Australian Government

Private Health Insurance Ombudsman

ANNUAL REPORT 2009

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CONTACT

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

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Inquiries and complaints
1800 640 695 Free Call (higher cost from mobiles)
1300 737 299 (website inquiries)

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) 8235 8777
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FREECALL TELEPHONE HOURS OF OPERATION

9.00 am – 5.00 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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Australian Government
Private Health Insurance Ombudsman

The Hon. Nicola Roxon
Minister for Health and Ageing
Parliament House
CANBERRA ACT 2600

Dear Minister

Section 253-50 of the *Private Health Insurance Act 2007* requires me to provide 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 2008 to 30 June 2009.

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

Samantha Gavel

Samantha Gavel
Ombudsman
24 September 2009

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OMBUDSMAN'S OVERVIEW

Samantha Gavel – Ombudsman

The Ombudsman's office has focussed on three areas during the year. Firstly, ensuring that all of our activities contribute to our objective of protecting the interests of consumers in relation to private health insurance. These activities include our independent complaints handling service, reporting and recommendations to government and industry, our consumer information and advice services, including the consumer website, and our mediation role in relation to disputes between insurers and healthcare providers.

The first point of contact for many consumers is the Ombudsman's independent complaints handling service, which is free of charge and operates nationwide. We aim to provide a best practice complaints handling service that is also accessible, flexible and responsive to consumers. This year, 88% of respondents to our customer satisfaction survey reported they were satisfied or very satisfied with our complaints handling service.

Not surprisingly, those people who received a satisfactory outcome to their complaint were the most positive about the service. Our statistics show that in about half of the complaints that were formally investigated, the consumer received a satisfactory outcome of their complaint, with an additional explanation being provided in the remaining half.

Secondly, the focus has been on promoting the Ombudsman's services to consumers. It is important that consumers are aware that they can approach the office, if they are not able to resolve a matter with their insurer or healthcare provider. It is also important to raise awareness of the PrivateHealth.gov.au website, which is the only independent source of comparative information about health insurance policies in Australia, and an excellent source of reliable and independent information about private health insurance. The release of the 2008 "State of the Health Funds" report in particular provided a good opportunity to profile the office in the media, educate consumers on how to choose a health insurance policy that meets their needs and advise them of the Ombudsman's services.

Thirdly, the focus has been on improving the office's corporate planning processes, to ensure longer term strategic priorities are identified and achieved. A corporate plan for the coming year has been developed in consultation with staff. This, along with the Ombudsman's Statement of Intent to the Minister for Health and Ageing, sets out the priorities and areas for focusing our efforts over the coming year.

Health Insurance Complaints

The Ombudsman received 2502 complaints during 2008/09, which was slightly more than the 2385 complaints received in 2007/08. This represented a small increase (5%) in complaints compared with the previous year. The increase in overall complaint numbers is attributable to complaints about demutualisation issues, general service issues and issues relating to the level of cover held by the member. The number of higher level complaints investigated by the Ombudsman decreased slightly in 2008/09 to 708, down from 723 in 2007/08.

There were a number of areas during the reporting period where changes in the level of complaint to the Ombudsman were notable. Firstly, service and premium payment issues have always been a significant cause of complaint to the office. It is pleasing that this year, the number of complaints about these issues declined compared with the previous year, where complaints were higher due to a problem with one insurer's computer system.

There have been improvements in recent years in fund internal complaint handling processes. In funds where these are good, there are fewer of these types of service issue complaints. A higher level of complaint about service issues can be an indicator that the fund has some problems with its internal complaints handling processes.

During the next twelve months, Ombudsman staff will be conducting a series of industry workshops to assist funds to improve their internal complaint handling processes and ensure that fund staff understand the Ombudsman's processes and expectations. The Ombudsman intends to provide this type of assistance to insurers on an on-going basis, as staff turnover means there is always a need to update new staff members.

These seminars will complement the Ombudsman's bi-annual industry seminars, which are also focussed on assisting insurers to better manage their internal complaints handling processes.

Another area which has seen an increase in complaints is the category of "level of cover". These complaints relate to issues where a member has found they are not covered to the extent they thought they were, usually as a result of a restriction, exclusion or limitation on their policy.

Over the past year, there have been some highly restricted policies offered for sale by some insurers. This is partly a response to demand for more affordable policies in more difficult economic times. These policies do allow people to keep their lifetime health status and, in some cases, avoid the Medicare levy surcharge. In choosing to take a policy with a restriction, however, a member is taking on a higher level of risk in return for a lower premium, because there is always the possibility they may need treatment for a service that is restricted under their policy.

It is important that consumers purchasing these policies understand their limitations and review them every year, so that once they are able to afford a more comprehensive policy, they are prompted to do so. All health insurers apply a standard set of waiting periods, which means that once a member becomes aware that they may need treatment, it is too late to upgrade their policy and be covered for that illness or condition.

There are now a number of tools that assist consumers to understand their policies, including the Standard Information Statement (SIS) they receive each year from their health insurer. In addition, the Ombudsman has requested that insurers put processes in place that enable them to send members a letter, when they take out or change their health insurance policy, setting out any waiting periods or restrictions on the policy. It is notable that insurers who currently do this receive very few complaints from members regarding level of cover issues.

The number of complaints about hospital contracting issues also increased during the reporting period. Hospital contracting has been a feature of health insurance for over ten years. Under hospital contracting arrangements, health insurers and healthcare providers are able to negotiate a contract for the provision of hospital services at an agreed price. This promotes competition within the market and assists insurers to better manage costs and premium income.

If a member attends a hospital with which their insurer has an agreement, they will have very few, if any, out of pocket costs for their hospitalisation. (They may still incur out of pocket costs for medical services by their treating doctors.) If a member chooses to attend a hospital that doesn't have a contract with their insurer, however, they can have significant out-of-pocket expenses. It is therefore important for consumers to be aware that their insurer may not contract with all hospitals and to check whether the hospital they are planning to attend is a contracted hospital before they are admitted.

The consumer website (privatehealth.gov.au) managed by the Ombudsman contains a list of contracted hospitals for all insurers across all states and territories. The Ombudsman will focus on providing more information to consumers about this feature over the coming year to raise awareness of this useful consumer resource.

Contracting disputes between insurers and hospitals have the potential to adversely affect consumers' entitlements under their private health insurance. Although these are essentially commercial arrangements, the Ombudsman is able to mediate informally or formally to protect consumers' interests. The Ombudsman has a set of Transition Protocols, developed in consultation with industry, to provide for transitional arrangements where there is a contract cessation. These are in the process of being updated to reflect the need for better guidance to insurers and hospitals about appropriate communication with members and patients when a contract is terminated.

It is pleasing to see that complaints about oral advice given over the phone by call centre staff and printed information in fund brochures have declined during the reporting period. This is a very positive development. A number of insurers have introduced call recording of their customer interactions over the past year. Call recording greatly reduces the number of complaints about oral advice and facilitates the resolution of those complaints that do arise. It is notable that in cases where Ombudsman staff have listened to a call recording in the process of investigating a complaint, it has highlighted information that the complainant may have misheard or misunderstood, as well as areas where fund staff have provided insufficient or incorrect information. Call recording is therefore also a good training tool for insurers.

Another issue during 2008/09 has been on-going complaints from members of one insurer that removed maternity benefits from a level of cover two years ago. Members complaining to the Ombudsman have been unaware of the change in their policy, even though the insurer sent a number of letters about the change to members. A member can be significantly disadvantaged if they discover they are no

longer covered for maternity services and they are already pregnant.

The Ombudsman will continue to monitor any detrimental changes of this nature that occur in future and require insurers to carry out more comprehensive communications campaigns with members, including outbound telephone and e-mail campaigns, to reduce the number of people who for a number of reasons, are not aware of the change.

Consumer Website (www.privatehealth.gov.au)

The Ombudsman is responsible for maintaining the consumer website (www.privatehealth.gov.au). The website enables consumers to access independent and reliable information about private health insurance, as well as download and view Standard Information Statements (SISs) showing the main features of their own and other health insurance policies they may wish to purchase. There are currently some 20,000 health insurance policies loaded onto the website.

Visits to the website have continued to increase and the Ombudsman is able to organise targeted internet advertising to ensure consumers are kept aware of the site and its services. The website currently receives an average of 950 unique visits a day and feedback from consumers continues to be positive.

The Ombudsman is currently undertaking a review of the website and recently completed consumer focus and usability testing as part of the review. The results of this testing will be used to inform the review and updating of the website over the next six months. The focus testing confirmed the usefulness of the site as an independent source of information for consumers and highlighted some areas where improvements in layout and content of information can be made.

Overseas Visitor Cover

During the reporting period, a number of complaints highlighted issues with some of the policies available for purchase by overseas visitors, who are ineligible for Medicare. Ineligible patients have no alternative treatment options if their health insurance is insufficient for their needs. The Ombudsman has been working with government and industry to resolve some of the systemic issues relating to this area. More information about overseas visitor complaints is provided later in the report. I have chosen to include more information about these complaints in this year's report in order to highlight some of the problems that some members on these policies are experiencing.

A new web page has been developed on the privatehealth.gov.au website to give overseas visitors better information about choosing a health insurance policy to provide them with appropriate cover while they are in Australia.

Industry Developments

The profile of the private health insurance industry underwent significant change during 2008, as a number of insurers moved from operating on a not-for-profit basis, to operating on a for-profit basis. The conversion of Medibank Private to for-profit status from 1 October 2009 will mean that the market share of for-profit insurers will increase to over 50% of the private health insurance market.

The past year has posed challenges to consumers and insurers alike, due to less favourable economic conditions. In spite of these difficulties, fund membership increased over the reporting period.

Changes to the Medicare Levy Surcharge thresholds were introduced from 1 July 2008, with changes to the application of the rebate for health insurance foreshadowed from 1 July 2010.

Insurers have continued to introduce broader healthcare initiatives during the reporting period, to give consumers access to chronic disease and health management programs, as well as access to more flexible treatment options. At least two insurers have negotiated partnerships with companies that specialise in broader health programs, which will enable them to implement new programs for their members.

The Ombudsman will shortly be providing more information about broader health programs offered by insurers on the www.privatehealth.gov.au website.

A Private Health Insurance Code of Conduct was introduced by the industry some years ago. The Code sets out standards for health insurers as well as agents, brokers and other intermediaries acting on their behalf, in relation to the provision of advice about private health insurance to consumers. The majority of health insurers have undergone Code compliance processes and been admitted to Code. The Ombudsman would like to see all insurers as signatories to the Code.

There has been a gradual reduction in overall complaints to the Ombudsman in recent years, even though health insurance membership over the same period has increased. While a number of factors have contributed to this, it does appear that in general, insurers' internal complaint handling processes and the information and advice to members have improved and it is likely that the introduction of the Code has been a factor in this improvement.

The Code of Conduct is currently undergoing a review, which the Ombudsman has had input into. The outcome of the review is likely to result in strengthening of the Code's provisions, which the office strongly supports.

Corporate Governance

The Ombudsman is a prescribed statutory agency under the *Financial Management and Accountability Act 1997* and works through its Audit Committee to ensure compliance with the requirements of the Act.

Ombudsman staff members are employed under the provisions of the *Public Service Act 1999* and are required to adhere to the APS Values and Code of Conduct. The Ombudsman provides a flexible working environment to its staff and training and development through its Performance Development Program.

In May 2009, the Minister for Health and Ageing provided a *Statement of Expectations*, setting out her priorities for the office going forward. The Ombudsman responded with a *Statement of Intent*, setting out the measures that will be implemented to ensure the Minister's objectives are met. Both statements are available on the Ombudsman's website at www.phio.org.au.

The Year Ahead

The Ombudsman has a number of priorities for the coming year including the review and updating of the privatehealth.gov.au website (postponed from the previous year); updating of its complaint handling software, and a focus on consumer and industry education through a series of industry workshops and new consumer publications.

Samantha Gavel
Ombudsman

Introduction

The Private Health Insurance Ombudsman is a statutory agency established under the *Private Health Insurance Act 2007*.

The role of the Ombudsman is to protect the interests of consumers in relation to private health insurance.

Functions

The Ombudsman is an independent body that resolves problems about private health insurance, and acts as the umpire in dispute resolution at all levels within the private health industry.

A summary of the functions of the Ombudsman, as provided by section 238-5 of the *Private Health Insurance Act 2007*, are to:

- Deal with complaints and conduct investigations;
- Publish aggregate data about complaints;
- Publish the *State of the Health Funds Report*;
- Make recommendations to the Minister or Department of Health and Ageing;
- Report to the Minister or the Department about the practices of particular private health insurers, private health providers and private health insurance brokers or other related parties;
- Collect and publish information about complying health insurance products (i.e. manage the Consumer Website privatehealth.gov.au);
- Promote a knowledge and understanding of the Ombudsman's functions;
- Undertake any other functions that are incidental to the performance of any of the preceding functions.

Who can make a complaint?

Generally, anyone can make a complaint, as long as the complaint is relevant to private health insurance. The objective of the Private Health Insurance Ombudsman is to "*protect the interests of people covered by private health insurance*". The Ombudsman will look into complaints that concern private health insurance consumers, but the office may not investigate complaints of a purely commercial nature that do not have significant impact on the rights of consumers.

Persons against whom a complaint may be made

Complaints may be made against private health insurers, health care providers and private health insurance brokers.

What can the Ombudsman do with a complaint?

The Ombudsman is able to deal with complaints by:

- Referring the complaint to the health insurer, broker, 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;
- Mediation;
- 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 insurers, health care providers and health insurance brokers, 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 insurers, health care providers and health insurance brokers take a specific course of action in relation to a complaint; and

Left to Right: Richard Van Der Male, Amelia Messner, Tanya Snowden, Hilary Bassingthwaighte, Ursula Schappi, Samantha Gavel, Damien Maynard, Kaylie Blyton, Leonie Hull, Joanna Wong

- A health insurer changes its rules or practices.

