(59,507)
(Decrease)/Increase in Accruals	**6,295**	6,809
Decrease/(Increase) in Other Prepayment	**9,018**	60,733
Net Cash provided for by operating activities	**192,470**	**(79,595)**

14 FINANCIAL INSTRUMENTS

a) Terms, conditions and accounting policies

Financial Instrument	Accounting Policies and Methods (including recognition criteria and measurement basis)	Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows)
Financial Assets	Financial assets are recognised when control over future economic benefits is established and the amount of the benefit can be reliably measured.	
Other Debtors	These receivables are recognised at the nominal amounts due less any provision for bad and doubtful debts. Provisions are made when collection of the debt is judged to be less rather than more likely.	Credit terms are net 14 days (1998-99: 14 days)
Financial Liabilities	Financial Liabilities are recognised when a present obligation to another party is entered into and the amount of the liability can be reliably measured.	
Trade Creditors	Creditors and accruals are recognised at their nominal amounts, being the amounts at which the liabilities will be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of being invoiced).	Settlement is usually made net 30 days.

b) 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		Carrying amount	
	2000	**1999**	**2000**	**1999**
Financial Assets	**%**	**%**	**$**	**$**
Cash	**5.40**	4.75	**191,366**	52,788
Debtors	**N/A**	N/A	**477**	8,466
Total Financial Assets			**191,843**	61,254
Financial Liabilities				
Trade Creditors	**N/A**	N/A	**0**	28,179
Total Financial Liabilities			**0**	28,179

c) 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 Statement of Assets and Liabilities and notes to the financial statements.

The Ombudsman has no significant concentration of credit risk.

d) Net Fair Values

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

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