# CONTACT DETAILS

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**Inquiries and complaints**
1800 640 695 Free Call – higher cost from Mobiles

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

**Deaf, hearing or speech impaired**
13 36 77 (National Relay Service)

E-mail info@phio.org.au
Internet http://www.phio.org.au

Administration (02) 9261 5855
Facsimile (02) 9261 5937

**Freecall telephone hours of operation**
9.00 am – 4.30 pm (Sydney time)
Monday – Friday

Readers with inquiries about the Ombudsman or this report should contact the administration at the above address.

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

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Private Health Insurance
OMBUDSMAN

The Hon Senator Kay Patterson
Minister for Health and Ageing
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 2001 to 30 June 2002.

This report has been prepared in accordance with the Finance Minister's orders and Government guidelines for the preparation of annual reports and financial statements.

Yours sincerely

Norman W Branson
OMBUDSMAN

19 September 2002.

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# OMBUDSMAN'S OVERVIEW

Personally, this will be my final report as Ombudsman. It is appropriate at such a time, not only to review the current year, but to also place in some perspective the way the Office views those aspects of the broader industry that have and still do impact on consumers of private health.

It is pleasing to be able to report the positive outcomes for consumers this office has been part of in its relatively short seven year history. It is also appropriate to place on record the commitment of those from the broader private health industry, the Government, the various consumer bodies and staff of my office (both past and present) who participated in the necessary changes.

The Office commenced in an environment within private health quite different from that which exists today. In some areas there was indifference or even hostility towards both the office and its perceived incursions into areas which were regarded as the purview of the funds. None-the-less, most participants had sufficient understanding of the issues and set about assisting in the resolution of the range of problems facing consumers.

- The resolution of the pre-existing ailment difficulties and the guidelines for determining what is pre-existing and how the various segments of the industry will act administratively to protect consumers was a very important achievement.
- The detailing of the conditions and rights applicable to persons wishing to change fund or product further enforced the consumer protection.
- The Key Features Guide to Private Health Insurance is another vehicle that consumers now have to assist them in determining the relative value of the various product offerings available.
- The acceptance by health funds in general, of the need to make their advertising and promotional material easier for the consumer to understand is commendable, though there still seem to be some glitches from time to time.
- The acceptance of the need to be more explicit in product descriptions particularly where there are benefit limitations is another achievement which will mean fewer consumers will purchase products that may not offer what they need.

The achievement of the resolution of these issues by the combined effort of this office, together with other consumer representatives, industry associations and individual health funds and hospitals and the support of the Government representatives is well worthy of note. This is not to say that from time to time complaints will still not be received regarding each of these issues, but the incidence of them should be fewer and the resolution more straight forward.

### CONSUMERS' ELIGIBILITY FOR BENEFITS—INFORMED FINANCIAL CONSENT

There is though still one big issue that needs to be fixed, membership verification and eligibility. The provision of timely verification of a consumer's financial status with respect to a particular procedure is vital if the consumer is to provide Informed Financial Consent to the hospital or practitioner.



Most of the high cost disputes between consumers and either health funds or hospitals eventuate because one or other of the parties has made an administrative error. The member's eligibility for benefits for the particular procedure has not been correctly established.

It is inconsequential why the consumer is not covered. It may result from a specific product deficiency, a delay in contributions or even not having current hospital cover.

The fact is every consumer has an absolute right to know if they themselves are going to be responsible for any of the cost of the procedure, and as far as possible exactly how much their personal contribution will have to be, before, not after the event.

This office has been conducting a detailed assessment of the capability of health funds to provide timely responses to requests for membership verification. There are some deficiencies in the existing systems, but in the main, the cause for complaint arises because insufficient and inaccurate information passes between provider and health fund. These are administrative problems that can be easily fixed.

In the past, hospitals have issued patients with accounts sometimes for many thousands of dollars to cover the residual fees for a procedure for which the patient was not adequately covered. This office has had to conduct intensive investigations between the health fund and the hospital to find out where the administrative failure occurred. Who didn't do their job properly?

Fixing up administrative oversights at this level shouldn't be the job of PHIO. There is generally a contractual arrangement between the funds and the hospital to sort out these issues and where there isn't, there is an obligation on the provider to obtain the information from the fund on behalf of the patient. Hospitals and health funds will in future be called upon to fix the problem, which was of their making and not pass the responsibility for administrative failure of the system to the patient.

It is appropriate to note the comment of the ACCC with respect to this general issue when in June 2001, they indicated in their opinion that silence in relation to fee disclosure may constitute misleading or deceptive conduct.

### REDUCTION IN DISPUTE LEVEL COMPLAINTS

Review of the activities of the Office over the past year shows a distinct contrast. There has been significant progress in some areas, leading to a reduction in the number of dispute level complaints, but also a return to high numbers of expressions of dissatisfaction where consumers genuinely felt aggrieved that the highly regulated system had fallen short of their expectations.

Disputes are recorded when this office has to become actively involved in the resolution of a complaint, where all the efforts of the consumer to resolve the issue themselves have failed. The financial effect of disputes is generally much greater than for other categories of complaint. The majority of disputes in the past came about because of systemic problems

in the administration of certain funds, or where differences in interpretation of specific issues existed.

The willingness of most funds to cooperate with the office to resolve systemic administrative problems is acknowledged and appreciated. The participation by the industry in working to resolve differences in interpretation on specific issues has been outlined above and recognised as highly beneficial to consumers generally. This cooperation has directly contributed to the reduction of the higher-level dispute category of complaint relative to the total number of complaints resolved.

None-the-less, overall complaint numbers will continue to rise until such time as all health funds have in place internal complaints review and resolution processes, which keep management aware of issues that create problems for consumers. It is difficult to understand, how in a highly competitive and consumer oriented industry, some funds feel they can meet consumer expectations and continue to operate effectively without consumer feedback that is a direct by-product of a formal complaints management system.

### MANAGEMENT AND DIRECTOR RESPONSIBILITIES

In past reports this office has refrained from identifying individual health funds but this year the significance of the issues and numbers of complaints associated with two funds necessitates a change in that practice. Both funds marketed products at unsustainable prices. The subsequent necessary changes to price and product created high levels of concern for consumers and highlighted a need for greater understanding and scrutiny by management, directors and regulators. While the complaints surrounding these issues have now been closed or referred on, it is still necessary to draw attention to the underlying factors to ensure there can be no repeat of the practice that caused the problems.

The Board and management of the Goldfields Medical Fund embarked on an expansion program that would transform the once regional Western Australian eastern goldfields based fund into a national fund with the majority of its contributors sourced from outside Western Australia. The implications on the cost structure of their products of higher reinsurance, utilisation and administration, and marketing through a broker with trailing commissions were not recognised or structured appropriately into their product prices.

The reality that the fund was marketing a significantly under priced product range was recognised by most in the broader industry. Even so, the current regulations made it difficult for the regulator to officially intervene until the fund had reached a crisis.

The appointment of an administrator to the fund was essential to safeguard the rights of the consumers, but it comes at a cost.

- The product price was increased in some instances up to 70%, with an average of around 40%.
- Rate protection for pre-paid contributions was unilaterally withdrawn even though it was clearly stated, as a right, in product brochures.
- After a joint meeting between PHIO, PHIAC, the Commonwealth Department of Health and Ageing, the ACCC and the appointed administrator, failed to resolve the rate protection issue, PHIO formally referred the matter of resolution to the ACCC in accordance with the requirements under Section 82ZSBA of the National Health Act.

The problems that occurred at the Goldfields Medical Fund highlight the need for both Directors and management of health funds to be fully aware of the complexity of the industry and regulations surrounding private health insurance.

It is inexcusable that the Directors and management of a once highly successful and financially stable fund can place existing members at risk in the pursuit of unsustainable expansion.

Contributors to a range of Medibank Private newly released products faced not only a significant increase in the price of their contributions, but also a marked reduction in the benefits available.

The way in which these changes were introduced and the short notice initially given to affected consumers required active intervention by this office.

The most significant change related to the imposition of member excesses for admissions to day surgery or day hospital procedures, where these did not previously exist. For those consumers who were already participating in treatment regimes such as chemotherapy or renal dialysis the cost implications were considerable. It was also difficult for some of these patients to immediately analyse the impact of the change and the combined effect of their treatment and the possible cost implications caused considerable distress.

PHIO recognised although it had no role in allowing or disallowing product changes, it certainly had a role in ensuring that affected consumers were given sufficient time to evaluate the effect the change was going to have on their individual circumstances.

Medibank Private subsequently varied the implementation date for the changes, which at least allowed consumers more time to source other products to better suit their needs.