In certain circumstances, the Ombudsman may request that a health insurer, health care provider or health insurance broker provide a report on any action taken as a result of the Ombudsman's recommendations.

Section 241-35 of the *Private Health Insurance Act 2007* provides various grounds for the Ombudsman to decide not to deal with a complaint. These include:

- If the complainant has not taken reasonable steps to negotiate a settlement;
- If the complainant is capable of assisting the Ombudsman in dealing with the complaint but does not do so on request;
- If the subject of the complaint has dealt, or is dealing, adequately with the complaint or has not yet had an adequate opportunity to do so;
- If the complainant does not have a sufficient interest in the subject matter of the complaint;
- The matter is trivial, vexatious or frivolous; or the complaint was not made in good faith;
- If the Ombudsman or another organisation has already been dealing with, or dealt with, the complaint adequately; or
- If the complaint is mainly about commercial negotiations and it is not appropriate to deal with the complaint.

How the Ombudsman's 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 insurer or provider, staff will usually refer complainants back to these parties in the first instance. Staff will often refer the complaint themselves in order to provide a faster and more convenient service to the complainant.

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

Staff members regularly keep complainants informed of developments about complaints, usually by telephone.

The Ombudsman will advise complainants of the outcome of a complaint lodged with the Ombudsman by phone, letter or e-mail. Complainants may seek a review of their case if they are not satisfied with the response, or seek further clarification of the reasons for a decision.

Output performance measures

The 2008/2009 Portfolio Budget Statement for the Health and Ageing Portfolio includes both quality and quantity measures for the Private Health Insurance Ombudsman's two output groups. The following is a summary of performance outcomes against these formal performance indicators during 2008/2009.

Output group 1 – Advice and recommendations about the private health insurance industry

Quality indicator: Quality, relevant, and timely advice, submissions and reports.
Measurement: Level of stakeholder satisfaction, as measured by stakeholder feedback.
Performance result: Overall high level of satisfaction achieved against the three measures – relevance, quality and timeliness.

Quantity indicator: Production of a range of advisory service products including submissions and public presentations.
Measurement: Production of at least 12 submissions and public presentations.
Performance result: 14 submissions and public presentations.

Output group 2 – Direct delivery of services (information and dispute resolution service)

Quality indicator: Efficient complaints handling service.
Measurement: Complaints received during the year finalised.
Performance result: 93% of complaints received during the year finalised.

Quantity indicator: Accessible, effective and timely complaints handling service.
Measurement: Consumer satisfaction survey.
Performance result: 89% of respondents satisfied or very satisfied.

Quantity indicator: Improved fund or industry practices as a result of PHIO investigation recommendations.
Measurement: Proportion of recommendations that have resulted in changes to fund or industry practices.
Performance result: The Ombudsman made one formal recommendation to an insurer to change its practice during the reporting period. The insurer agreed to accept the Ombudsman's recommendation. The performance result for this indicator is therefore 100%.

Quantity indicator: Information products produced are useful and informative for consumers.
Measurement: Client satisfaction survey
Performance result: 97% of respondents found PHIO written information easy to understand.

Quantity indicator: Timeliness of complaint resolution.
Measurement: Percentage of complaints finalised within one month of receipt and a reduction in the average time taken to finalise Level-3 disputes.
Performance result: 85% of complaints finalised in one month compared to 87% the previous year. Average time taken to finalise Level-3 disputes increased.

Quantity indicator: Quality, accurate information about private health insurance
Measurement: Publication of the "State of the Health Funds" report by 31 March 2008, the Consumer Website (privatehealth.gov.au) accessible to consumers.
Performance result: "State of the Health Funds" report released on 31 March 2008. No reported access issues with website and 195 960 unique visitors during the year.

PERFORMANCE
Complaints

The Ombudsman received 2502 complaints during 2008/09. This was 117 (5%) more complaints than the previous year.

There were 708 Level-3 complaints received during the year, 15 (2%) less than the year before. Level-3 complaints are categorised as those where the Ombudsman's staff contacts the health fund or other body and requests a report which is reviewed and either closed as a satisfactory response or investigated further.

Figure 1 shows the distribution of complaints throughout the four quarters of the 2008/2009 financial year.

Consumer Inquiries

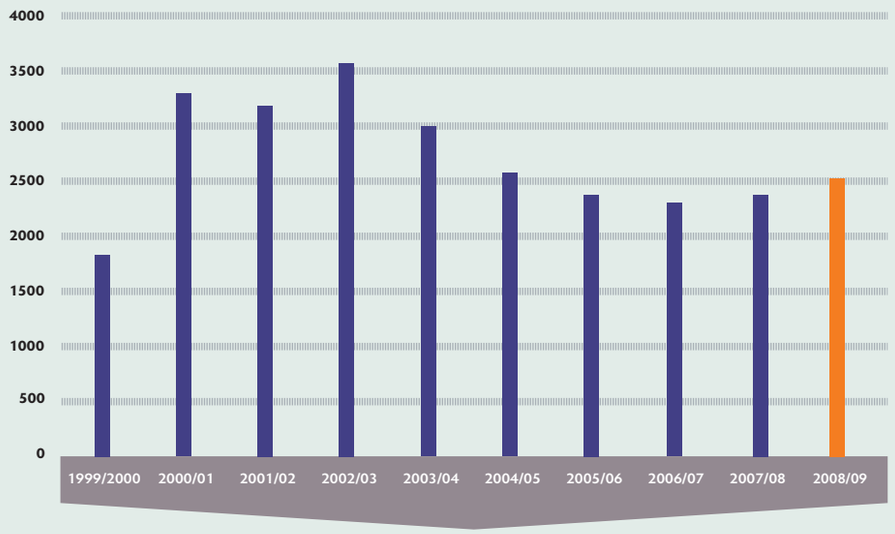
The Ombudsman recorded 605 consumer inquiries during 2008/09. These were questions from consumers about their health insurance which did not meet the definition of a complaint, but where a record of the advice provided needed to be made.

Figure 2 shows the total number of complaints received per year for the last 10 years. The increase in the number of complaints in the 2000/2001 year was associated with a large increase in the number of Australians covered by private health insurance as a result of introduction of the 30% Health Insurance Rebate and Lifetime Health Cover.

The reduction in complaints after 2002/03 is mostly attributable to a decline in complaints about premium increases, as well as improvements in health insurance industry complaint handling processes.

Figure 1 Total Complaints Received per Quarter

Figure 2 **Total Complaints Received per Year**



Recording and categorisation of complaints

An approach to the Ombudsman's office is recorded as a complaint when it meets the criteria contained in the *Private Health Insurance Act 2007*. A complaint must be an expression of dissatisfaction with any matter arising out of or connected with a private health insurance arrangement. Complaints can be made by, and be concerned with, a member of a health insurer, a hospital, a doctor or other practitioner, a health insurer or health insurance broker.

Complaints dealt with by the Ombudsman range from simple contacts that do not require investigation and can be referred to the service provider, through to matters requiring mediation or a formal recommendation under the Act.

The Ombudsman's complaints categorisation takes account of the following factors:

- Type of approach;
- Degree of effort required by Ombudsman staff to resolve the matter; and
- Any potential sensitivity.

Currently this categorisation is:

Complaint Level-1 (Problems):
Moderate level of complaint

Level-1 complaints are dealt with by referring the complainant back to the health insurer, health care provider or health insurance broker. 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 of approaching the problem. 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 empowers the consumer to try to resolve the complaint directly and if they are not successful, they return and reactivate the complaint.

Eighty-two percent of complaints were handled as "Assisted Referrals," where the Dispute Resolution Officer referred a complaint directly to the insurer or service provider on behalf of the complainant. This approach ensures a quicker turnaround time and enables the approriate person within an organisation to assist the complainant. The Ombudsman's client satisfaction survey indicates that complainants are more often satisfied with the office if assistance is provided by staff members in this way.

If complainants are still not satisfied after their health insurer or healthcare provider contacts them, the Ombudsman can then contact the other party and ask for a report in order to assess the complaint. When this occurs, the complaint is re-classified as a Level-3 complaint.

Complaint Level-2 (Grievances):
Moderate level of complaint resolved without requiring a report from the subject of the complaint

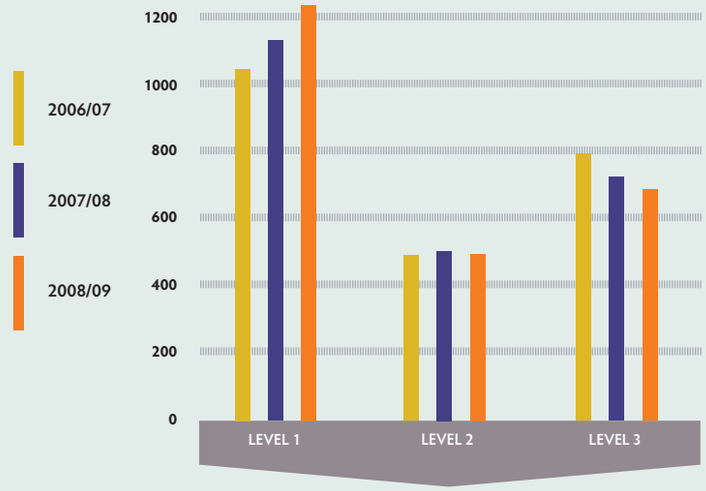
Level-2 complaints are dealt with by staff of the Ombudsman investigating the complainant's grievance directly and providing additional information or a clearer explanation. Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy they have purchased, including concerns about service levels provided by the insurer or provider, price increases, 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.

Complaint Level-3 (Disputes):
Highest level of complaint where significant intervention is required

Level-3 complaints are dealt with by Ombudsman staff contacting the health insurer, health care provider or health insurance broker about the matter and requesting a formal report. 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 include pre-existing ailments, lack of informed financial consent, benefits available on transfer of membership, benefits not in accordance with brochure descriptions and contribution errors.

The 2502 complaints recorded in 2008/09 consisted of 708 Level-3 complaints, 531 Level-2 complaints and 1282 Level-1 complaints. Figure 3 shows this ratio and shows a significant increase in Level-1 complaints and a small reduction in Level-2 and Level-3 complaints.

Figure 3 **Complaints Received per Year by Category**



Hilary Bassingthwaighte, Director Policy and Client Services

Complaint Audit and Escalation

During the reporting period, approximately one quarter of the Level-3 complaints reported were initially recorded as Level-1 complaints. These were upgraded to the higher level category, either because the complainant was not satisfied with the fund's initial response or further investigation of the matter was required; or because the complaint record was corrected in audit.

All complaints are audited by a senior member of staff, who reviews details of the complaint to ensure the complainant's concerns have been addressed and that the categorisation of complaints is accurate and consistent. If the audit shows, for example, that a complaint initially thought to be a simple (assisted referral) complaint turned out to be a more complex matter requiring further investigation, it is reclassified as a Level-3 complaint.

Complaints handling procedures

The process and timeframes for the different complaint categories are depicted in Figure 5.

The majority of complaints are (not surprisingly) from members of health insurers about their own insurer. However, there are instances where a complaint needs to be recorded against both the health insurer and a health care provider. This occurs, for example, where the complaint involves contradictory advice from an insurer and a hospital about how much of a hospital bill will be paid by the insurer.

Members of health insurers also lodge complaints about health care providers, including:

- Hospitals (generally about inadequate information to enable informed financial consent);
- Doctors (almost always about lack of informed financial consent or the gap between charges and benefits paid through Medicare and the fund); or
- Other practitioners (generally about the gap between the charges and the benefit paid through ancillary tables); or
- Health Insurance Brokers (usually related to information provided when joining an insurer).

Overall, complaints against provider groups are small in number when compared with complaints against health insurers.

Health care providers can also lodge complaints against health insurers. These are 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.

Figure 4 Complaints by Category 2008/2009

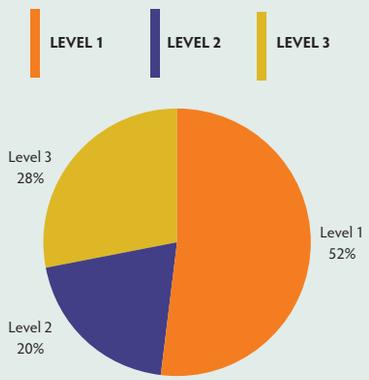


Figure 5 Steps in Handling Approaches to the Ombudsman

LEVEL 3 [DISPUTE]	LEVEL 2 [GRIEVANCE]	LEVEL 1 [PROBLEM]
Timeframe Depends on the nature and complexity of matter and responses from health fund and provider	**Timeframe** Usually within 24 hours	**Timeframe** Immediate
Action PHIO contacts health fund or provider to obtain a report, then mediates the dispute between the parties or investigates the matter further	**Action** Complainant provided with explanation or information to resolve matter, or if there is no avenue for the Ombudsman to take up the matter	**Action** If complainant has made insufficient effort to resolve the matter with fund or provider, refer complaint to fund on behalf of complaint or empower the complainant to take the matter up directly.
Outcomes Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal recommendation by Ombudsman	**Outcomes** Detailed information provided which appropriately resolves the issue	**Outcomes** Referral to health fund or provider. Complainant may also contact PHIO and request a review in which case the matter may be upgraded to a Level 3 Complaint

Workload

The office received 2502 complaints (Levels 1, 2 & 3) in 2008/09, an average of 209 per month compared with 199 complaints per month in the previous year.

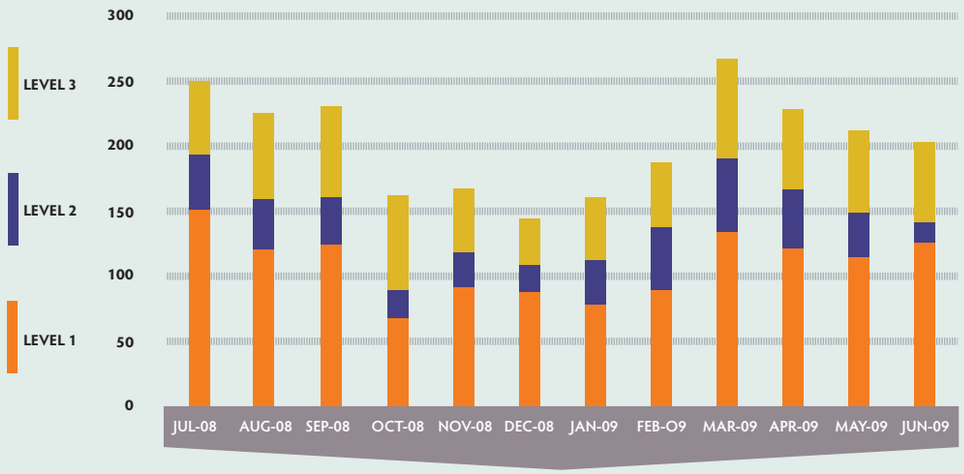
The office finalised 2463 complaints during the year; an average of 205 per month compared to 197 per month in the previous year.

The office finalised 679 complaint investigations (Level-3 complaints) during the year, compared to 711 in the previous year.

The Ombudsman recorded 605 consumer enquiries during 2008/09.

Figure 6 shows the number of complaints

Figure 6 Total Complaints Received by Month



received in each month of the year, indicating changes in workload over the year in the various complaint categories. The office tends to receive higher numbers of contacts during March to July each year, which coincides with the annual premium adjustment for all health insurers.

Time taken to resolve complaints

Figures 7 and 8 provide information on the time taken to resolve complaints this year compared to last year. There has been a small increase in the time taken in handling complaints. Eighty-three percent of complaints were handled within one month compared to 87% the previous year. Although this is a small increase in the time taken to handle a complaint, the Ombudsman will be focussing on reducing this timeframe over the coming year, because timeliness is an important aspect of a complaint handling service for consumers.

Figure 7 **Time Taken to Finalise Complaints**

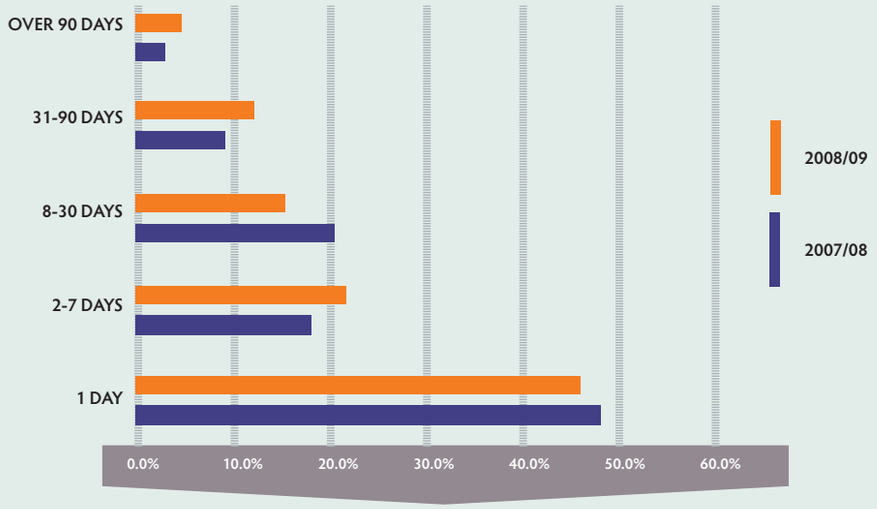


Figure 8 **Complaints Completed Since Day of Lodgement**

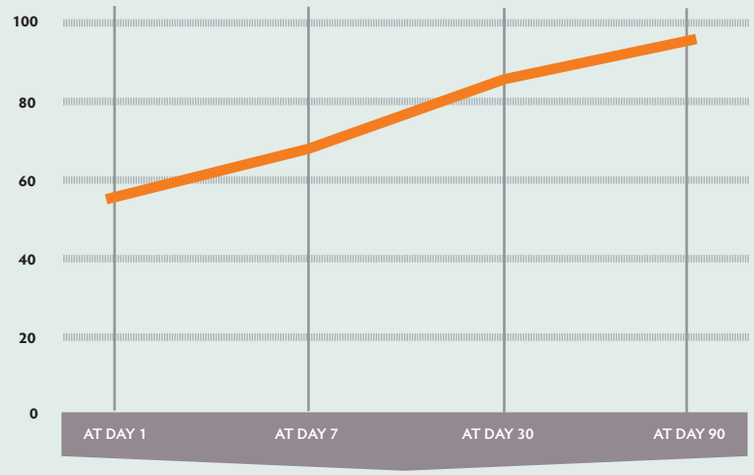


Figure 9 **Who Was Complained About 2008/09**

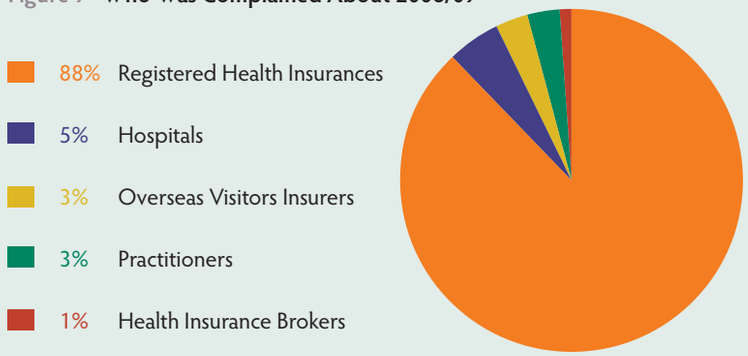


Figure 10

	2007/08	2008/09
Registered Health Insurances	2267	2325
Hospitals	133	134
Overseas Visitors Insurers	55	92
Practitioners	55	72
Health Insurance Brokers	23	19

Who was complained about

Most complaints were made about registered health insurers, followed by hospitals, overseas visitors' insurers, practitioners and health insurance brokers.

Some complaints concerned one or more health insurers, or a health insurer as well as a health care provider. Consequently, the total number of organisations or people that were complained about (2642) adds up to more than the total number of individual complainants contacting the Ombudsman (2502).

Complaints about registered health insurers

Figure 11 provides a summary of all complaints (Levels 1, 2 and 3) for individual health insurers compared with their market share. This data is also presented for the higher category "Level-3" complaints. Analysing the information at this further level of detail provides a more realistic picture of the way insurers respond to their members' complaints. Higher Level-3 complaints to market share ratios are a pointer to a less than adequate internal disputes resolution process for complex issues within the insurer.

Complaints about hospitals

During the year, there were 134 complaints about hospitals; this was similar to the number received the previous year.

Complaints about hospitals usually occur when patients experience unexpected gaps for a hospital admission. In most cases, there are adequate processes in place in private hospitals to ensure the provision of *informed financial consent (IFC)* to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year.

The reasons why the 134 complainants who contacted the Ombudsman experienced hospital gaps varied. Most gaps occurred

Figure 11 Complaints by Health Insurer Market Share (01 July 2008 - 30 June 2009)

NAME OF FUND	COMPLAINTS (1)	PERCENTAGE OF COMPLAINTS	LEVEL-3 COMPLAINTS (2)	PERCENTAGE OF LEVEL-3 COMPLAINTS	MARKET SHARE (3)
ACA Health Benefits	1	0.0%	1	0.2%	0.1%
AHM	146	6.3%	51	8.0%	3.0%
Australian Unity	106	4.6%	29	4.5%	3.2%
BUPA (HBA)	191	8.2%	49	7.7%	9.8%
CBHS	21	0.9%	4	0.6%	1.2%
CDH (Cessnock District Health)	1	0.0%	0	0.0%	<0.1%
CUA Health	5	0.2%	0	0.0%	0.4%
Defence Health	20	0.9%	4	0.6%	1.4%
Doctors' Health Fund	2	0.1%	0	0.0%	0.1%
GMHBA(4)	39	1.7%	14	2.2%	1.5%
Grand United Corporate Health	13	0.6%	6	0.9%	0.3%
HBF Health	61	2.6%	17	2.7%	7.5%
HCF (Hospitals Cont. Fund)	151	6.5%	23	3.6%	8.9%
Health Care Insurance	1	0.0%	0	0.0%	0.1%
Health Insurance Fund of W.A.	14	0.6%	3	0.5%	0.4%
Healthguard	12	0.5%	2	0.3%	0.5%
Health-Partners	8	0.3%	0	0.0%	0.6%
Latrobe Health	13	0.6%	5	0.8%	0.6%
Manchester Unity	89	3.8%	29	4.5%	1.5%
MBF Alliances	100	4.3%	24	3.8%	2.0%
MBF Australia Limited	551	23.7%	127	19.8%	15.7%
Medibank Private	490	21.1%	148	23.1%	28.7%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	<0.1%
NIB Health Funds	208	8.9%	83	13.0%	7.0%
Navy Health	4	0.2%	2	0.3%	0.2%
Peoplecare	7	0.3%	0	0.0%	0.3%
Phoenix Health Fund	1	0.0%	0	0.0%	0.1%
Police Health	2	0.1%	0	0.0%	0.3%
QLD Country Health Fund	4	0.2%	0	0.0%	0.2%
Railway & Transport Health	8	0.3%	2	0.3%	0.3%
Reserve Bank Health	1	0.0%	0	0.0%	<0.1%
St Lukes Health	1	0.0%	0	0.0%	0.4%
Teacher Federation Health	31	1.3%	9	1.4%	1.7%
Teachers Union Health	9	0.4%	2	0.3%	0.4%
Transport Health	1	0.0%	1	0.2%	0.1%
Westfund	13	0.6%	5	0.8%	0.7%
Total for Health Insurers	**2325**	**100%**	**640**	**100%**	**100%**

1. Number of Complaints (Levels 1, 2 & 3) from those holding registered health fund policies.
2. Level 3 Complaints required the intervention of the Ombudsman and the health fund.
3. Source: PHIAC, Market Share, All Policies, 30 June 2008
4. Druids health fund was transferred to GMBHA from 1 October 2008

because people held lower cost hospital policies with restrictions on certain treatments, or because patients were within waiting periods. The office also assisted a small number of consumers who were asked to pay unexpected hospital gaps because their health insurer did not have a contractual agreement with the hospital they were intending to visit.

Complaints about practitioners

Most complaints about doctors and practitioners concerned medical gap issues and/or a *lack of informed financial consent (IFC*). During the 2008/09 year, the office received 84 complaints about medical gap issues, which was 8 more than the previous year. The office registered 72 complaints against practitioners (doctors, dentists, other practitioners), compared to 55 in the previous year.

Complaints about practitioners have gradually declined in recent years, suggesting that initiatives to improve the rate of IFC by medical practitioners have had some success. As noted in previous reports, however, consumers report higher levels of lack of IFC in consumer surveys than complaints to the Ombudsman would suggest and the Ombudsman will continue to monitor and investigate complaints about this issue received by the office.

Complaints about brokers

Most complaints about brokers concerned issues relating to the information provided on joining and the level of cover chosen. There were 19 complaints about brokers during 2008/09.

Resolving complaints

Thirty-two percent of complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint.

Forty-three percent of complaints were referred directly to health insurers with the assistance of the Ombudsman's staff, on the understanding that the complainant could request a review of the complaint by the Ombudsman if they remained unsatisfied. The Ombudsman's arrangements for assisted referrals are designed to allow complainants and insurers to quickly resolve the majority of complaints using an informal approach, where the Ombudsman may suggest ways for the complaint to be resolved. Complainants are made aware that if they remain dissatisfied with the response they receive via the informal referral process, they are able to approach the Ombudsman again for a review of their case.

Nine percent of complaints were resolved by the complainant obtaining advice from the Ombudsman's office and then referring their complaint to the appropriate body themselves.

Nine percent of complaints (32% of the Level-3 complaint category) were resolved by a payment by the health insurer, or the writing-off of accounts by hospitals. These payments usually followed an investigation by the Ombudsman where the health insurer agreed that a member was entitled to a benefit payment or some other payment. In some cases, payment was made by health insurers on an *ex-gratia* basis; for instance, where the insurer paid a benefit the member was not entitled to under their policy.

Figure 12 **Outcome of Finalised Complaints**

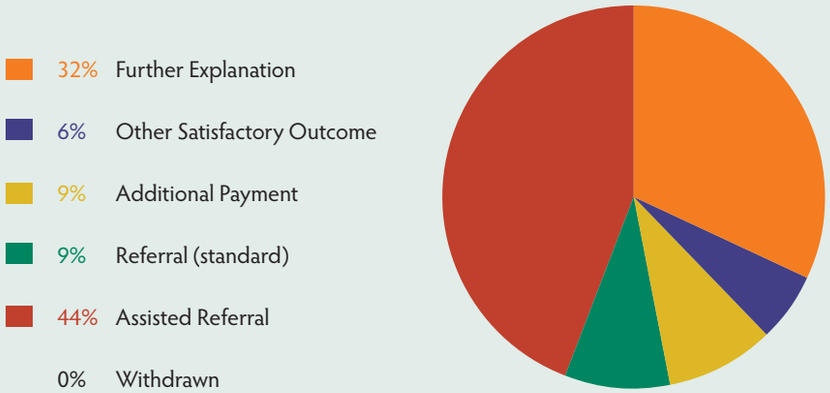
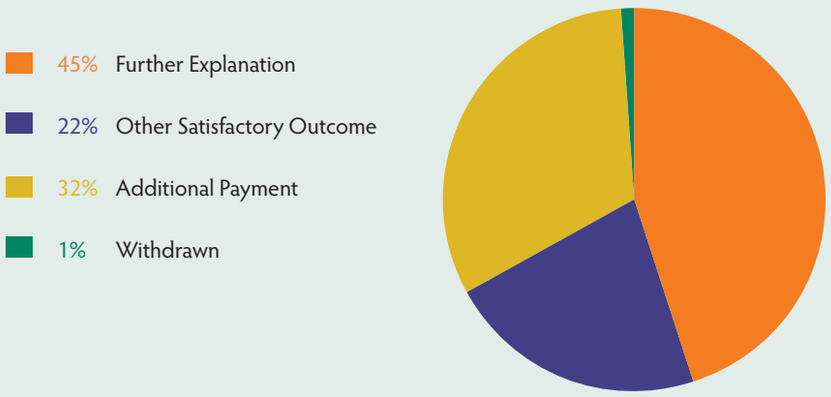


Figure 13 **Outcome of Finalised Level 3 Complaints**



An additional 6% of complaints (22% of the Level-3 complaint category) were resolved by taking other remedial action, such as re-instating a membership or confirming that a health insurance record had been corrected.