Again this problem arose out of a successful marketing campaign, which saw large numbers of consumers purchase products, the long-term price and/or structure of which was not sustainable. The same message needs to be heeded by Directors of this fund as was provided above for the Goldfields Medical Fund. Health insurance is complex with many factors influencing the success or otherwise of individual products. Directors have a significant role in not only determining the relative value of products to their own organisation, but also the protection of those consumers who purchase the product.

I was reminded recently of the underlying principle adopted by one fund when addressing changes to their fund rules. The foremost question that needed to be answered prior to introducing a change was "what effect does this change have on the rights of our existing members". All funds could do well by adopting the same philosophical approach.

# ROLE & FUNCTION

### INTRODUCTION

The Private Health Insurance Ombudsman is a statutory corporation under the National Health Act 1953.

The Ombudsman is an independent body, which resolves problems about private health insurance, and acts as 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 Ageing;
- Make available and publicise the existence of the Private Patients' Hospital Charter; and
- Promote an understanding of the Ombudsman's functions.

### 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, hospital or provider, 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 explanation or proposed action, the Ombudsman may further investigate the complaint and make a formal recommendation;
- Referring the complaint to the Australian Competition and Consumer Commission; and
- 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; and
- A health fund changes its rules or practices.

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.

**Private Health Insurance Ombudsman Staff:** (L-R) Taran Sahdeva, Hillary Stirrat (seated), Ginette Bulmer, Ursula Schappi, Norman Branson, David McGregor, Samantha Gavel (seated), Sarah Bell.

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 fax and e-mail. Where complainants have not made a sufficient attempt to resolve their complaint with their health fund or provider, staff will usually refer complainants back to these parties in the first instance.

Where complaints are complex or where formal contact with the health fund has been unable to resolve the problem, the Ombudsman will write to the health fund or provider seeking further information.

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

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

# PERFORMANCE

The Ombudsman received 3182 complaints in the reporting period 1 July 2001 to 30 June 2002, compared with 3357 for the corresponding period of the last report, a 5.2% decrease. During the first half of the year there was a significant drop in the level of complaints compared with the previous year, but this turned around in the second half following the problems associated with the Goldfields Medical Fund and then the increases in contribution rates for a number of funds.

Complaint numbers, which tend to average out at around 12 new cases per day, peaked at 62 cases on 28 March and 56 new cases on 2 April. This workload level tested both the communications systems of the office and the capacity of the staff to adequately address the concerns of individual consumers.

Figure 1 shows the distribution of these complaints through the four quarters of the year.

The 3182 complaints recorded consisted of 580 disputes, 1288 grievances and 1314 problems. Figure 2 is a representation of these ratios and clearly shows the change associated within the categories of complaint. The reduced incidence of dispute level complaints is welcome. It clearly indicates that many of the underlying fundamental issues which were previously evident within the industry have been resolved. It is now up to the industry to ensure that these issues do not resurface.

FIGURE 1: TOTAL COMPLAINTS RECEIVED BY QUARTER

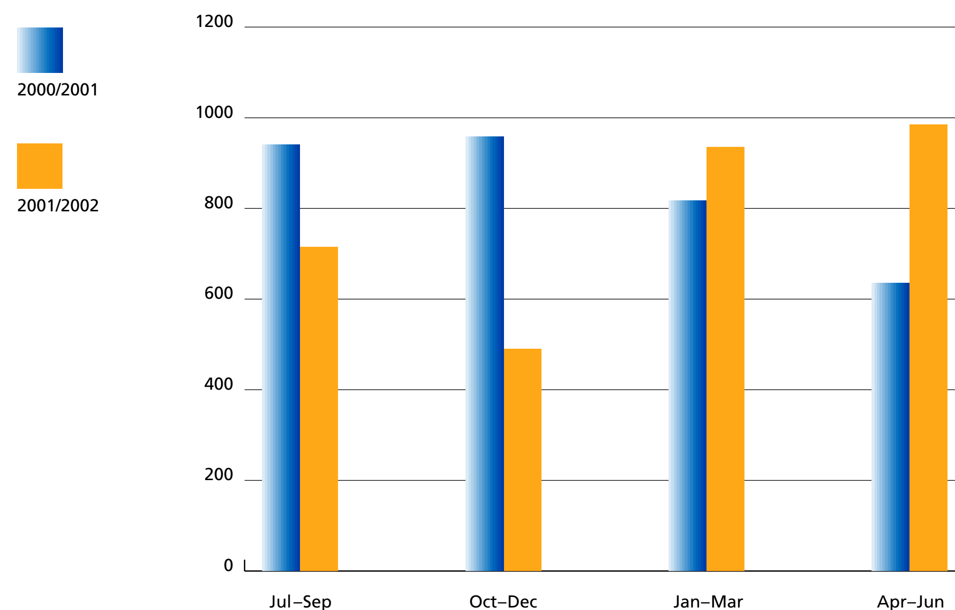
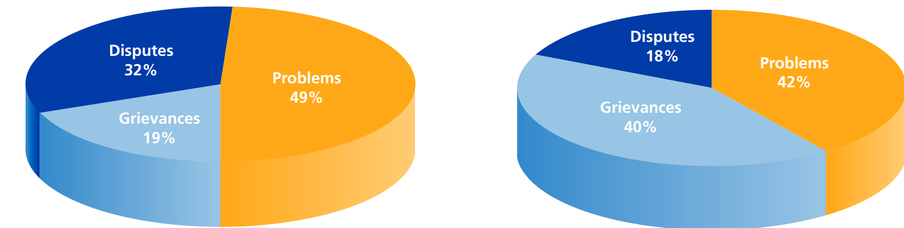



FIGURE 2: PERCENTAGE OF COMPLAINTS BY CATEGORY 2001/2002




## 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;
- 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 are depicted in Figure 3.

The majority of complaints handled are from fund members about their own fund. There are instances where a complaint needs to be recorded against both the health fund and a provider, particularly when the complaint relates to a member not having their membership status and category verified to enable an accurate assessment of their personal obligation to contribute to the cost of a procedure.

Fund members also lodge complaints about their hospital, (generally about inadequate information to enable informed financial consent) doctor (almost always relating to either the gap between charges and benefits paid through Medicare and the fund, and the failure to inform of the discrepancy before proceeding) or other practitioners (generally about the gap between the charges and the benefit paid through ancillary tables). Overall complaints against these provider groups are small in number when compared with complaints against health funds.

**FIGURE 3: STEPS IN HANDLING APPROACHES TO THE OMBUDSMAN**

| DISPUTE | GRIEVANCE | PROBLEM |
|---|---|---|
| **Timeframe**<br>Depends on the nature and complexity of matter and responses from health fund and provider | **Timeframe**<br>Usually within 24 Hours | **Timeframe**<br>Immediate |
| **Actions**<br>PHIO contacts health fund or provider to obtain a report, then mediate the dispute between the parties or investigate the matter further. | **Actions**<br>Complainant provided with explanation or information to resolve matter, or if there is no avenue for the Ombudsman to take up the matter | **Actions**<br>If complainant has made insufficient effort to resolve the matter with fund or provider, empower them with detail enabling them to take up the issue at an appropriate level. |
| **Outcomes**<br>Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal recommendation by Ombudsman | **Outcomes**<br>Detailed information provided which appropriately resolves the issue. | **Outcomes**<br>Referral to health fund or provider |