The remaining 1% of complaints which met the criteria for a complaint under *Private Health Insurance Act 2007* were either withdrawn, or referred to another agency such as a hospital's patient liaison officer, a state based health complaints body, the Privacy Commissioner or a state Department of Fair Trading.

Summarised information about the resolution of complaints and Level-3 complaints is provided in Figures 12 and 13.

Who complained?

The *Private Health Insurance Act 2007* allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. Overwhelmingly, 97% of complaints were made by health insurance members (2430), followed by practitioners (30) and hospitals (15).

How complaints were made

Seventy-four percent of complaints were made initially by telephone, 21% were lodged through the internet or by email, 5% by letter, and less than 1% by fax, personal visit to the Ombudsman's office in Sydney or by parliamentary representation.

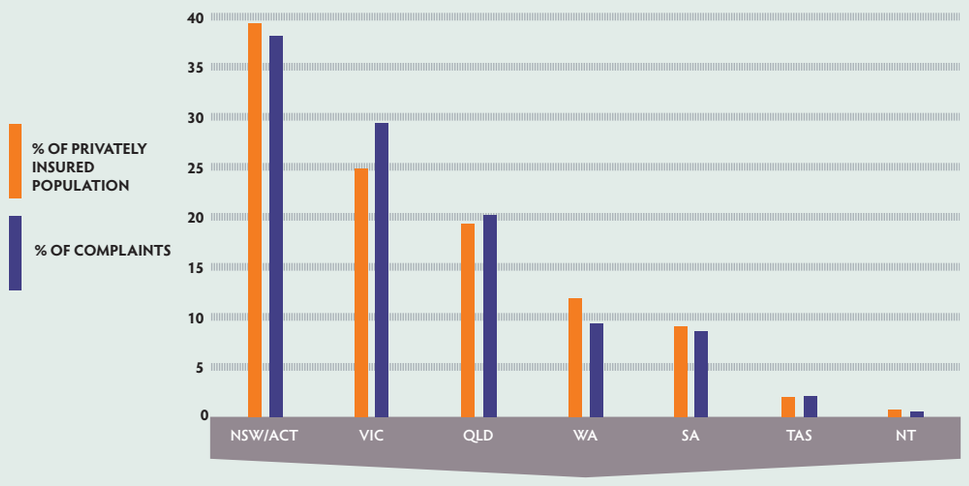
Complaints by State/Territory

Figure 14 identifies, on a state-by-state basis, where complaints originate. This data is shown by state and territory, against the percentage of people who have private health insurance coverage. It is notable that the traditional tendency for a greater number of Queenslanders to make a complaint about their health insurance did not occur in 2008/2009. The figures show that Victorians had a greater tendency to have a health insurance complaint than previous years.

Investigations

From 1 July 2008 to 30 June 2009 there were no investigations under section 244 of the *Private Health Insurance Act 2007* (or under the preceding Act).

Figure 14 **Complaints by Population Covered by State & Territory**



Introduction

Complaints to the Ombudsman must first meet the requirements of section 241-10 of the *Private Health Insurance Act 2007*. Embodied in that section is the requirement that a complaint be about a health insurance arrangement. For reporting purposes, complaints are classified in terms of broad issues and sub issues. The most significant type of complaints concern benefits, followed by service issues, membership issues, information and waiting periods.

Figures 15 and 16 illustrate the proportion of complaints corresponding to each issue type.

Benefit Issues

The Ombudsman received 960 complaints concerning a wide range of benefit issues; this was 90 more than the previous year. The most significant concerns for consumers were inadequate levels of cover, inadequate benefit amounts, delays in benefit payments and providers not being recognised. Figure 17 lists the complete number of benefits issue complaints raised by consumers with the Ombudsman's office.

Service and Payment Related Issues

The Ombudsman received 305 complaints regarding general service issues with health insurers, which is a small improvement on the previous year but still almost 3 times more than the figure recorded in 2005/06. Similarly, the office received a smaller, though still significant, number of complaints concerned with premium payment problems mostly associated with direct debit computer systems. During the year, 168 complaints were made about premium payment problems, compared to 236 in the previous year.

Membership Issues

The Ombudsman received 298 complaints about membership issues, which is an improvement from the 350 received the previous year. The more common membership issues raised with the Ombudsman are related to the cancellation or transfer of memberships and problems with membership payment arrears.

Information Issues

The office received 259 complaints relating to information issues. Of these, 156 concerned oral information, 56 concerned a lack of notification of changes to policies and the remainder concerned printed material from health insurers.

Health Fund Premium Increases

During 2008/09 the Ombudsman received 89 complaints regarding health insurance premiums, which was 7 fewer than the previous year and the second lowest number of premium complaints received since the Ombudsman's office was established.

Figure 15 **Percentage of Complaint Issues 2008/09**

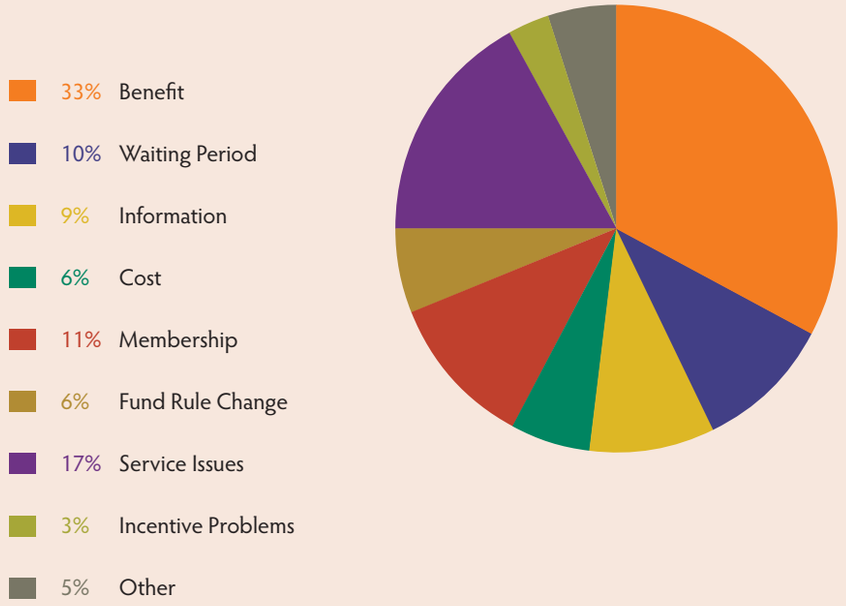


Figure 16 **Complaint Issues 2006/07- 2008/09**

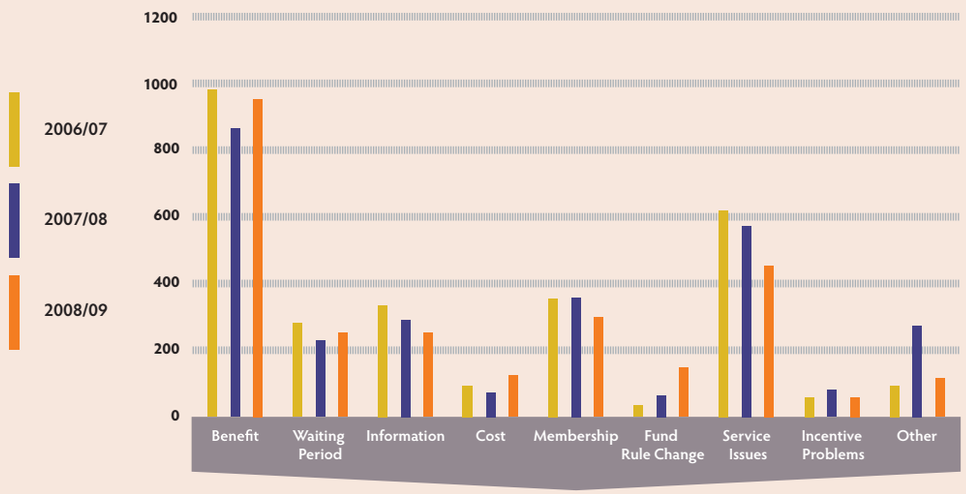


Figure 17 **Complaint Sub-issues**

		2007/08	2008/09
Benefit	Accident and Emergency	9	3
Benefit	Accrued	4	16
Benefit	Ambulance	41	44
Benefit	Amount	91	131
Benefit	Community Rating	0	1
Benefit	Delay in Payment	180	94
Benefit	Excess	34	56
Benefit	Gap - Hospital	43	68
Benefit	Gap - Medical	76	84
Benefit	Level of Cover	156	262
Benefit	Limit Reached	18	20
Benefit	New Baby	8	6
Benefit	Non Acute Care	1	2
Benefit	Non Health Insurance	8	6
Benefit	Non Recognised Other Practitioner	22	32
Benefit	Non-Recognised Podiatry	34	24
Benefit	Other Compensation	9	8
Benefit	Out of Pocket NEC	54	34
Benefit	Out of Time	16	15
Benefit	Preferred Provider Schemes	34	35
Benefit	Prostheses	12	10
Benefit	Workers Compensation	2	1
Contract	2nd Tier Default Benefit	5	2
Contract	Code of Conduct Violations	1	0
Contract	Doctors & Dentists	2	6
Contract	Hospitals	13	35
Cost	Dual Charging	1	4
Cost	Fees / Informed Financial Consent	47	66
Cost	Premiums	96	89
Incentives	Problems (LHC 30% rebate Medicare levy)	102	76
Information	Lack of Notification	34	63
Information	Oral	187	156
Information	Printed	50	25
Information	Radio / Television	0	2
Information	Written	12	12
Membership	Arrears	81	75
Membership	Cancellation / Suspension	144	103
Membership	Non-Contributor	2	7
Membership	Rate & Benefit Protection	1	4
Membership	Transfer / Continuity	112	88
Membership	Young People	10	17
Service	General Service Issues	334	305
Service	Premium Payment Problems	236	168
Waiting Period	Benefit Limitation Period	3	4
Waiting Period	General	17	39
Waiting Period	Obstetric	53	49
Waiting Period	Other	12	11
Waiting Period	Pre Existing Ailment	158	165
Other	Access	5	4
Other	Acute Care Certificates	0	2
Other	Complaint NEC	46	30
Other	Confidentiality & privacy	15	12
Other	Demutualisation/Sale Health Insurers	67	125
Other	Discrimination	2	0
Other	Fund Rule Change	91	63
Other	Private Patient Election	3	1

Overseas Visitors Health Cover

The Ombudsman assisted 92 consumers with complaints concerning overseas visitors cover (for visitors to Australia); this is an increase on the 55 complaints received last year.

Overseas visitor covers are not "complying health insurance policies" under the Act and these complaints are therefore not included in figure 11, which lists complaints by each health insurer.

The 92 complaints were registered across a small number of insurers who offer these policies. As market share information for overseas visitor cover was unavailable at the time of publishing, the number of complaints against each insurer has not been listed, because it would not allow a fair comparison of complaint numbers against the number of policies held.

Unlike Australian residents, overseas visitors to Australia who hold temporary visas are not eligible for Medicare benefits. Some visitors from countries with which Australia has a Reciprocal Health Care Agreement do receive emergency treatment in public hospitals free of charge, but aren't otherwise entitled to Medicare benefits. This means that when

Leonie Hull, Principal Policy Officer

overseas visitors need medical attention, whether that takes the form of a visit to their local GP or an extended hospital stay, they can find themselves responsible for the full cost of treatment unless they hold an appropriate level of insurance.

To insure themselves against potential medical expenses, overseas visitors can take out Overseas Visitors Health Cover (OVHC). A number of funds offer cover specifically for people who aren't eligible for Medicare benefits, including: AHM, Australian Unity, HBA (Mutual Community), HIF, Manchester Unity, MBF, Medibank Private and HCF *(diplomats, certain visas only).*

Some OVHC policies provide similar cover to those available to Australian residents, while others can be very different. Benefits, membership costs and eligibility can vary greatly between insurers, so the Ombudsman recommends that anyone looking to take out OVHC should take care to ensure the policy they select is suitable for their needs.

The most common complaints investigated by the office in relation to OVHC concern waiting periods and other restrictions on the policy. Complaints about the application of the pre-existing waiting period tend to be complicated, because information about a person's medical history before coming to Australia is held overseas. Sometimes fund members are not aware that they are not covered for pre-existing ailments for periods of up to 12 months or more, and with some funds not at all.

The following case studies illustrate some of the issues that are presented to the Ombudsman by consumers and lessons to be learned by both health insurers and consumers. The names and some details have been changed to protect confidentiality.

1. Hospital Policy Upgrade

Mr and Mrs White joined a basic hospital policy in 2000, in order to lock in their Lifetime Health Cover age of entry. At the time, many people joined similar policies to lock in their age of entry before the Lifetime Health Cover penalty loading came into effect.

Last year, Mr and Mrs White received correspondence from their health insurer suggesting that they consider upgrading to a higher level of cover. Mr White considered it was a good idea to be covered in a private hospital for services like hip replacements and phoned the fund to upgrade. The salesperson upgraded his policy and a few days later, the Whites received a new membership card and a brochure in the post. Mr White thought this information was sent in error, because the letter and brochure welcomed him to the fund and he didn't need a new card. He kept the new card but threw the paperwork into the recycling bin without reading it thoroughly.