**FIGURE 4: TIME TAKEN TO FINALISE COMPLAINTS (PROBLEMS, GRIEVANCES, DISPUTES)**

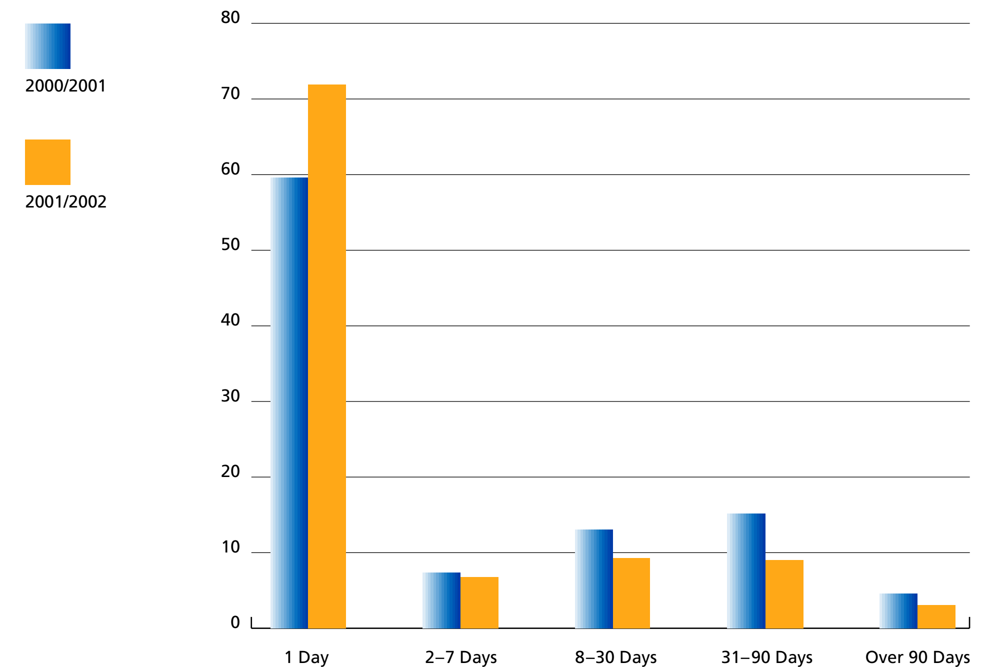
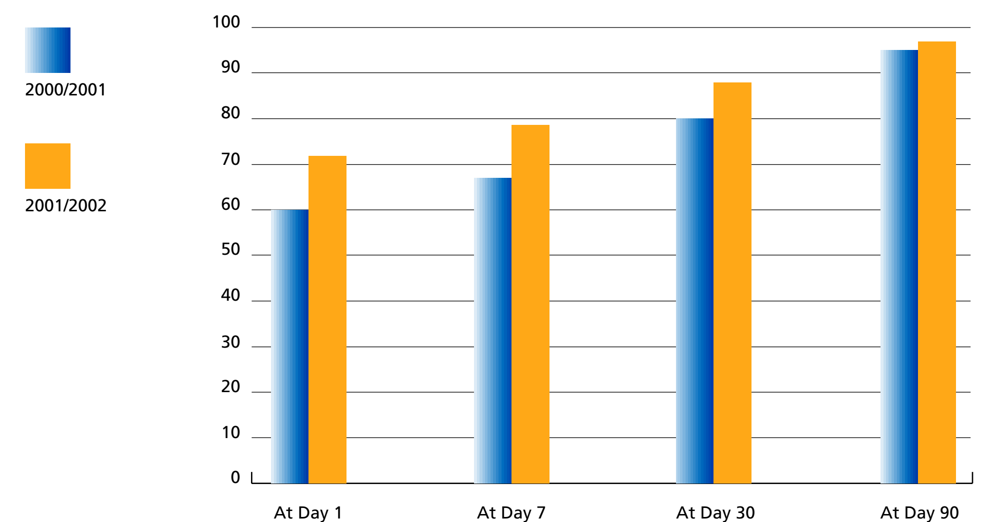



**FIGURE 5: COMPLAINTS COMPLETED SINCE DAY OF LODGEMENT**



Hospitals and some providers can also lodge complaints against health funds. These are also numerically small but generally of a complex nature. Issues surrounding selective contracting and difficulties in arriving at a satisfactory conclusion to a contract or arrangement constitute the majority of complaints from this group.

## WORKLOAD

The office received 3182 complaints (problems, grievances and disputes) in 2001/2002, an average of 265 per month compared with 290 complaints per month in the previous year.

The office finalised 3181 complaints during the year; an average of 265 per month, compared with an average 274 complaints finalised per month in the previous year.

## TIME TAKEN TO RESOLVE COMPLAINTS

Figures 4 and 5 provide information on the time taken to resolve complaints and show a decrease in resolution time. This is attributable to the fact that a much larger number of complaints fell into the categories of grievance and problem. Because of their nature, these complaints are generally closed on the day of referral.

Response from funds on complaint handling is continuing to improve and most health funds respond to informal telephone and e-mail requests for information by the Ombudsman's staff, assisting with the speedy resolution of complaints. The Office has worked with funds who had previously had difficulty meeting acceptable turn around times for complaints and most of these are now meeting the standard.

## WHO WAS COMPLAINED ABOUT

Most complaints were made about health funds (2943), followed by practitioners, doctors and dentists (181) and hospitals (176). Some complaints concern a health fund as well as a hospital, doctor or dentist; consequently the total number of organisations or people being complained about (3300) adds up to more than the total number of complaints (3182).

## COMPLAINTS ABOUT HEALTH FUNDS

Figure 6 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.

The impact of the Goldfields Medical Fund complaint numbers is quite disproportionate to their market share and significantly imbalances the relativities of what would be considered a normal distribution of complaints. Figure 6A has been provided to show what the relative fund statistics would have been in the event the Goldfields Medical Fund statistics had been normal.

## COMPLAINTS ABOUT HOSPITALS

Complaints about hospitals are almost always related to the consequences of inadequate membership verification prior to a procedure being carried out. It is



### FIGURE 6: COMPLAINTS BY HEALTH FUND MARKET SHARE

| Name of Fund | Total number of complaints (1) | % of total complaints | Total of disputes (2) | % of total disputes | Health fund Market share (3) |
|---|---|---|---|---|---|
| ACA Health Benefits Fund | 1 | 0.0 | 0 | 0.0 | 0.1 |
| AMA Health Fund Limited | 1 | 0.0 | 0 | 0.0 | 0.1 |
| Australian Health Management Group Limited | 138 | 4.7 | 20 | 3.5 | 2.6 |
| Australian Unity Health Limited | 71 | 2.4 | 14 | 2.5 | 3.1 |
| AXA Australia Health Insurance | 243 | 8.3 | 68 | 12.0 | 9.9 |
| CBHS Friendly Society Limited | 13 | 0.4 | 3 | 0.5 | 0.9 |
| Cessnock District Health Benefits Fund | 0 | 0.0 | 0 | 0.0 | 0.0 |
| Credicare Health Fund | 8 | 0.3 | 1 | 0.2 | 0.4 |
| Defence Health Benefits Society | 28 | 1.0 | 9 | 1.6 | 1.1 |
| Federation Health | 9 | 0.3 | 5 | 0.9 | 0.2 |
| Geelong Med. & Hosp. Benefits Ass. Limited | 16 | 0.5 | 6 | 1.1 | 1.2 |
| Goldfields Medical Fund (Inc.) | 324 | 11.0 | 18 | 3.2 | 0.7 |
| Grand United Corporate Health Limited | 7 | 0.2 | 1 | 0.2 | 0.2 |
| Grand United Health Fund Pty Ltd | 13 | 0.4 | 5 | 0.9 | 0.4 |
| Health Care Insurance Limited | 2 | 0.1 | 0 | 0.0 | 0.1 |
| Health Insurance Fund of W.A. | 8 | 0.3 | 2 | 0.4 | 0.4 |
| Health-Partners Inc. | 9 | 0.3 | 1 | 0.2 | 0.5 |
| Healthguard Health Benefits Fund Limited | 1 | 0.0 | 0 | 0.0 | 0.1 |
| HBF Health Funds Inc. | 94 | 3.2 | 18 | 3.2 | 8.8 |
| Hospitals Contribution Fund of Australia Limited | 109 | 3.7 | 38 | 6.7 | 7.3 |
| IOOF Health Services Limited | 7 | 0.2 | 0 | 0.0 | 0.2 |
| I.O.R. Australia Pty Limited | 73 | 2.5 | 10 | 1.8 | 1.1 |
| Latrobe Health Services Inc. | 5 | 0.2 | 2 | 0.4 | 0.5 |
| Lysaght Peoplecare | 0 | 0.0 | 0 | 0.0 | 0.2 |
| Manchester Unity Friendly Society In N.S.W. | 48 | 1.6 | 7 | 1.2 | 1.2 |
| Medibank Private Limited | 977 | 33.2 | 218 | 38.6 | 30.7 |
| Medical Benefits Fund of Australia Limited | 502 | 17.1 | 58 | 10.3 | 16.9 |
| Mildura District Hospital Fund Limited | 0 | 0.0 | 0 | 0.0 | 0.3 |
| Navy Health Limited | 3 | 0.1 | 0 | 0.0 | 0.2 |
| N.I.B. Health Funds Limited | 127 | 4.3 | 34 | 6.0 | 4.9 |
| NRMA Health Pty. Limited | 32 | 1.1 | 4 | 0.7 | 1.5 |
| Phoenix Health Fund | 0 | 0.0 | 0 | 0.0 | 0.1 |
| Queensland Country Health Limited | 4 | 0.1 | 0 | 0.0 | 0.2 |
| Railway & Transport Emp'ees Friendly Soc. H.F. Ltd. | 3 | 0.1 | 1 | 0.2 | 0.3 |
| Reserve Bank Health Society | 0 | 0.0 | 0 | 0.0 | 0.0 |
| SA Police Employees' Health Fund Inc. | 1 | 0.0 | 0 | 0.0 | 0.1 |
| St Luke's Medical & Hospital Benefits Ass. Ltd. | 10 | 0.3 | 5 | 0.9 | 0.4 |
| Teachers Federation Health Limited | 21 | 0.7 | 5 | 0.9 | 1.4 |
| Transition Benefits Fund Pty Limited | 0 | 0.0 | 0 | 0.0 | 0.1 |
| Queensland Teachers' Union Health Fund Limited | 6 | 0.2 | 2 | 0.4 | 0.4 |
| Transport Friendly Society Limited | 2 | 0.1 | 0 | 0.0 | 0.1 |
| United Ancient Order of Druids Victoria | 2 | 0.1 | 2 | 0.4 | 0.1 |
| United Ancient Order of Druids G/L NSW | 1 | 0.0 | 0 | 0.0 | 0.0 |
| Western District Health Fund Ltd | 24 | 0.8 | 8 | 1.4 | 0.7 |
| **Total for Registered Funds** | **2943** | **100.0** | **565** | **100** | **100.0** |

Note 1. Complaints = problems, grievances and disputes.
Note 2. Disputes require intervention by the Ombudsman and the fund.
Note 3. Proportion of people covered by health fund as at 30 June 2001 as stated in the PHIAC Annual Report.

absolutely inexcusable in this day and age for patients to submit to a routine procedures without having been provided with up to date information as to their personal liability for expenses enabling them to make an informed financial decision on proceeding.