Unfortunately, almost two months later Mrs White suffered a serious heart attack and Mr White called an ambulance. Mrs White had never previously suffered any cardiac symptoms. While transporting his wife to the hospital, one of the ambulance officers asked Mr White if his wife was privately insured. Mr White pulled out his membership card which showed she was covered and told the ambulance officer to take her to a private hospital. She was taken straight into the emergency department and operated on immediately.

Following her surgery, Mrs White was recovering well, but soon received some bad news from a hospital staff member. The hospital had been informed by the Whites' health insurer that they were not fully covered for cardiac treatment in a private hospital. The bill for Mrs White's treatment had already reached $9000 and each additional night in the hospital would cost $957. Although the Whites had upgraded their hospital policy, they were still within waiting periods and therefore entitled to the lower benefits under their old policy for this admission. This meant they would only receive $251 per day back from their insurer, leaving them to pay a substantial gap.

Mr White arranged for his wife to be transferred to a public hospital to prevent the bill increasing any further. He was still in shock over his wife's heart attack and anxious because he knew they couldn't afford to pay this bill. He appealed to the insurer, who responded by sending him some forms to assess whether his wife's heart condition was a pre-existing condition or not. Mr White felt relieved when the insurer explained what the forms were for, because in his view, his wife's condition was an emergency admission and so should be payable.

A few days later, the insurer contacted Mr White to explain that benefits would not be payable because Mrs White was within the general two month waiting period and this applied to any treatment in the first two months on the new policy, regardless of whether she had a pre-existing condition or not.

Mr White contacted the Ombudsman for assistance. The Ombudsman staff member arranged with the hospital to hold off any demands for payment while the matter was investigated and asked Mr White a number of questions about the advice he had received from the insurer about waiting periods when he upgraded his policy.

Mr White's insurer, like many insurers, records phone conversations with members and staff members also make notes. The Ombudsman believes that recording phone calls and keeping careful records of all communications with members are important consumer protections.

In responding to the Ombudsman's request for information about the complaint, the insurer made a careful assessment of the information provided to Mr White when he upgraded his policy and concluded that waiting periods had not been explained clearly to him. The insurer also considered that if the waiting periods had been re-iterated during the phone calls made after upgrading the cover, Mr White would have remembered this important information at the time the ambulance was called. The insurer therefore agreed to pay the outstanding hospital bill.

2. Membership Suspension

Mrs Blue was planning to travel overseas for several months. Two weeks before she left home, she had paid her health insurance a full year in advance, because she didn't want her policy to lapse while she was away. After taking out travel insurance, she realised that her health insurance wouldn't pay for services overseas, so she phoned her health insurer to ask whether she could suspend her membership to save some money on premiums.

The customer service officer told her that she could suspend her membership and to complete a form that was being sent out in the post. Mrs Blue completed the form and received a letter back advising her that the suspension had taken her date paid forward by two months, so she would not have to pay her policy for another 14 months. The letter also told her to reinstate the policy by sending a letter back to the fund within 30 days of returning to Australia.

Mrs Blue returned from overseas and shortly afterwards phoned the fund to reinstate her policy. She was told that she needed to locate boarding passes to prove that she had been overseas and that she needed to send a letter to the fund re-instate the policy. After speaking to the fund staff member, she went looking for the boarding passes but couldn't locate them and realised she had probably left them in the seat pocket of the aircraft. She forgot to follow up the matter and assumed her membership had been re-instated following her call to the fund.

Several months later, Mrs Blue was booked in for surgery and was surprised to be told by hospital admissions staff that she wasn't covered because her policy had been cancelled. She was told that because she never re-instated her policy in writing, she would be treated as a new member and waiting periods would prevent benefits being paid for her operation. Mrs Blue complained to her insurer, who insisted she was aware of the rules and declined to assist her.

When Mrs Blue raised the matter with the Ombudsman, it was important to realise that the insurer was still in possession of several months of advance membership payments.

The Ombudsman's view was that if Mrs Blue had not properly complied with the insurer's rules for suspending and reinstating her membership, the insurer would be entitled to revoke the suspension, but not to cancel the membership.

The Ombudsman also made some suggestions to the insurer for improving its documentation relating to membership suspension. The Ombudsman suggested that rather than using one form to suspend

membership and a letter to re-instate it, it would better to send forms for both actions at the same time. The forms should clearly indicate the consequences to the member if the re-instatement form was not completed and stress the importance of retaining boarding passes for re-instating the membership. The Ombudsman considered that Mrs Blue would have been more careful with her paperwork if she had realised her policy could be cancelled if she didn't send a letter requesting the membership be re-instated.

Following the Ombudsman's investigation of the complaint, the insurer reinstated Mrs Blue's policy and cancelled the refund cheque it had issued. Mrs Blue was very relieved as she was about to be admitted to hospital for a procedure and had been concerned about whether or not she could proceed.

There is no requirement under legislation for an insurer to allow for suspension of membership. Each insurer has its own rules and processes relating to membership suspension, so it is important for consumers to check in advance with their insurer if they are considering suspending their membership.

3. Migration to Unsuitable Level of Cover

Some years ago, Mrs Green had a hip replacement and her health insurer paid benefits for private hospital treatment.

At the age of 79, she was advised that she needed a second hip replacement. On contacting her insurer, she was told that she wouldn't be covered in a private hospital for this hip replacement, as her policy only covered her as a private patient in a public hospital for this procedure. Mrs Green was very surprised, because she hadn't changed her policy and didn't understand why she no longer covered for the same procedure in a private hospital as previously.

The staff member she contacted told her that the insurer had moved her onto a restricted policy several years ago, because her original policy had been closed. Mrs Green asked to upgrade her policy and was told she could, but she would need to wait 12 months for her hip replacement, as it would be a pre-existing condition.

Mrs Green was very dissatisfied with the insurer's response and her son-in-law contacted the Ombudsman on her behalf.

The Ombudsman's view about closing policies and migrating policy holders onto new policies is that this should not involve a downgrade of cover, unless very specific information is given to the member about the consequences of the downgrade and an opportunity is provided for the member to choose a higher level of cover without the application of waiting periods.

During the Ombudsman's investigation, it became apparent that this insurer had taken insufficient care to moving Mrs Green onto a new policy. The policy that Mrs Green had been moved to was clearly not suitable for someone her age, who had previously required hip surgery. The new policy excluded a number of services that are often needed by older people; these procedures are also expensive to self-fund if their policy does not include them.

The insurer's advice to members about the restrictions on the new policy was, in the Ombudsman's view, insufficient. It had sent a general letter to Mrs Green advising that her policy had changed but stating that *"xyz fund remains competitively priced and continues to cover you for the things you need"*. This turned out to be incorrect and Mrs Green should have been warned of the restrictions on her new policy on the first page of her letter. Instead, she was required to locate the new policy in a sales brochure.

The Ombudsman considered that Mrs Green should not have been migrated onto this policy and that she would not knowingly have downgraded her level of cover, given her medical history. The Ombudsman had some difficulty in negotiating with the insurer in relation to this, because it was the insurer's view that this policy was suitable for Mrs Green at age 79.

The Ombudsman found the length of time taken by the insurer to deal with Mrs Green's complaint disappointing. The insurer did, however, eventually agree to resolve the matter and Mrs Green was able to proceed with her surgery.

4. Waiting Period Waiver

Mrs Yellow and her husband had been living overseas and joined their insurer via the internet shortly after returning to Australia. At the time of joining, the insurer was offering a waiver of some waiting periods.

Mrs Yellow had a family history of breast cancer and had regular medical check-ups, as well as self-examining. Not long after joining the insurer, she noticed a small lump in her breast, and immediately visited her doctor, who referred her to a specialist. Tests confirmed that the lump was cancerous and immediate surgery was required.

Mr Yellow called the fund to ask whether his wife's surgery would be covered. The fund staff member advised it would not be, due to the two month waiting period on joining for all treatment. Mr Yellow thought this advice was incorrect, because he recalled they had joined the fund during a waiting period waiver. He therefore read through the information provided by the insurer in the brochure and membership guide.

The main reference to hospital waiting periods he could find was in relation to the pre-existing ailment waiting period. Mr Yellow believed his wife's condition would not be considered pre-existing, because she had gone to the doctor as soon as she noticed a lump in her breast, due to her family history of breast cancer. The lump had not been in evidence when she joined the fund.

Believing the fund staff member had given him incorrect information about the waiting periods, Mr Yellow rang back the same day. This time, the staff member he spoke to indicated that pre-existing condition forms would need to be completed and that if it was confirmed that the illness was not pre-existing, the insurer would pay benefits. There was no mention of a two month waiting period. On the basis of this advice, Mrs Yellow booked into a private hospital for surgery.

Later the same day, Mr Yellow rang back with item numbers and was again advised that the two month waiting period would apply to Mrs Yellow's admission. Due to the conflicting advice he was receiving, Mr Yellow requested to speak to a manager and was advised someone would call him back. This did not happen until two days later, just as his wife was coming out of surgery. The manager confirmed that no benefit would be payable, due to the two month waiting period.

Mr Yellow contacted the Ombudsman for assistance. Ombudsman staff reviewed the insurer's internet join process and the information sent to Mr and Mrs Yellow on joining. It was noted that at the start of the fund's internet join process, there was a box declaring that prospective members could

"Join today claim straight away"; underneath in smaller lettering it indicated that there was *"no two month wait to claim on extras"*. The waiting periods still applying to the policy were not listed until the last page of the join process and had to be accessed by clicking on a separate link.

The brochure and information sent to the member did not highlight which waiting periods were waived and which still applied. In addition, the advice from fund staff to Mr Yellow when he rang to check whether his wife would be covered was not always consistent. Although several staff members advised him he was within the two month waiting period, he believed this was incorrect, because he thought the two month waiver applied to the whole policy and not just the extras component.

The Ombudsman took the view that had the two month waiting period been fully explained during the internet join process and in the welcome letter sent to the member, Mrs Yellow would have been aware that she would not be covered for her surgery and could have discussed other treatment options with her doctors. Instead, she had incurred significant out-of-pocket costs for her treatment in a private hospital.

This case was more complex because Mrs Yellow's condition required urgent surgery. This meant there wasn't time for Mr Yellow or the insurer to clarify Mrs Yellow's entitlements under her policy.

The Ombudsman was able to negotiate a satisfactory resolution of the complaint with the insurer.

5. 24-Hour Emergency Admission Rule

Mr Red was on a budget health insurance policy. He had chosen this particular policy because he was fit and healthy, and only wanted cover for accidents and emergencies.

Late one afternoon, three days before Christmas, Mr Red was playing cricket and badly injured his foot. The next day it was swelling rapidly and needed urgent treatment, so he was admitted to the accident and emergency department at a nearby public hospital. The hospital provided some treatment, but told him he required urgent surgery to repair a ruptured Achilles tendon. As there were no surgeons available at that hospital to perform the surgery immediately, and because he thought he had accident cover, Mr Red was discharged from the public hospital and booked to have surgery in a private hospital the next day.

On admission, staff at the private hospital told him that his health insurer would probably not cover his treatment, because he was on a budget policy and the amount of benefits he received would be less than his excess of $300. Mr Red thought that this information must be incorrect, because he had emergency accident cover. He therefore paid for the hospitalisation upfront on his credit card, intending to claim the cost back from his insurer.

The surgery was successful and his leg recovered well, but Mr Red's claim was rejected by his health insurer on the grounds that it was not an accident. Mr Red didn't agree with this, so he contacted the Ombudsman for assistance.

In its response to the Ombudsman, the insurer advised that it was not implying Mr Red had not had an accident; rather, that Mr Red's admission to the private hospital did not meet the requirements of his policy for claiming the accident benefit.

According to his policy brochure, in order to be covered for an accident, Mr Red needed to:

- Be admitted into a hospital within 24 hours of the accident;
- Attend only one hospital; and
- Not be able to claim compensation from any other source, such as third party compensation.

Mr Red's policy would therefore only pay private hospital benefits for an accident in the event he was admitted directly into a private hospital within 24 hours of the accident. In addition, because it was a budget policy, it only paid benefits for most services as a private patient in a public hospital.

This type of policy is often sold on the basis that it assists the member to avoid the Medicare Levy Surcharge, while providing full benefits for a small range of services such as wisdom tooth extraction. For the majority of services, this type of policy is not sufficient to cover the cost of an admission to a private hospital. Consumers need to ensure they understand the restrictions on these polices and do not attend a private hospital unless they have checked with their insurer and have received advice that they will be covered for the admission.

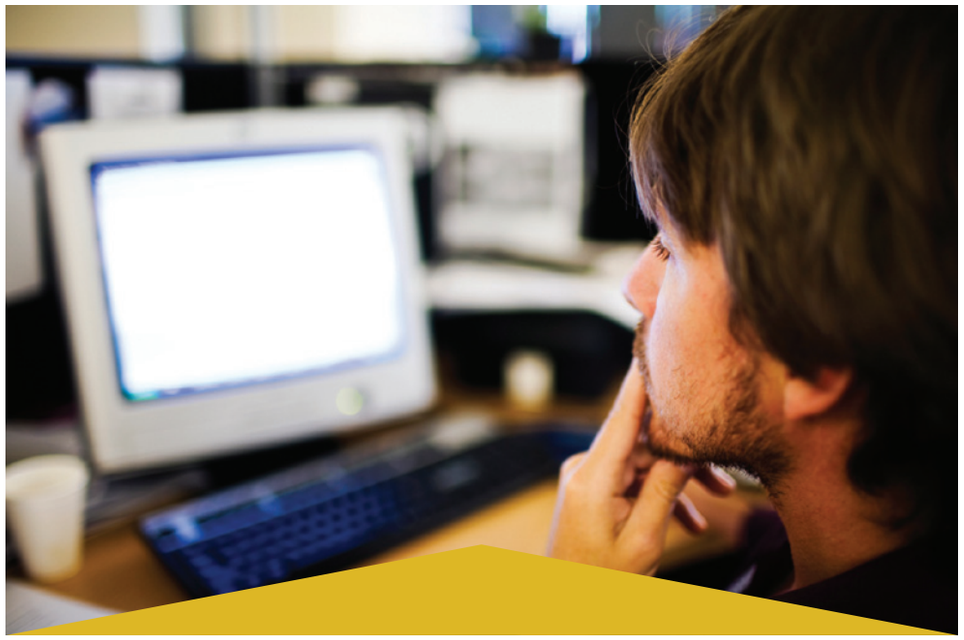
At the time of printing, the PHIO was still looking into Mr Red's case. The office will continue to monitor the information provided to consumers about budget policies to ensure members have sufficient understanding of the limitations on the benefits they will receive under these policies.