The *National Health Act 1953* provides for 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. It is unfortunate this still does not routinely occur. For situations where no contract exists, there is still an obligation for the hospital to advise the patient of their anticipated exposure to costs. The ACCC stated publicly in June 2001 "silence in relation to fee disclosure may constitute misleading or deceptive conduct where there is a duty to disclose this information."

## COMPLAINTS ABOUT DOCTORS

Most complaints about doctors concern the lack of informed financial consent, although there has been a tendency this year for some complaints to be lodged because practitioners have advised of significant increases to original quotations ostensibly to cover higher medical indemnity insurance costs.

The vast majority of practitioners provide their patients with appropriate information on their fees and anticipated out of pocket expenses and the AMA has continued to support voluntary open fee disclosure by the profession. The Government has held an inquiry into fee disclosure, supported by this office and the ACCC. There are still practitioners who steadfastly refuse to cooperate and as a consequence their patients are left to proceed with medical procedures without adequate financial knowledge. Although loath to recommend sanctions against doctors who do not provide patients with adequate advice, there appears to be a difficulty in protecting consumers without some sort of compulsion.

## RESOLVING COMPLAINTS

46% of complaints were resolved by the Ombudsman's office providing an independent and impartial explanation of the health fund member's grievance. This year the prevalence of this was higher, particularly as it related to issues associated with increases in contribution rates above the publicly stated levels.

39% of complaints were referred directly back to the health fund through the complainant. The Ombudsman was generally able to suggest alternative 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 5% of complaints. This outcome is significantly smaller than in past years, not because the Office has been less successful, but because the type of dispute that requires such an outcome has lessened substantially. This is a natural consequence of the success in resolving the underlying fundamental causes of disputes.

Payments by health funds generally result from a health fund agreeing with the

**FIGURE 6A: COMPLAINTS BY HEALTH FUND MARKET SHARE (ADJUSTED FOR 2002 GOLDFIELDS MEDICAL FUND ANOMALY)**

| Name of Fund | % of total complaints | Health fund Market share (3) |
|---|---|---|
| AMA Health Fund Limited | 0.0 | 0.1 |
| Australian Health Management Group Limited | 5.2 | 2.6 |
| Australian Unity Health Limited | 2.7 | 3.1 |
| AXA Australia Health Insurance | 9.2 | 9.9 |
| CBHS Friendly Society Limited | 0.5 | 0.9 |
| Cessnock District Health Benefits Fund | 0.0 | 0.0 |
| Credicare Health Fund | 0.3 | 0.4 |
| Defence Health Benefits Society | 1.1 | 1.1 |
| Federation Health | 0.3 | 0.2 |
| Geelong Med. & Hosp. Benefits Ass. Limited | 0.6 | 1.2 |
| Goldfields Medical Fund (Inc.) (2) | 0.7 | 0.7 |
| Grand United Corporate Health Limited | 0.3 | 0.2 |
| Grand United Health Fund Pty Ltd | 0.5 | 0.4 |
| Health Care Insurance Limited | 0.1 | 0.1 |
| Health Insurance Fund of W.A. | 0.3 | 0.4 |
| Health-Partners Inc. | 0.3 | 0.5 |
| Healthguard Health Benefits Fund Limited | 0.0 | 0.1 |
| HBF Health Funds Inc. | 3.6 | 8.8 |
| Hospitals Contribution Fund of Australia Limited | 4.1 | 7.3 |
| IOOF Health Services Limited | 0.3 | 0.2 |
| I.O.R. Australia Pty Limited | 2.8 | 1.1 |
| Latrobe Health Services Inc. | 0.2 | 0.5 |
| Lysaght Peoplecare | 0.0 | 0.2 |
| Manchester Unity Friendly Society In N.S.W. | 1.8 | 1.2 |
| Medibank Private Limited | 37.0 | 30.7 |
| Medical Benefits Fund of Australia Limited | 19.0 | 16.9 |
| Mildura District Hospital Fund Limited | 0.0 | 0.3 |
| Navy Health Limited | 0.1 | 0.2 |
| N.I.B. Health Funds Limited | 4.8 | 4.9 |
| NRMA Health Pty. Limited | 1.2 | 1.5 |
| Phoenix Health Fund Limited | 0.0 | 0.1 |
| Queensland Country Health Limited | 0.2 | 0.2 |
| Railway & Transport Emp'ees Friendly Soc. H.F. Ltd. | 0.1 | 0.3 |
| Reserve Bank Health Society | 0.0 | 0.0 |
| SA Police Employees' Health Fund Inc. | 0.0 | 0.1 |
| St Luke's Medical & Hospital Benefits Ass. Ltd. | 0.4 | 0.4 |
| Teachers Federation Health Limited | 0.8 | 1.4 |
| Transition Benefits Fund Pty Limited | 0.0 | 0.1 |
| QLDTeachers' Union Health Fund Limited | 0.2 | 0.4 |
| Transport Friendly Society Limited | 0.1 | 0.1 |
| United Ancient Order of Druids Victoria | 0.1 | 0.1 |
| United Ancient Order of Druids G/L NSW | 0.0 | 0.0 |
| Western District Health Fund Ltd | 0.9 | 0. |
| **Total for Registered Funds** | **100.0** | **100.0** |

Note 1. Source: PHIAC Annual report, population covered as at 30 June 2001.
Note 2. Adjusted complaint figures assume Goldfiends Medical Fund's percentage of complaints = percentage of market share.

FIGURE 7: OUTCOMES OF FINALISED COMPLAINTS

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.

Accounts written off by hospitals would have been as a direct result of a hospital needing to accept their responsibility after failing initially to adequately inform patients of their costs.

An additional 6% 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.

2% of complaints were withdrawn or required no further action.

It was necessary this year to refer 2% of complaints, which met the criteria for complaint contained in the National Health Act to another agency such as the ACCC.

Information about the resolution of complaints is provided in Figure 7.

## TYPE OF COMPLAINANT

The National Health Act allows health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf to lodge complaints. Overwhelmingly, complaints were made by health fund members (99%), followed by hospitals/day hospitals, practitioners, and health funds.

## HOW COMPLAINTS WERE MADE

92% of all problems, grievances and disputes were made initially by telephone. 6% 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

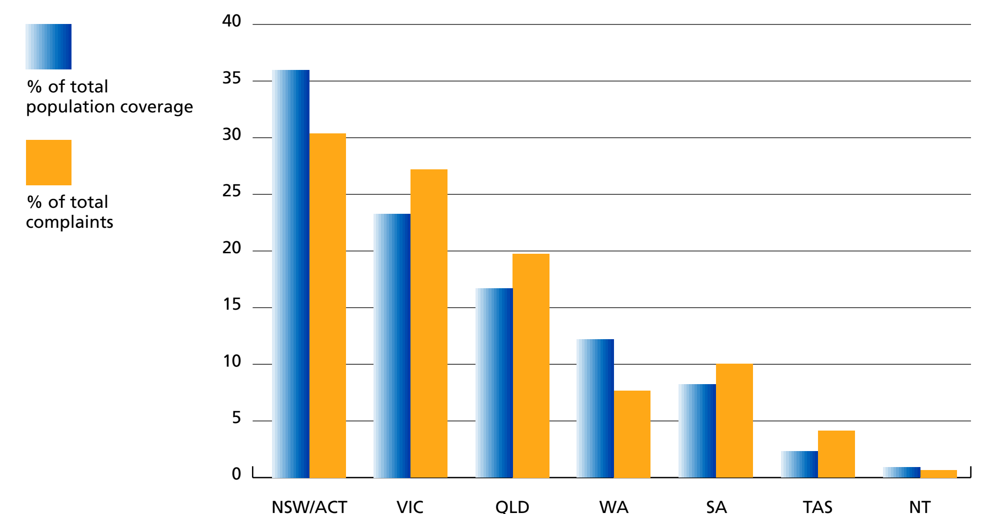
The Ombudsman commenced an investigation to determine the capability of health funds to provide information to hospitals to determine membership eligibility for procedures. This investigation is being conducted under Section 82ZT of the *National Health Act 1953*.

There were no investigations conducted under Section 82ZTA of the *National Health Act 1953*.

## COMPLAINTS BY STATE/TERRITORY

Figure 8 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.

FIGURE 8: COMPLAINTS BY POPULATION COVERED BY STATE & TERRITORY



# COMPLAINT ISSUES

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.

This year, the distribution of complaints amongst the complaint categories has been markedly different to previous years. Premium increases and fund rule changes were the predominant issues, replacing waiting periods, which was the major issue in the last report.

Figure 9 below compares the relative complaint issues over the past two years.

### CONTRIBUTION INCREASES

Contribution increases was numerically the single most complained about issue.

The major concern of consumers with respect to contribution increases, was not that they occurred, but that media reports led them to believe the Minister had only approved single digit increases and their health fund was now applying much higher increases. The difficulty for PHIO was to convince the consumer that all the contribution increases had received regulator approval. The issues as presented by consumers were:

- There was acceptance of the inevitability of premium increases; it was the unexpected level of the increase that led to the concern.
- Small increases more often were preferable to large increases less often.
- They were being forced to pay for mistakes made by management in the previous pricing of the product. This was a particularly strong feeling with the 40% plus increases associated with Goldfields Medical Fund and the double digit increases associated with some Medibank Private products when the media had convinced them it would be less than 10%.
- Rate protection was not guaranteed for those consumers who had paid in advance.

There were a large number of complaints, some quite complex, but most related to the quantum.

Mrs Murray from Wodonga had a relatively low cost product negotiated through her employer, based on New South Wales rates. She complained to the fund that her contribution had risen by around 40% and even though her nearest available private hospital was in Albury, her fund now rated her on the higher level Victorian rates. What the fund failed to explain adequately, was that not only was the rate for her product increased higher than the media had led her to believe, but because she had been on a grandfathered corporate product, the previous discount was now illegal and as such she faced a three-point increase. Mrs Murray was extremely aggrieved particularly because media reports had indicated her fund had been refused permission to increase rates by 13%.

### RATE AND BENEFIT PROTECTION

A further complication arose due to the decision by the Administrator appointed to Goldfields Medical Fund not to honour the written undertaking in the fund brochure with respect to a rate protection guarantee for contributions paid in advance.

Mr Melbourne joined GMF Health on 1 September 2001 and paid a full 12 months subscription. He received a letter from the Administrator which allayed his fears on the viability of the fund. He raised a complaint with the Ombudsman when he received a notice from the fund advising of a 53% increase in contribution rates effective from 1 April 2002.

Mr Melbourne contended that by paying 12 months in advance he had locked in both rate and benefit levels for that period. He said the general principle of contract had been further backed up by explicit guarantees in the brochure he was provided with when he joined the fund.

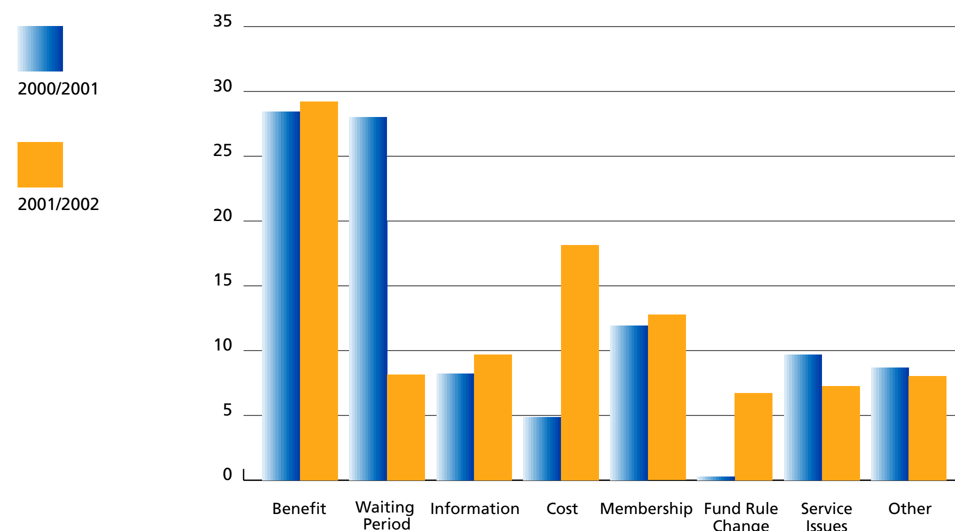
On behalf of Mr Melbourne and many other consumers like him, the Ombudsman convened a meeting with the Administrator, the ACCC, PHIAC, the Commonwealth Department and his Office to seek an assurance that the Administrator would abide by the written guarantee provided in the brochures.

After a lengthy and detailed meeting, the Administrator failed to provide such an assurance and stood by his decision to deny the guarantee.

The Ombudsman was left with no option but to formally direct the complaints to the ACCC for possible legal action. The ACCC is proceeding.

The health insurance industry and regulators need to take note of the expressions of grievance by consumers during this round of premium increases. Many of the concerns of consumers and the associated poor publicity could have been avoided had those responsible for briefing the media on the quantum of increases given greater consideration to the effect the statements would have on consumers rather than their own constituents.

FIGURE 9: COMPLAINT ISSUES



### INFORMED FINANCIAL CONSENT

Of highest concern to this office, is the continuing financial difficulty faced by consumers when they find themselves significantly out of pocket because the administrative systems of the hospital or health fund have not protected them. Too often patients are faced with unexpected hospital accounts following procedures for which they were not fully covered, even when the hospital episode is booked. Some of the cases presented to the Office are complex, others more routine.

Administrative procedures between the health funds and the hospitals should be capable of providing prior warning to patients of their exposure.

Mr Tokyo had been sent to Australia by his Japanese employer and had taken out the highest level of overseas visitors cover. Three months after arriving he suffered a cerebral brain haemorrhage and was operated on in a private hospital. The hospital approached the fund and obtained full details of the cover for the patient. Ascertaining the incident was not affected by a pre-existing ailment exclusion, the fund paid for the operation and the initial ten days hospitalisation amounting to nearly $21,000.

It was not possible for Mr Tokyo to arrange airline transport back to Japan as he required extensive rehabilitation, within the same hospital, before being fit for travel. The insurance product did not cover rehabilitation.

The hospital had no ongoing contact with the health fund even though the reason the patient remained in hospital was different from the original acute episode and the initial membership verification information was sufficient to alert the hospital to the restrictions of the cover.

On being denied benefits from the health fund, the hospital proceeded to pursue the patient for a further $18000, even though it had not advised the patient of the lack of cover. The case is still ongoing.

Funds have an obligation to protect members from unexpected expense and to follow up with the hospital when they fail to comply with the contractual obligations imposed upon them by Section 73BD(2)(d), in that they are required to inform patients of any out of pocket expenses associated with their treatment. The health fund is required to include the provisions of Section 73BD(2)(d) in their contractual arrangement with the hospital, and as such is the responsible party to take action when this provision of contract is breached by a hospital. This is an ongoing responsibility and does not cease with one initial contact with a health fund, particularly when the patient category changes.

A further case where the system failed the consumer relates to a member whose fund did not have an agreement with the hospital his surgeon operated from.

Mr Country was a pensioner and had to travel over 250 kms. to his nearest private hospital. Contact with the fund by both himself and his daughter confirmed that the hospital did not have a contract with the fund and there would be out of pocket expenses. The amount he was informed by the fund is in dispute but was nowhere near the $1724 he finally paid the hospital when leaving.



The patient arrived at the hospital on the Friday for pathology tests and presented again the following morning for surgery. The hospital asked how they were settling the account and were informed of the health fund details. Contact with the fund did not clearly establish the benefit to be paid and the patient signed an admission form which contained no financial detail.

In this instance the hospital clearly knew what the expense would be and had an obligation to fully inform the patient significantly prior to the procedure rather than wait until the morning of the scheduled operation.

These are unfortunately not isolated cases. The technology is available to enable consumers to have financial information on which to base an informed financial consent to hospitalisation. The office clearly recognises that there will be a number of occasions where a quotation provided to a member may turn out to be incorrect due to the outcome of a procedure, however except in these cases, there is no excuse for failures in administration causing financial hardship for patients.

### BENEFIT LIMITATIONS AND EXCLUSIONS

Consumers continue to experience difficulty with products which have limitations on the benefits they receive. These restrictions may be for a period of time only, or may remain for the life of the product. Difficulties associated with these products have been the subject of high level discussions between the industry, Government and PHIO. In the main, complications arise because consumers do not understand all of the restrictions or how they apply, particularly when they change product.