Access and Public Awareness

The Private Health Insurance Ombudsman was established primarily for the benefit of health insurance members. It is therefore important that they know about their right to approach the Ombudsman for assistance.

To raise awareness of the services provided by the Ombudsman, the following strategies were employed during 2008/09:

- Details of the Ombudsman's services are referenced in various government publications and in publications produced by other agencies and consumer bodies.
- Health insurers provide information about the availability of the Ombudsman's services and contact details in brochures, publications and in some correspondence to their members. These details are also included on health insurers' internet sites.
- The Ombudsman produces and distributes a range of brochures on health insurance issues.
- The Ombudsman participated in a number of media interviews during the year.
- The Ombudsman also contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites.
- The Ombudsman publishes a regular quarterly report which is distributed in both printed format and on the PHIO website.
- The Ombudsman produced the annual "State of the Health Funds" report to give consumers better information to assist them in making decisions about their health insurance.
- 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. 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 a number of health industry conferences during the year.



The Ombudsman provides a speedy and informal complaints and inquiry service which is free of charge. Complaints and inquiries can be made from anywhere in Australia on a free-call hotline, 1800 640 695. Complaints may be lodged by telephone, fax, internet complaint form, e-mail or by post.

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.

Relations with Stakeholders

The Ombudsman seeks to work in a collaborative way with its stakeholders in order to achieve the best outcome for consumers. The Ombudsman maintains regular contact with health insurer, hospital and consumer organisations. During the last year, the Ombudsman gave regular presentations to industry conferences and meetings of industry, consumer and other stakeholder associations.

The Ombudsman produces a Quarterly Bulletin containing general information about current problem areas and health insurance complaint statistics that is sent in printed form to members of Federal Parliament, health insurers, hospitals and others who specifically request the printed version. The Bulletin is released simultaneously in electronic form on the Ombudsman's website at www.phio.org.au.

The Ombudsman also produces a "State of the Health Funds" report each year, to assist consumers to make decisions about their health insurance.

The Ombudsman held a seminar in August 2008 which provided a forum to enable the private health insurance industry to focus on and share ideas about issues and concerns presented to the Ombudsman's office by consumers. The seminar featured a range of speakers, including the Commonwealth Ombudsman, Professor McMillan, who shared their experiences of good practice initiatives. The Ombudsman intends to hold the seminar at least bi-annually.

Over the coming year, the Ombudsman will hold a series of industry workshops, also aimed at improving the internal complaint handling practices of insurers. The Ombudsman will also be releasing some consumer fact sheets, to assist consumers with understanding their health insurance entitlements.

CLIENT SURVEY

About the Survey

In June 2009, the office carried out a postal survey of 360 randomly selected complainants. One-hundred and twenty-eight clients responded to the survey (36%), which is a high participation rate for a postal survey.

The aim of the survey was to gauge the degree to which PHIO was meeting its clients' needs and to identify areas where improvements could be made. This year's survey has shown an improvement in client satisfaction compared to the previous year, in which some complainants felt aggrieved that the office was unable to assist them in obtaining a higher allocation following the MBF merger with BUPA Australia.

Eighty-eight percent of clients were satisfied or very satisfied with the overall handling of their complaint, which was an improvement on the 78% the previous year.

Analysis of the results has shown that for complainants who obtain a payment or other outcome from a health insurer, satisfaction levels with the office were 100%. This indicates that complainants correlate the service that the office provides directly with the outcome that the office is able to achieve, regardless of whether they are satisfied with the way the Ombudsman's staff deal with their complaint.

The challenge for the Ombudsman's office is to improve satisfaction levels for the 12% of complainants who indicated they weren't satisfied with the Ombudsman's office, who did not receive an outcome to their complaint that was satisfactory from their perspective.

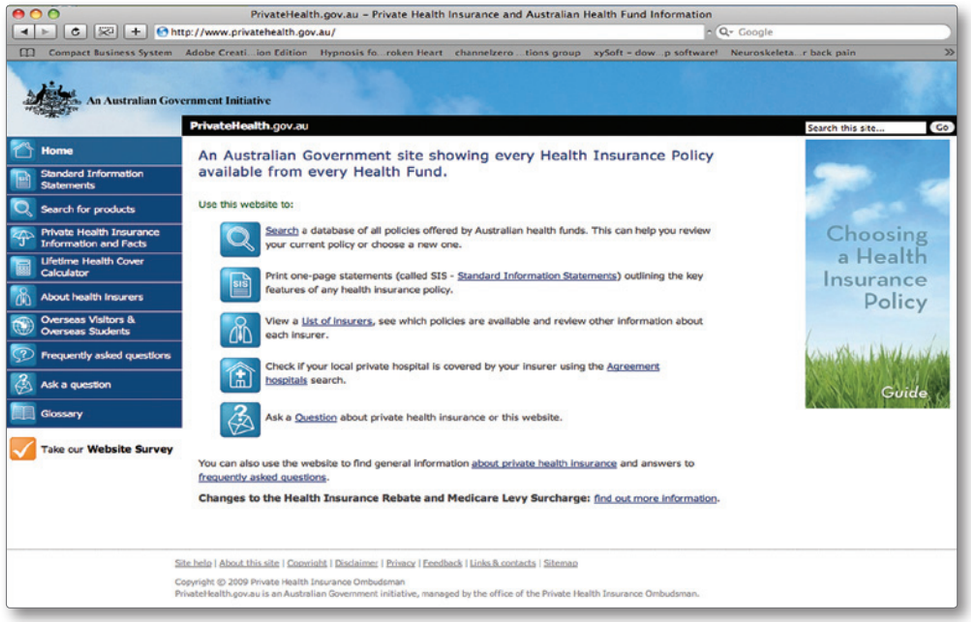
In summary, of the respondents to the survey:

	2008	2009
Overall satisfaction with complaint handling service	78%	88%
Agreed that staff listened to concerns adequately	87%	98%
Satisfied with staff manner	75%	89%
Resolved complaint (or provided an adequate explanation)	65%	87%
Thought PHIO acted independently	80%	87%
Would recommend PHIO service to others	76%	91%
Happy with time taken resolving complaint	74%	83%

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 provided information and assistance to various bodies involved in the formulation of health policy and compliance with established rules and laws. Some significant activities included:

- Submission on the draft *Good Medical Practice Code of Conduct* in relation to the provision of informed financial consent by medical practitioners
- Submission to the ACCC's report to the Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance
- Submission to the Productivity Commission Study of the Performance of Public and Private Hospitals.



The consumer website (privatehealth.gov.au) was established to provide independent information to consumers about health insurance and allow them to view standard information for their own health insurance policy and compare it with other policies available for purchase.

Activities undertaken in relation to the site during 2008/09 were:

- Reorganisation of the home page and addition of new icons to assist with site navigation;
- Addition of a website survey to the home page to provide for feedback on the site;
- Colour coding of health insurance policies to assist consumers to identify suitable policies and search through results;
- Addition of a new section on Overseas Visitors Cover;
- Streamlining of processes for uploading of policy information (this was to designed to allow insurers to more easily update more than 20 000 standard information statements each year);
- Addition of an "Ask a Question" section;
- Consumer focus testing conducted to drive the next year of site changes and improvements.

Usage

The website recorded 195917 unique visitors during the year, an increase of 34% on the previous year. Analysis of the available data suggests that growth of the site's usage can be attributed to the site becoming better known via recommendations and search results, as there was no specific advertising of the website or additional references in letters sent to consumers during the reporting period.

Survey Results

A consumer survey was added to the site in July 2008 and during the year 457 unique users completed the survey. Survey results are used to highlight areas where improvements can be made to the website, to track satisfaction with the site and whether changes have been successful.

The key ratings for the site are summarised in Figure 19

Figure 18 **Unique Visitors to www.privatehealth.gov.au**

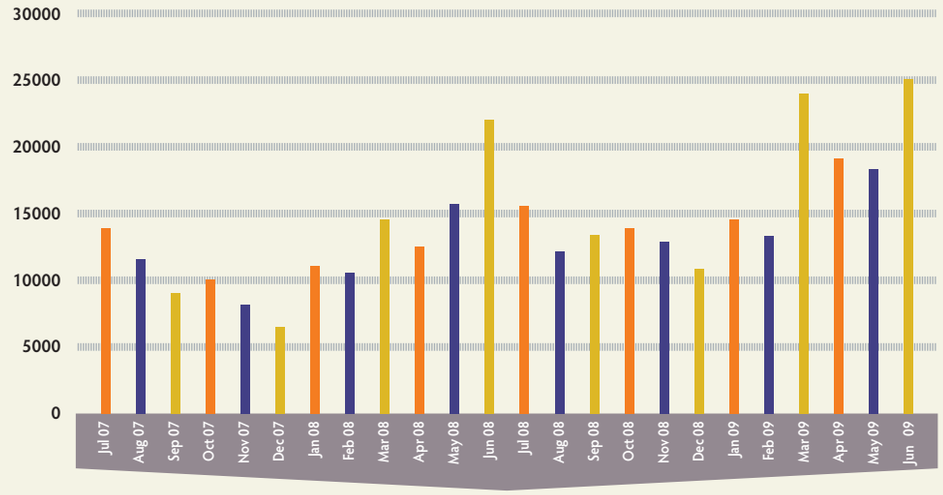
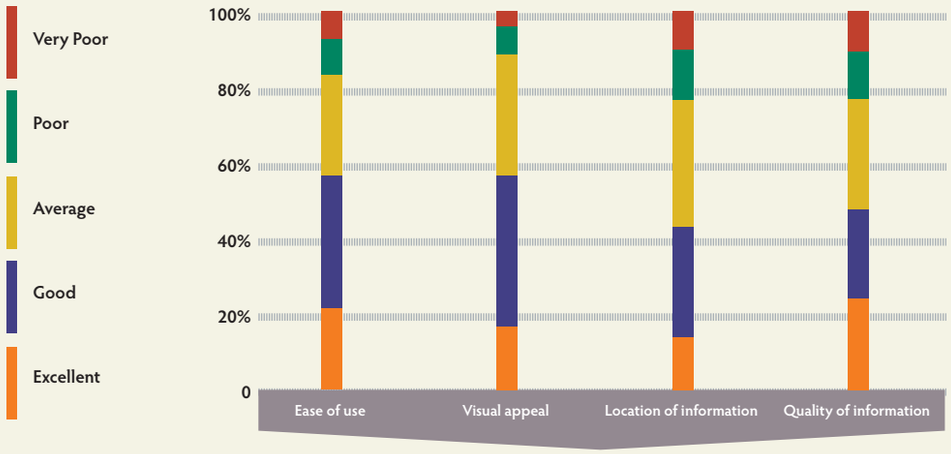


Figure 19 **Website Survey Ratings for www.privatehealth.gov.au**



Ask a Question

On 26 March 2009, a new "Ask a Question" feature was added to the website home page. This feature allows consumers to ask quick questions of the Ombudsman using a web form. It has been well received by consumers who have been unable to obtain answers to general health insurance questions elsewhere on the website or by contacting individual health insurers.

Between 26 March and 30 June 2009, 393 consumers received answers to their questions.

The most frequently raised questions have been about the following topics:

- Lifetime health cover
- Medicare Levy surcharge
- Waiting periods for people currently uninsured
- How to use the website
- What is the best type of cover to buy
- Overseas visitors cover and how to buy it.

Statutory Reporting Information

Corporate Governance

Being a small office with duties specified by the *Private Health Insurance Act 2007*, 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.

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 insurers 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 tasks 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 for bringing potential and actual issues which require broader investigation to the attention of the Ombudsman and the Director of Policy and Client Services. Dispute resolution staff members need to be highly trained and sourced from such disciplines as law or nursing.

Staff Details

As at 30 June 2009, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman	1	-
Director, Policy & Client Services	1	-
Principal Project Officer	-	1
Principal Policy Officer	1	-
Project & Policy Officer (Acting)	1	-
Financial Officer	1	-
Resolution Officers	4	1
Resolution Officers	-	1
Total	9	3

Statutory Positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry Date
Ms Samantha Gavel	Ombudsman	3 years	2011

Staff Development and Training

During the 2008/09 financial year, $50,024.25. was spent directly on PHIO staff attending training and development courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff. Staff training and development is an important priority for the office, to ensure staff members have the appropriate skills and knowledge to provide high level advice and services to consumers, as well as providing for staff career development, satisfaction and retention.

Staff Employment Status

All Ombudsman staff members are employed under the provisions of the *Public Service Act,* 1999 and are required to adhere to the Public Service Values and Code of Conduct.

The Ombudsman is committed to providing a safe working environment that supports the

rights, responsibilities and legitimate needs of all staff. The Ombudsman is also 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 were employed on 30 June 2009.