Ms Malvern had a single membership which previously had one year limitations for a range of medical procedures, including psychiatric. When she married, she varied her cover from single to family and reduced the level of cover to one with a two year benefit limitation.

After being on the family cover for over 12 months, she required hospitalisation for psychiatric care.

Both she and PHIO believed that as she had already served her limitation period of 12 months on her previous cover, she only needed to serve an additional 12 months. It was fully recognised her other new family members had to serve the two years on limited benefits.

The fund insisted that the product had been designed and priced so that all new or transferring members would have to serve the full two years on limited benefits.

Because the correspondence provided to Ms Malvern when she changed cover did not explicitly indicate that all persons on the cover had to re-serve waiting periods for full benefits, the fund agreed to meet the quite substantial hospitalisation costs which were incurred.

The industry has informally agreed to put in place administrative procedures ensuring members are fully informed of the limitations to their cover and to identify more adequately the level of benefit consumers will receive when hospitalised for a restricted procedure.

### REDUCTION IN BENEFIT ENTITLEMENT

Another issue which created considerable concern to consumers related to the decision by some funds to downgrade the benefits available to existing products. In one instance this occurred at the same time as the fund significantly increased the cost of its products.

Ms Capital had been diagnosed with breast cancer and was undergoing chemotherapy that required a day admission to hospital twice a month. She had concluded four treatments and had to undergo eight more over the next four months. In her letter to the fund Ms Capital pointed out " We have been with your company for some thirty years. Having a life threatening disease like breast cancer is difficult enough without sudden, unexpected changes to our private health insurance cover. My concern is that not even half way through my treatment (you) have decided to change the rules about day admissions thus making it necessary for me to pay another $600 over the next few months to complete my treatment.

PHIO found it necessary to intervene with the fund, not just because of this specific case, but to ensure that all such persons who had commenced an ongoing treatment regime or who were committed already to a day procedure would not have to meet the additional cost imposed by the approved change in rules.

Although the fund relented slightly on the implementation date of the change when the implications to certain categories of member was brought to its attention, the fund should not have embarked on such a change without first safeguarding its consumers and allowing them sufficient time to seek out alternative products.

It is pleasing to note though that other funds seek input from PHIO as to consumer imperatives if they are going to materially effect changes to product.

# 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:

- The Ombudsman was able to participate in a considerable number of radio programs during the year. Because of the public interest in health insurance, it was possible to arrange for radio interviews and talk-back in all mainland States.
- The Ombudsman publishes a regular quarterly report which is distributed in both written format and available on the PHIO website.
- The Ombudsman hosts an internet site where consumers can access a range of brochures, 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 web-site is located at: http://www.phio.org.au;
- The Ombudsman and staff spoke at numerous conferences during the year and again sponsored a successful national seminar open to the whole private health industry.
- Details of the Ombudsman's services are referenced in various Government publications and in publications produced by other agencies and consumer bodies.

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*.

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 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 36 77.

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

A primary goal is to raise community awareness about the Ombudsman through the media 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.

## RELATIONS WITH STAKEHOLDERS

The Ombudsman produces a Quarterly Bulletin containing general information about current problem areas and health insurance complaint statistics which is sent in printed form to members of Federal Parliament, health funds and others who specifically request the printed version. The Bulletin is released simultaneously in electronic form on the PHIO website.

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

In February, the Office conducted a seminar in Sydney, inviting participation from the private health industry. Feedback from participants was again excellent and it is intended to conduct further seminars to assist in maintaining an awareness by appropriate personnel of the issues which come before the office and the means adopted to resolve complaints.

## CLIENT SURVEY

In March 2002, the office carried out a mail survey of a randomly selected 150 complainants who had lodged completed complaints during November 2001 through to February 2002. 58 complainants responded, 28 disputes,14 grievances and 16 problems.

The aim of the survey 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. It was also evident that those who had higher levels of dispute category complaints found the assistance of the office to be the most helpful, whereas negative comments generally came from those persons who lodged complaints which the office felt could be more appropriately handled by further action by the concerned complainant. Among the findings, the study showed that:

- 86% reported that staff listened to their concerns, with a similar response to the office explaining their role.
- 88% of respondents said they were satisfied or mostly satisfied with the way staff handled the complaint.
- 79% were satisfied with the time it took to finalise the complaint.
- 97% were of the view that the Ombudsman's staff were independent in dealing with their complaint.
- 78% reported they were satisfied with the Ombudsman's service overall.

## 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:

- Assistance with the development of procedures to assist in processes associated with contracting for surgically implanted prostheses.
- Participation in the industry forum to look at perceived access problems in the private hospital sector.
- Participation in the industry forum and consultative process to determine

an appropriate course of action for medical practitioners who do not provide consumers with detailed costing information prior to private surgical procedures.

- 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".
- Provision of evidence to the Australian Competition and Consumer Commission with respect to certain health fund practices.



# STATUTORY REPORTING INFORMATION

## CORPORATE GOVERNANCE

Being a small office with duties specified by the National Health Act 1953, the business of the Ombudsman's 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 Compliance, potential and actual issues, which require broader attention. Dispute 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 2002, the staff employed by the Private Health Insurance Ombudsman comprised:

| Permanent & Part-Time Employees | Female | Male |
|---|---|---|
| Ombudsman | - | 1 |
| Director, Policy & Compliance | 1 | - |
| Projects and Research Officer | | 1 |
| Senior Dispute Resolution Officers | 1 | |
| Dispute Resolution Officers | 3 | |
| Administrative Assistant | 1 | - |
| **Total** | **6** | **2** |

# STATUTORY REPORTING INFORMATION

## 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 |

The Ombudsman's remuneration is determined by the Remuneration Tribunal.

## STAFF DEVELOPMENT AND TRAINING

During the 2001-2002 financial year $4256 was spent directly on PHIO staff attending training courses, conferences and seminars. During the financial year the Ombudsman continued its internal staff development and training program for dispute resolution staff.

In February 2002 the Ombudsman's Office conducted its second annual "Consumer Issues In Private Health" seminar, which is a significant training event attended by customer service and dispute staff associated with the private health insurance funds, together with staff from hospitals and other key industry stakeholders. This seminar is 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.

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

The following table shows the numbers and status of staff who are employed on 30 June 2002.

| Occupational Group | Women | Men | Total Staff | NESB1 |
|---|---|---|---|---|
| SES | 1 | 1 | - | |
| Other | 6 | 1 | 7 | 3 |
| **Total** | **6** | **2** | **8*** | **3** |

Note: SES — Senior Executive Service
Other — All other staff – temporary and permanent
NESB1 — Non-English speaking background, 1st Generation
*includes part time employees. Actual EFT = 7.4.

## PERFORMANCE APPRAISAL

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

The Ombudsman has engaged Hall Chadwick Chartered Accountants to manage the high level accounting functions including finalisation of annual accounts. The office utilises the MYOB suite of accounting programs internally and has contracted Complete GST Solutions for day-to-day administration of general accounting functions.

The Ombudsman's Audit Committee, which comprises PHIO's representatives from our office, Hall Chadwick and the National Audit Office held appropriate discussions during the financial year.

## OUTCOMES AND OUTPUTS

The Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 8, Choice Through Private Health.

The Ombudsman provides regular advice and makes recommendations about the private health insurance industry. It directly delivers services that contribute to the outcome of a viable private health insurance industry by improving consumer confidence in private health insurance.

## CONSULTANTS ENGAGED

The Ombudsman engaged Complete GST Solutions as a consultant during the financial year to assume responsibility for in-house accounting functions previously undertaken by the Director of Corporate Services. The office continues to involve JMR Consulting for maintaining the complaints management and reporting system, and PT and A Health as a medical referee on cases requiring a detailed medical opinion. Both of these latter consultants are engaged on an ad-hoc basis.

## INFORMATION SYSTEMS

The Ombudsman's information system is based upon a Windows NT network server and the Microsoft Office 2000 suite. 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 continues to engage 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 has been produced and all staff made aware of their obligations and responsibilities. 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 clients can expect and the steps they can take if these standards are not met. The Charter was developed in consultation with staff and clients.

## OCCUPATIONAL HEALTH AND 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 Compliance 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*.

No reportable incidents occurred during the year.

## EQUAL EMPLOYMENT OPPORTUNITY

The Ombudsman is committed to the principles outlined in the Disability Discrimination Act 1992 and the Equal Employment Opportunity (Commonwealth Authorities) Act 1987. The Ombudsman has reviewed the requirements of the Commonwealth Disability Strategy and the office complies with these requirements.



# 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 2002.

## 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.

## 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 series of consumer brochures produced by the Office
- A booklet and brochure "Private Patients' Hospital Charter"
- 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 brochures 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 brochure "The Right to Change - Portability in Health Insurance".

- 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 (Free-call)
- by fax on (02) 9261 5937
- by e-mail to info@phio.org.au
- from the web site http://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 $30.00 application fee, as required by the Act, and directed to:

Director, Policy and Compliance
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

*Th*e office subjects itself to regular review of its performance by way of the conduct of a survey of complainants.

Detail of the review for this year is provided 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 which was reviewed in 2001.

The Service Charter covers all of PHIO's clients and sets out the service delivery standards which they can expect from the office. The Charter was developed in consultation with staff and clients 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, there were two formal complaints about our service recorded, 34 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 Ageing**

**Scope**

I have audited the financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2002. The financial statements comprise:

- Statement by the Ombudsman;
- Statements of Financial Performance, Financial Position and Cash Flows;
- Schedules of Commitments and 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 Accounting Standards and other mandatory professional reporting requirements in Australia and statutory requirements so as to present a view which is consistent with my understanding of the Private Health Insurance Ombudsman's financial position, its financial performance 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 the financial statements:

(i) have been prepared in accordance with Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*; and

(ii) give a true and fair view, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Finance Minister's Orders, of the financial position of the Private Health Insurance Ombudsman as at 30 June 2002, and its financial performance and cash flows for the year then ended.

Australian National Audit Office

P Hinchey

Delegate of the Auditor-General

Sydney
5 September 2002





**Private Health Insurance Ombudsman**

**Statement by the Ombudsman**

In my opinion, the attached financial statements for the year ended 30 June 2002 give a true and fair view of the matter required by the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*.

Norman W Branson

02 September 2002
Dated

Suite 1201 Level 12
31 Market St Sydney NSW 2000
Telephone (02) 9261 5885
Facsimile (02) 9261 5937
http://www.phio.org.au
Complaints Hotline 1800 640 695
ABN 61 673 137 709

# STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 2002

| | Note | 2002 $ | 2001 $ |
|---|---|---|---|
| **Revenues from ordinary activities** | | | |
| Revenues from Government | 2A | 950,000 | 950,000 |
| Interest | 3A | 14,564 | 19,539 |
| Other | 3B | 60 | 189 |
| **Total revenues from ordinary activities** | | 964,624 | 969,728 |
| **Expenses from ordinary activities** | | | |
| Suppliers | 4A | 322,719 | 340,273 |
| Employees | 4B | 560,292 | 598,504 |
| Depreciation and Amortisation | 4C | 60,274 | 60,704 |
| **Total expenses from ordinary activities** | | 943,285 | 999,481 |
| **Net operating surplus (deficit) from ordinary activities** | | 21,339 | (29,753) |
| **Total changes in equity other than those resulting from transactions with owners as owners** | | 21,339 | (29,753) |

The above statements should be read in conjunction with the accompanying notes.



# STATEMENT OF FINANCIAL POSITION

As at 30 June 2002

| | Note | 2002 $ | 2001 $ |
|---|---|---|---|
| **ASSETS** | | | |
| **Financial assets** | | | |
| Cash | 5A | 285,348 | 219,020 |
| Receivables | | - | 1,294 |
| **Total financial assets** | | 285,348 | 220,314 |
| **Non-financial assets** | | | |
| Infrastructure, plant and equipment | 6 | 44,338 | 69,765 |
| Prepayments | | 644 | - |
| **Total non-financial assets** | | 44,982 | 69,765 |
| **Total assets** | | 330,330 | 290,079 |
| **LIABILITIES** | | | |
| **Payables** | | | |
| Suppliers | 7A | 33,863 | 16,519 |
| **Total payables** | | 33,863 | 16,519 |
| **Provisions** | | | |
| Employees | 7B | 51,413 | 49,845 |
| **Total provisions** | | 51,413 | 49,845 |
| **Total liabilities** | | 85,276 | 66,364 |
| **EQUITY** | | | |
| Accumulated surplus | | 245,054 | 223,715 |
| **Total equity** | | 245,054 | 223,715 |
| **Current liabilities** | | 85,276 | 52,417 |
| **Non-current liabilities** | | 0 | 13,947 |
| **Current Assets** | | 285,992 | 220,307 |
| **Non-current assets** | | 44,338 | 69,765 |

The above statements should be read in conjunction with the accompanying notes.

# STATEMENT OF CASH FLOWS

For the year ended 30 June 2002

| | Note | 2002 $ | 2001 $ |
|---|---|---|---|
| **OPERATING ACTIVITIES** | | | |
| **Cash Received** | | | |
| Appropriations | | **950,000** | 950,000 |
| Interest | | **14,564** | 19,539 |
| Other | | **60** | 189 |
| **Total cash received** | | **964,624** | 969,728 |
| **Cash Used** | | | |
| Suppliers | | **(318,297)** | (307,906) |
| Employees | | **(558,724)** | (603,565) |
| **Total cash used** | | **(877,021)** | (911,471) |
| **Net cash from operating activities** | 13 | **87,603** | 58,257 |
| **INVESTING ACTIVITIES** | | | |
| **Cash used** | | | |
| Purchase of property, plant and equipment | | **(21,275)** | (30,573) |
| **Total cash used** | | **(21,275)** | (30,573) |
| **Net cash used by investing activities** | | **(21,275)** | (30,573) |
| **Net increase in cash held** | | **66,328** | 27,684 |
| Cash at the beginning of the reporting period | | **219,020** | 191,336 |
| **Cash at the end of the reporting period** | 5A | **285,348** | 219,020 |

The above statements should be read in conjunction with the accompanying notes.



# SCHEDULE OF COMMITMENTS

As at 30 June 2002

| | 2002 $ | 2001 $ |
|---|---|---|
| **BY TYPE** | | |
| **Other Commitments** | | |
| Operating Leases | **195,300** | 285,019 |
| **Total other commitments** | **195,300** | 285,019 |
| **BY MATURITY** | | |
| **Operating lease commitments** | | |
| One Year or Less | **97,650** | 105,994 |
| From one to two years | **97,650** | 97,650 |
| From two to five years | **-** | 81,375 |
| | **195,300** | 285,019 |

One lease expired on 30 April 2001 and another lease for the premises has commenced.

# SCHEDULE OF CONTINGENCIES

As at 30 June 2002

| | 2002 $ | 2001 $ |
|---|---|---|
| **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 2002

## NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

### 1.1 Basis of Accounting

The financial statements are required by Schedule I to the *Commonwealth Authorities and Companies Act 1997* and are a general purpose financial report.

The statements have been prepared in accordance with:

- Schedule 1 of the Commonwealth Authorities and Companies

  (Financial Statements 2001–2002) Orders in relation to the financial year ending on 30 June 2002;
- Australian Accounting Standards and Accounting Interpretations issued by Australian Accounting Standards Board;
- Other authoritative pronouncements of the Board; and
- Consensus Views of the Urgent Issues Group.

The statements have been prepared having regard to:

- The Explanatory Notes to Schedule 1 issued by the Department of Finance and Administration.
- Finance Briefs issued by that Department.

The Statements of Financial Performance and Financial Position have been prepared on an accrual basis and are in accordance with historical cost convention, except for certain assets which, as noted, are at valuation. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

### 1.2 Changes in Accounting Policy

The accounting policies used in the preparation of these Financial statements are consistent with those used in 2000–2001.

### 1.3 Revenue

The revenues described in this Note are revenues relating to the core operating activities of the Authority.

Interest revenue is recognised on a proportional basis taking into account the interest rates applicable to the financial assets.

Revenue from the disposal of non-current assets is recognised when control of the asset has passed to the buyer.

*Revenue from Government – Output Appropriations*

The full amount of the appropriation for departmental outputs for the year is recognised as revenue.





### 1.4 Employee Entitlements

The liability for employee entitlements includes provision for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the Authority is estimated to be less than the annual entitlement for sick leave.

The liability for annual leave reflects the value of total annual leave entitlements of all employees at 30 June 2002 and is recognised at its nominal amount.

The non-current portion of the liability for long service leave is recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at 30 June 2002. In determining the present value of the liability, the Ombudsman has taken into account attrition rates and pay increases through promotion and inflation.

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

### 1.5 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.

### 1.6 Cash

Cash means notes and coins held and any deposits held at call with a bank or financial institution.

### 1.7 Financial Instruments

Accounting policies for financial instruments are stated at Note 15.

### 1.8 Property, Plant and Equipment

*Asset Recognition Threshold*

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

*Revaluations*

Infrastructure, plant and equipment are re-valued every 3 years in accordance with the deprival' method of valuation. The last valuation was carried out as at 30 June 2000. Assets acquired after this valuation date are recorded at cost.

*Recoverable Amount Test*
Schedule 1 requires the application of the recoverable amount test to the Authority's non-current assets in accordance with AAS 10 Recoverable Amount of Non-Current Assets. The carrying amounts of these non-current assets have been reviewed to determine whether they are in excess of their recoverable amounts. In assessing recoverable amounts, the relevant cash flows have been discounted to their present value.

*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:

| | 2001-02 | 2000-01 |
|---|---|---|
| Leasehold Fitout | **3 years** | 3 years |
| Plant and Equipment | **3 to 5 years** | 3 to 5 years |

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 6C.

**1.9 Taxation**
The Ombudsman are exempt from all forms of taxation except fringe benefits tax and the goods and services tax.

**1.10 Capital Usage Charge**
A capital usage charge of 11% (2001: 12%) is imposed by the Government on the net assets of the Ombudsman. The charge is adjusted to take account of asset gifts and revaluations increments during the financial year.

**1.11 Insurance**
The Ombudsman has insured for risks through the Government's insurable risk managed fund, called 'Comcover'. Workers compensation is insured through Comcare Australia.

**1.12 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 30 June 2002

| | 2002 $ | 2001 $ |
|---|---|---|
| **2 REVENUES FROM GOVERNMENT** | | |
| **2A Parliamentary appropriations** | | |
| Appropriation Act No. 1 | **950,000** | 950,000 |
| | **950,000** | 950,000 |
| **3 REVENUES FROM INDEPENDENT SOURCES** | | |
| **3A Interest** | | |
| Deposits | **14,564** | 19,539 |
| | **14,564** | 19,539 |
| **3B Other Income** | | |
| Other | **60** | 150 |
| Employee Reimbursements | **0** | 39 |
| | **60** | 189 |
| **4 GOODS AND SERVICES EXPENSES** | | |
| **4A Suppliers expenses** | | |
| Supply of Goods and Services | **217,628** | 238,767 |
| Operating Lease Rentals | **105,090** | 101,506 |
| | **322,719** | 340,273 |
| **4B Employee expenses** | | |
| Remuneration for Services Provided | **560,292** | 598,504 |
| | **560,292** | 598,504 |
| **4C Depreciation and Amortisation** | | |
| Depreciation | **50,930** | 46,999 |
| Amortisation - Lease Fitout | **9,344** | 13,705 |
| | **60,274** | 60,704 |

| | 2002 $ | 2001 $ |
|---|---|---|
| **5 FINANCIAL ASSETS** | | |
| **5A Cash** | | |
| Cash on Hand | **129** | 250 |
| Cash at Bank | **85,219** | 218,770 |
| | **285,348** | 219,020 |
| **6 NON FINANCIAL ASSETS** | | |
| **6A Land and Buildings** | | |
| Leasehold Fitout - at valuation 30 June 2000 | **80,620** | 80,620 |
| Less: Accumulated Amortisation | **(78,689)** | (69,346) |
| | **1,931** | 11,274 |
| **6B Plant and Equipment** | | |
| Plant and Equipment - at valuation 30 June 2000 | **265,019** | 265,019 |
| Less: Accumulated Depreciation | **(262,505)** | (225,071) |
| | **2,514** | 39,948 |
| Plant and Equipment - at cost | **38,766** | 21,333 |
| Less: Accumulated Depreciation | **(10,452)** | (2,790) |
| | **28,314** | 18,543 |
| Intangibles | **17,412** | 0 |
| Less: Accumulated Depreciation | **(5,833)** | 0 |
| | **11,579** | 0 |
| Total Property, Plant and Equipment | **44,338** | 69,765 |





**6C Movement Summary 2001-02 for all assets irrespective of valuation base**

| Item | Leasehold Fitout $ | Plant & Equip,Computer $ | Intangibles $ | Total $ |
|---|---|---|---|---|
| **Gross value as at 1 July 2001** | 80,620 | 286,352 | 0 | 366,972 |
| Additions | 0 | 17,433 | 17,412 | 34,845 |
| Disposals | 0 | 0 | 0 | 0 |
| **Gross value as at 30 June 2002** | **80,620** | **303,785** | **17,412** | **401,817** |
| **Accumulated depreciation/ amortisation as at 1 July 2001** | 69,346 | 227,861 | 0 | 297,207 |
| Depreciation/amortisation charge for assets held at 1 July 2001 | 9,344 | 44,810 | 0 | 54,154 |
| Depreciation/amortisation charge for additions | 0 | 286 | 5,833 | 6,119 |
| **Accumulated depreciation/ amortisation as at 30 June 2002** | **78,689** | **272,957** | **5,833** | **357,479** |
| **Net book value as at 30 June 2002** | **1,931** | **30,828** | **11,579** | **44,338** |
| **Net book value as at 1 July 2001** | **11,274** | **58,491** | **0** | **69,765** |

| 6D Assets At Valuation | Plant & Equipment $ |
|---|---|
| As at 30 June 2002 | |
| Gross Value | **345,639** |
| Accumulated depreciation/amortisation | **-341,194** |
| **Net Book Value** | **4,445** |
| As at 30 June 2001 | |
| Gross Value | 345,639 |
| Accumulated depreciation/amortisation | -294,417 |
| **Net Book Value** | 51,222 |

## 7 PROVISIONS AND PAYABLES

| | 2002 $ | 2001 $ |
|---|---|---|
| **7A Suppliers** | | |
| Trade creditors | **18378** | 9034 |
| Accruals | **15485** | 7485 |
| | **33,863** | 16,519 |
| **7B Employees** | | |
| Salaries and Wages | **18942** | 15064 |
| Annual Leave | **26308** | 17731 |
| Long Service Leave | **6163** | 17050 |
| Aggregate Employee Entitlements | **51,413** | 49,845 |





| | 2002 $ | 2001 $ |
|---|---|---|
| **8 REMUNERATION OF OFFICERS** | | |
| The position of Ombudsman was filled by 1 person during the reporting period. The remuneration, when at least $100,000 fell within the following bands: | | |
| $160,000 - $169,999 | **0** | 1 |
| $190,000 - $199,999 | **1** | 0 |
| The aggregate amount of total remuneration of officers shown above. | **193,451** | 165,000 |
| **9 REMUNERATION OF AUDITORS** | | |
| Remuneration to the Auditor-General for Auditing the Financial Statements The auditors received no other benefits | **3,500** | 3,500 |

## 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 23.8% of salary (CSS) and 9.9% 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 8%.

## 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 - provision of complaint resolution services in Australia.

| | 2002 $ | 2001 $ |
|---|---|---|
| **13 CASH FLOW RECONCILIATION** | | |
| **Operating Surplus (Deficit)** | **21,339** | (29,753) |
| Amortisation - Lease fitout | **9,344** | 13,705 |
| Non Cash Adjustments - | | |
| Internet Costs | **(13,570)** | 0 |
| Computer Consumables | **(314)** | 0 |
| Annual Leave Provision | **5,474** | (4,162) |
| Depreciation | **50,930** | 46,999 |
| Long Service Leave | **(7,784)** | 13,947 |
| Salaries & Wages | **3,878** | |
| Decrease/(Increase) in GST Credits | **1,609** | 0 |
| Decrease/(Increase) in Other Debtors | **0** | (817) |
| (Decrease)/Increase in Trade Creditors | **9,344** | 18,275 |
| (Decrease)/Increase in Accruals | **8,000** | 63 |
| Decrease/(Increase) in Other Prepayment | **(646)** | 0 |
| **Net Cash provided by operating activities** | **87,603** | 58,257 |





## 14 FINANCIAL INSTRUMENTS

### a) Terms, Conditions and accounting policies

| Financial Instruments | 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 benefits 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 (2000-01: 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 | |
|---|---|---|---|---|
| | 2002 % | 2001 % | 2002 $ | 2001 $ |
| **Financial Assets** | | | | |
| Cash | 4.15 | 4.5 | **285,348** | **219,020** |
| Debtors | N/A | N/A | **-** | **1,294** |
| Total Financial Assets | | | **285,348** | **220,314** |
| **Financial Liabilities** | | | | |
| Trade Creditors | N/A | N/A | **18,378** | **9,035** |
| Total Financial Liabilities | | | **18,378** | **9,035** |

### 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 Financial Position 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.

## 15 STAFFING LEVELS

| | 2002 | 2001 |
|---|---|---|
| The average staffing levels for the Authority during the year were: | **8** | **9** |





## 16 REPORTING OF OUTCOMES

The Ombudsman is structured to meet one outcome, namely Choice Through Private Health.
Two output groups support the outcome:
Output 1: To provide advice and recommendations about the Private Health Services Industry.
Output 2: To facilitate direct delivery of services.

**Reporting by Outcome for 2001-2002**

| | Budget | Actual |
|---|---|---|
| Net Cost to Budget Outcome | **950,000** | **928,661** |
| Outcome specific assets | **527,000** | **330,330** |

Private Health Insurance Ombudsman is not able to attribute costs between outputs.

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