Occupational Group	Women	Men	Total Staff	NESB1
SES	1	0	1	-
Other	8	3	11	3
Total	**9**	**3**	**12***	**3**

NOTE:

SES Senior Executive Service, Ombudsman

Other All other staff - temporary and permanent

NESB1 Non-English speaking background, 1st Generation

* Includes part-time employees and those on maternity leave. Actual EFT = 10

Performance Appraisal

The Ombudsman has a Performance Development Program to measure staff performance and provide for staff training and development. The Program is used to assist the Ombudsman with general staff management and annual salary reviews. All staff are subject to a half-yearly and an annual performance appraisal. Salary and promotion advancement is based on performance and productivity.

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 has an Audit Committee, chaired by an independent Chair, Mr Neill Buck, which holds regular meetings to ensure appropriate oversight of the office's compliance with the requirements of the *Financial Management Act 1997*.

Outcomes and Outputs

The 2008/09 Portfolio Budget Statement indicates that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 9, *Private Health.*

The Ombudsman provides regular advice and makes recommendations about the private health insurance industry. PHIO also delivers direct services (information provision and dispute resolution). These two outputs contribute to a viable private health insurance industry by improving consumer confidence in private health insurance arrangements. A report of performance against the performance indicators established for the PHIO outputs is provided at the commencement of the *Performance* section of this report.

The Private Health Insurance Ombudsman's agency outcome is specified as *Consumers and providers have confidence in the administration of private health insurance*. The Ombudsman reports on achievements towards this outcome and a set of performance indicators (see the Performance section of this report for more information).

Consultants Engaged

Complete GST Solutions provided financial, accounting and reporting assistance to the office during the financial year.

P T & A Health provided services on an ad hoc basis as medical referees on cases requiring a medical opinion.

Human Solutions continued to maintain and develop the consumer website (privatehealth.gov.au) under the contract awarded in 2006.

Information Systems

The Ombudsman's information system is based on a Windows 2000 Network Server and the Microsoft Office suite. Accounting software used is *Mind Your Own Business (MYOB) Accounting and Asset Manager*. In addition, the Ombudsman has a purpose built *Complaints Management and Reporting system* on-site. PHIO's Internet service is maintained by Nicols Price (Business ADSL).

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, which 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. The Ombudsman have reported the agency's fraud data to the Australian Institute of Criminology in accordance with the Commonwealth Fraud Control Guidelines.

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

The Ombudsman has a staff member who is designated as 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 2009.

Establishment

The Private Health Insurance Ombudsman (the Ombudsman) is established under the *Private Health Insurance Act 2007* to resolve complaints about any matter arising out of, in or connection with a private health insurance arrangement. The Ombudsman is an independent statutory agency.

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
- 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 "Making a Complaint"
- A brochure "The Ten Golden Rules of Private Health Insurance"
- A brochure "About Our Service"
- A brochure "Doctors' Bills?"
- A brochure "The Right to Change - Portability in Health Insurance"
- A brochure "Waiting Periods"
- A brochure "Health Insurance Choice"
- A booklet and brochure "Private Patients' Hospital Charter"
- "The State of The Health Funds Report"
- Individual Summaries for each fund of "The State of the Health Funds Report".

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 Level 7, 362 Kent Street, Sydney, NSW 2000
- by telephoning (02) 8235 8777 or 1800 640 695 (Free-call)
- by fax on (02) 8235 8778
- 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

Informal requests for access to information held by the Ombudsman's office can be made by telephone, email, personal visit or by letter. People can make the request either via the dispute resolution officer allocated to their case or that person's supervisor.

If a person wishes to make a formal request under the FOI Act, requests can be made in writing and directed to:

Director, Policy & Client Services
Private Health Insurance Ombudsman
Level 7
362 Kent Street
SYDNEY NSW 2000

External Review and Scrutiny

The office subjects itself to regular review of its performance by conducting 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 Australian Government agencies, the Ombudsman has a Service Charter which was last reviewed during 2008/09.

The Service Charter covers all of the Ombudsman'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; copies of the charter are routinely sent out to people who contact the office (in the brochure "About our Service").

The Charter includes a number of 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.

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

FINANCIAL INFORMATION

Australian National
Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Ageing

Scope

I have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2009, which comprise: a Statement by the Ombudsman; Income Statement; Balance Sheet; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments; Schedule of Contingencies and Notes to and forming part of the Financial Statements, including a Summary of Significant Accounting Policies.

The Responsibility of the Ombudsman for the Financial Statements

The Ombudsman is responsible for the preparation and fair presentation of the financial statements in accordance with Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, including Australian Accounting Standards, which include Australian Accounting Interpretations. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I have conducted my audit in accordance with Australian National Audit Office Auditing Standards, which incorporate Australian Auditing Standards. These auditing standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Private Health Insurance Ombudsman's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Private Health Insurance Ombudsman's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Ombudsman, as well as evaluating the overall presentation of the financial statements.

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

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

In conducting the audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

Auditor's Opinion

In my opinion, the financial statements of the Private Health Insurance Ombudsman:

(a) have been prepared in accordance with Finance Minister's Orders made under the *Financial Management and Accountability Act 1997,* including Australian Accounting Standards; and

(b) give a true and fair view of the matters required by the Finance Minister's Orders including the Private Health Insurance Ombudsman's financial position as at 30 June 2009 and its financial performance and cash flows for the year then ended.

Australian National Audit Office

P Hinchey
Senior Director
Delegate of the Auditor-General

21 August 2009

PRIVATE HEALTH INSURANCE OMBUDSMAN
STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2009 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, as amended.

Signed. Samantha Gavel

Samantha Gavel
Ombudsman

21 August 2009

	NOTES	2009 $	2008 $
INCOME			
Revenue			
Revenue from Government	2A	1,962,000	1,957,000
Sale of goods and rendering of services	2B	12,433	805
Other revenue	2C	41,910	11,000
Total Revenue		2,016,343	1,968,805
TOTAL INCOME		2,016,343	1,968,805
EXPENSES			
Employee benefits	3A	842,260	729,192
Suppliers	3B	694,135	596,494
Depreciation and amortisation	3C	201,391	151,816
Losses from asset sales	3D	350	6,771
TOTAL EXPENSES		1,738,136	1,484,273
SURPLUS		278,207	484,532

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

Private Health Insurance Ombudsman Balance Sheet

AS AT 30 JUNE 2009

	NOTES	2009 $	2008 $
ASSETS			
Financial Assets			
Cash and cash equivalents	4A	65,857	54,960
Trade and other receivables	4B	2,252,932	2,003,496
Total financial assets		2,318,789	2,058,456
Non-financial assets			
Land and buildings	5A,C	87,145	2,992
Infrastructure, plant and equipment	5B,C	77,824	65,700
Intangibles	5D,E	713,442	661,850
Other non-financial assets	5F	1,960	-
Total non-financial assets		880,371	730,542
TOTAL ASSETS		3,199,160	2,788,998
LIABILITIES			
Payables			
Suppliers	6A	131,788	41,669
Total payables		131,788	41,669
Provisions			
Employee provisions	7A	194,592	152,756
Total provisions		194,592	152,756
TOTAL LIABILITIES		326,380	194,425
Net Assets		2,872,780	2,594,573
EQUITY			
Retained earnings		2,872,780	2,594,573
TOTAL EQUITY		2,872,780	2,594,573
Current Assets		2,318,789	2,058,456
Non-Current Assets		880,371	730,542
Current Liabilities		267,169	128,349
Non-Current Liabilities		59,211	66,076

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

Private Health Insurance Ombudsman Cash Flow Statement

FOR THE PERIOD ENDED 30 JUNE 2009

	NOTES	2009 $	2008 $
OPERATING ACTIVITIES			
Cash received			
Appropriations		1,692,000	1,505,000
GST received from ATO		20,564	28,425
Other cash received		41,143	805
Total cash received		1,753,707	1,534,230
Cash used			
Employees		803,597	682,396
Suppliers		589,604	540,274
Total cash used		1,393,201	1,222,670
Net cash from operating activities	8	360,506	311,560
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		125,877	26,350
Purchase of intangibles		223,732	170,443
Total cash used		349,609	196,793
Net cash (used by) investing activities		(349,609)	(196,793)
FINANCING ACTIVITIES			
Cash received			
Contributed equity		-	1,454,915
Total cash received		-	1,454,915
Cash used			
Transfer to the Official Public Account		-	1,514,722
Total cash used		-	1,514,722
Net cash (used by) financing activities		-	(59,807)
Net increase in cash held		10,897	54,960
Cash and cash equivalents at the beginning of the reporting period		54,960	-
Cash and cash equivalents at the end of the reporting period	4A	65,857	54,960

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

Private Health Insurance Ombudsman Schedule of Commitments

AS AT 30 JUNE 2009

	2009 $	2008 $
BY TYPE		
Commitments receivable		
GST recoverable on commitments	41,501	46,028
Total commitments receivable	41,501	46,028
Other commitments		
Operating leases	156,455	-
Other commitments	300,061	506,311
Total other commitments	456,516	506,311
Net commitments by type	415,015	460,283
BY MATURITY		
Commitments receivable		
Other commitments receivable		
One year or less	19,562	18,750
From one to five years	21,939	27,278
Total other commitments receivable	41,501	46,028
Commitments payable		
Operating lease commitments		
One year or less	76,694	-
From one to five years	79,761	-
Total operating lease commitments	156,455	-
Other commitments		
One year or less	138,490	206,250
From one to five years	161,571	300,061
Total other commitments	300,061	506,311
Net commitments by maturity	415,015	460,283

NB: Commitments were GST inclusive where relevant.

Operating leases

Operating leases comprise of a lease for office accommodation. Lease payments are subject to increase 4% per annum as per the lease agreement. The lease term is three years.

Other commitments

Other commitments comprise of a contract for maintenance and development of the www.privatehealth.gov.au website. Payments are per the contract agreement. The contract is over five years.

Private Health Insurance Ombudsman Statement of Changes in Equity

FOR THE PERIOD ENDED 30 JUNE 2009

	RETAINED EARNINGS		CONTRIBUTED EQUITY / CAPITAL		TOTAL EQUITY	
	2009 $	2008 $	2009 $	2008 $	2009 $	2008 $
OPENING BALANCE						
Balance carried forward from previous period	484,532	-	2,110,041	-	2,594,573	-
Opening balance	484,532	-	2,110,041	-	2,594,573	-
INCOME AND EXPENSES						
Surplus (Deficit) for the period	278,207	484,532	-	-	278,207	484,532
Total income and expenses	278,207	484,532	-	-	278,207	484,532
CONTRIBUTIONS BY OWNERS						
Restructuring	-	-	-	2,110,041	-	2,110,041
Sub-total transactions with owners	-	-	-	2,110,041	-	2,110,041
CLOSING BALANCE AT 30 JUNE	762,739	484,532	2,110,041	2,110,041	2,872,780	2,594,573

Private Health Insurance Ombudsman Schedule of Contingencies

AS AT 30 JUNE 2009

There were no contingent losses or gains as at 30 June 2009.

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Objectives of Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman is an Australian Government controlled entity. The objective of the Ombudsman is to be an independent body which resolves complaints about private health insurance, and act as the umpire in dispute resolution at all levels within the private health industry.

The Ombudsman is structured to meet one outcome:

- Outcome 1: Consumers and Providers have Confidence in the Administration of Private Health Insurance.

Agency activities contributing toward this outcome are classified as departmental. Departmental activities involve the use of assets, liabilities, income and expenses controlled or incurred by the Ombudsman in its own right.

Departmental activities are identified under two Outputs. Both Outputs are identified for Outcome 1.

- Output 1: To provide advice and recommendations about the Private Health Services Industry.
- Output 2: To facilitate direct delivery of services.

The continued existence of the Ombudsman in its present form and with its present programs is dependent on Government policy and on continuing appropriations by Parliament for the Agency's administration and programs.

1.2 Basis of Preparation of the Financial Report

The financial statements and notes are required by section 49 of the Financial Management and Accountability Act 1997 and are a general purpose financial report.

The financial statements and notes have been prepared in accordance with:

- Finance Minister's Orders (or FMOs) for reporting periods ending on or after 1 July 2008; and
- Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial report has been prepared on an accrual basis and is in accordance with the historical cost convention, except for certain assets at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

The financial report is presented in Australian dollars.

Unless an alternative treatment is specifically required by an accounting standard or the FMOs, assets and liabilities are recognised in the balance sheet when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under agreements equally proportionately unperformed are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the schedule of commitments and the schedule of contingencies.

Unless alternative treatment is specifically required by an accounting standard, income and expenses are recognised in the income statement when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured.

1.3 Significant Accounting Judgements and Estimates

No accounting assumptions or estimates have been identified that have a significant risk of causing a material adjustment to carrying amounts of assets and liabilities within the next accounting period.

1.4 Changes in Australian Accounting Standards

Adoption of New Australian Accounting Standard Requirements

No accounting standard has been adopted earlier than the application date as stated in the standard.

No new accounting standards, amendments to standards, and interpretations issued by the Australian Accounting Standards Board that are applicable in the current period have had a material financial effect on the Ombudsman.

Future Australian Accounting Standard Requirements

New standards, amendments to standards, and interpretations that are applicable to future periods have been issued by the Australian Accounting Standards Board. It is estimated that adopting these pronouncements, when effective, will have no material impact on future reporting periods.

1.5 Revenue

Revenue from Government

Amounts appropriated for departmental output appropriations for the year (adjusted for any formal additions and reductions) are recognised as revenue when the Ombudsman gains control of the appropriation, except for certain amounts that relate to activities that are reciprocal in nature, in which case revenue is recognised only when it has been earned.

Appropriations receivable are recognised at their nominal amounts.

Resources Received Free of Charge

Resources received free of charge are recognised as revenue when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition, unless received from another Government agency or authority as a consequence of a restructuring of administrative arrangements (refer to Note 1.6).

Resources received free of charge are recorded as either revenue or gains depending on their nature.

Other Types of Revenue

Revenue from the sale of goods is recognised when:

- the risks and rewards of ownership have been transferred to the buyer;
- the seller retains no managerial involvement nor effective control over the goods;
- the revenue and transaction costs incurred can be reliably measured; and
- it is probable that the economic benefits associated with the transaction will flow to the entity.

Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when:

- the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- the probable economic benefits associated with the transaction will flow to the entity.

The stage of completion of contracts at the reporting date is determined by reference to services performed to date as a percentage of total services to be performed.

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any impairment allowance account. Collectability of debts is reviewed at balance date. Allowances are made when collectability of the debt is no longer probable.

1.6 Transactions with the Government as Owner

Equity Injections

Amounts appropriated which are designated as 'equity injections' for a year (less any formal reductions) are recognised directly in contributed equity in that year.

Restructuring of Administrative Arrangements

Net assets received from or relinquished to another Australian Government agency or authority under a restructuring of administrative arrangements are adjusted at their book value directly against contributed equity.

1.7 Employee Benefits

Liabilities for services rendered by employees are recognised at the reporting date to the extent that they have not been settled.

Liabilities for 'short-term employee benefits' (as defined in AASB 119 Employee Benefits) and termination benefits due within twelve months of balance date are measured at their nominal amounts.

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability.

All other employee benefit liabilities are measured at the present value of the estimated future cash outflows to be made in respect of services provided by employees up to the reporting date.

Leave

The liability for employee benefits 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 Ombudsman is estimated to be less than the annual entitlement for sick leave.

The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will apply at the time the leave is taken, including the Ombudsman's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long service leave has been determined by reference to the work of an actuary as at 30 June 2009. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Superannuation

Staff of the Ombudsman are members of the Public Sector Superannuation Scheme (PSS) or the PSS accumulation plan (PSSap).

The PSS is a defined benefit scheme for the Australian Government. The PSSap is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported by the Department of Finance and Deregulation as an administered item.

The Ombudsman makes employer contributions to the employee superannuation scheme at rates determined by an actuary to be sufficient to meet the current cost to the

Government of the superannuation entitlements of the Agency's employees. The Ombudsman accounts for the contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the final fortnight of the year.

1.8 Leases

A distinction is made between finance leases and operating leases. Finance leases effectively transfer from the lessor to the lessee substantially all the risks and rewards incidental to ownership of leased non-current assets. An operating lease is a lease that is not a finance lease. In operating leases, the lessor effectively retains substantially all such risks and benefits.

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

The Ombudsman has no finance leases.

1.9 Cash

Cash and cash equivalents includes notes and coins held and any deposits in bank accounts with an original maturity of 3 months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value. Cash is recognised at its nominal amount.

1.10 Financial Liabilities

Supplier and other payables

Supplier and other payables are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received, irrespective of having been invoiced.

1.11 Contingent Liabilities and Contingent Assets

Contingent Liabilities and Contingent Assets are not recognised in the Balance Sheet but are reported in the relevant schedules and notes. They may arise from uncertainty as to the existence of a liability or asset or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain and contingent liabilities are disclosed when settlement is greater than remote.

1.12 Acquisition of Assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and income at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor agency's accounts immediately prior to the restructuring.

1.13 Property, Plant and Equipment

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the Balance Sheet, except for purchases costing less than $1,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total)

Revaluations

Fair values for each class of asset are determined as shown below:

Asset Class	*Fair value measured at*
Leasehold improvements	Depreciated replacement cost
Infrastructure, plant and equipment	Market appraisal

Following initial recognition at cost, property plant and equipment are carried at fair value less subsequent accumulated depreciation and accumulated impairment losses. Valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets do not differ materially from the assets' fair values as at the reporting date. The regularity of independent valuations depends upon the volatility of movements in market values for the relevant assets.

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of asset revaluation reserve except to the extent that it reverses a previous revaluation decrement of the same asset class that was previously recognised through operating result.

Revaluation decrements for a class of assets are recognised directly through operating result except to the extent that they reverse a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset restated to the revalued amount.

Depreciation

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.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

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

	2009	2008
Leasehold improvements	10 years	Lease term
Plant and Equipment	4 to 10 years	4 to 10 years

Impairment

All assets are assessed for impairment at 30 June. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs to sell and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the Ombudsman were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

No indicators of impairment were found for assets at fair value.

1.14 Intangibles

The Ombudsman's intangibles comprise internally developed software for internal use. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives

of the Ombudsman's software is 5 years (2007-08: 5 years).

All software assets are assessed for indications of impairment as at 30 June 2009.

1.15 Taxation

The Ombudsman is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses and assets are recognised net of GST:

- except where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
- except for receivables and payables.

NOTE 2: INCOME

REVENUE

NOTE 2A: REVENUE FROM GOVERNMENT	2009 $	2008 $
Appropriations:		
Departmental outputs	1,962,000	1,957,000
Total revenue from Government	1,962,000	1,957,000

NOTE 2B: SALE OF GOODS AND RENDERING OF SERVICES		
Rendering of services - external parties	12,433	805
Total sale of goods and rendering of services	12,433	805

NOTE 2C: OTHER REVENUE		
Resources received free of charge:		
Audit services	13,200	11,000
Other Income	28,710	-
Total other revenue	41,910	11,000

NOTE 3: EXPENSES

NOTE 3A: EMPLOYEE BENEFITS	2009 $	2008 $
Wages and salaries	704,042	592,484
Superannuation:		
Defined contribution plans	92,112	79,849
Leave and other entitlements	41,836	52,091
Other employee expenses	4,270	4,768
Total employee benefits	842,260	729,192

NOTE 3B: SUPPLIERS		
Provision of goods – external parties	616,043	536,816
Operating lease rentals – external parties:		
Minimum lease payments	74,132	54,340
Workers compensation premiums	3,960	5,338
Total supplier expenses	694,135	596,494

NOTE 3C: DEPRECIATION AND AMORTISATION		
Depreciation:		
Infrastructure, plant and equipment	25,917	16,607
Leasehold improvements	3,334	507
Total depreciation	29,251	17,114
Amortisation:		
Intangibles:		
Computer Software	172,140	134,702
Total amortisation	172,140	134,702
Total depreciation and amortisation	201,391	151,816

NOTE 3D: LOSSES FROM ASSET DISPOSAL		
Carrying value of assets disposed	350	6,771
Total losses from assets sales	350	6,771

NOTE 4: FINANCIAL ASSETS

NOTE 4A: CASH AND CASH EQUIVALENTS	2009 $	2008 $
Cash on hand or on deposit	65,857	54,960
Total cash and cash equivalents	65,857	54,960

NOTE 4B: TRADE AND OTHER RECEIVABLES		
Appropriations receivable:		
for existing outputs	2,236,722	1,966,722
Total appropriations receivable	2,236,722	1,966,722
GST receivable from the Australian Taxation Office	16,210	36,774
Total trade and other receivables (net)	2,252,932	2,003,496

All receivables are current.

NOTE 5: NON-FINANCIAL ASSETS

NOTE 5A: LEASEHOLD IMPROVEMENTS	2009 $	2008 $
Leasehold improvements		
– fair value	90,986	3,499
– accumulated depreciation	(3,841)	(507)
Total leasehold improvements (non-current)	87,145	2,992

No indicators of impairment were found for leasehold improvements.

NOTE 5B: INFRASTRUCTURE, PLANT AND EQUIPMENT		
Infrastructure, plant and equipment:		
– gross carrying value (at fair value)	120,197	82,307
– accumulated depreciation	(42,374)	(16,607)
Total infrastructure, plant and equipment (non-current)	77,824	65,700

Plant and equipment under finance leases were subject to revaluation. The carrying amount is included in the valuation figures above.

All revaluations were conducted in accordance with the revaluation policy stated at Note 1.

No indicators of impairment were found for infrastructure, plant and equipment.

NOTE 5C: ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

TABLE A – RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT (2008-09)

ITEM	LEASEHOLD IMPROVEMENTS $	INFRASTRUCTURE, PLANT & EQUIPMENT $	TOTAL $
AS AT 1 JULY 2008			
Gross book value	3,499	82,307	85,806
Accumulated depreciation/ amortisation and impairment	(507)	(16,607)	(17,114)
Net book value 1 July 2008	2,992	65,700	68,692
Additions:			
By purchase	87,487	38,390	125,877
Depreciation/amortisation expense	(3,334)	(25,917)	(29,251)
Disposals:			
Other disposals	-	(350)	(350)
Net book value 30 June 2009	87,145	77,824	164,968
NET BOOK VALUE AS OF 30 JUNE 2009 REPRESENTED BY:			
Gross book value	90,986	120,197	211,183
Accumulated depreciation/ amortisation and impairment	(3,841)	(42,374)	(46,215)
	87,145	77,824	164,968

TABLE B – RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT (2007-08)

ITEM	LEASEHOLD IMPROVEMENTS $	INFRASTRUCTURE, PLANT & EQUIPMENT $	TOTAL $
Net book value 1 July 2007	-	-	-
Additions:			
By purchase	-	26,350	26,350
From acquisition of entities or operations (including restructuring)	3,371	63,250	66,621
Depreciation/amortisation expense	(507)	(16,607)	(17,114)
Other movements	128	(522)	(394)
Disposals:			
Other disposals	-	(6,771)	(6,771)
Net book value 30 June 2008	2,992	65,700	68,692
NET BOOK VALUE AS OF 30 JUNE 2008 REPRESENTED BY:			
Gross book value	3,499	82,307	85,806
Accumulated depreciation/ amortisation and impairment	(507)	(16,607)	(17,114)
	2,992	65,700	68,692

NOTE 5D: INTANGIBLES	2009 $	2008 $
Computer software at cost:		
Consumer website	1,043,386	819,653
Total Computer Software	1,043,386	819,653
Accumulated amortisation	(329,944)	(157,803)
Total intangibles (non-current)	713,442	661,850

No indicators of impairment were found for intangible assets.

NOTE 5E: ANALYSIS OF INTANGIBLES

TABLE C: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF INTANGIBLES (2008-09).

	CONSUMER WEBSITE $	TOTAL $
AS AT 1 JULY 2008		
Gross book value	819,653	819,653
Accumulated depreciation/amortisation and impairment	(157,803)	(157,803)
Net book value 1 July 2008	661,850	661,850
Additions:		
By purchase or internally developed	223,732	223,732
Amortisation	(172,140)	(172,140)
Net book value 30 June 2009	713,442	713,442
NET BOOK VALUE AS OF 30 JUNE 2009 REPRESENTED BY:		
Gross book value	1,043,385	1,043,385
Accumulated depreciation/amortisation and impairment	(329,943)	(329,943)
	713,442	713,442

TABLE D: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF INTANGIBLES (2007-08).

	CONSUMER WEBSITE $	TOTAL $
Net book value 1 July 2007	-	-
Additions:		
By purchase or internally developed	170,443	170,443
From acquisition of entities or operations (including restructuring)	626,109	626,109
Amortisation	(134,702)	(134,702)
Net book value 30 June 2008	661,850	661,850
NET BOOK VALUE AS OF 30 JUNE 2008 REPRESENTED BY:		
Gross book value	819,653	819,653
Accumulated depreciation/amortisation and impairment	(157,803)	(157,803)
	661,850	661,850

NOTE 5F: OTHER NON-FINANCIAL ASSETS	2009 $	2008 $
Prepayments	1,960	-
Total other non-financial assets	1,960	-

All other non-financial assets were current assets.

No indicators of impairment were found for other non-financial assets.

NOTE 6: PAYABLES

NOTE 6A: SUPPLIERS	2009 $	2008 $
Trade creditors	131,788	41,669
Total supplier payables	131,788	41,669
Supplier payables are represented by:		
Current	131,788	41,669
Total supplier payables	131,788	41,669

Settlement is usually made net 30 days.

NOTE 7: PROVISIONS

NOTE 7A: EMPLOYEE PROVISIONS	2009 $	2008 $
Leave	194,592	152,756
Total employee provisions	194,592	152,756
Employee provisions are represented by:		
Current	135,381	86,681
Non-current	59,211	66,076
Total employee provisions	194,592	152,756

The classification of current employee provisions includes amounts for which there is not an unconditional right to defer settlement by one year, hence in the case of employee provisions the above classification does not represent the amount expected to be settled within one year of reporting date. Employee provisions expected to be settled in twelve months from the reporting date were $86,370 (2008: $66,996), and in excess of one year $108,222 (2008: $85,760).

NOTE 8: CASH FLOW RECONCILLIATION	2009 $	2008 $
RECONCILIATION OF CASH AND CASH EQUIVALENTS AS PER BALANCE SHEET TO CASH FLOW STATEMENT		
Report cash and cash equivalents as per:		
Cash Flow Statement	65,857	54,960
Balance Sheet	65,857	54,960
Difference	-	-
RECONCILIATION OF OPERATING RESULT TO NET CASH FROM OPERATING ACTIVITIES:		
Operating result	278,207	484,532
Depreciation /amortisation	201,391	151,816
Net write down of non-financial assets	350	6,771
(Increase) / decrease in net receivables	(249,436)	(423,575)
(Increase) / decrease in prepayments	(1,960)	-
Increase / (decrease) in employee provisions	41,836	49,952
Increase / (decrease) in supplier payables	90,118	42,064
Net cash from operating activities	360,506	311,560

NOTE 9: SENIOR EXECUTIVE REMUNERATION	2009 $	2008 $
The number of senior executives who received or were due to receive total remuneration of $130,000 or more:		
$160 000 to $174 999	-	1
$220 000 to $234 999	1	-
Total	1	1
The aggregate amount of total remuneration of senior executives shown above.	$222,792	$167,544

NOTE 10: REMUNERATION OF AUDITORS	2009 $	2008 $
Financial statement audit services are provided free of charge to the Ombudsman.		
The fair value of the services provided was:		
Revenue received free of charge	13,200	11,000
	13,200	11,000

No other services were provided by the Auditor-General.

NOTE 11: FINANCIAL INSTRUMENTS

NOTE 11A: CATEGORIES OF FINANCIAL INSTRUMENTS	2009 $	2008 $
FINANCIAL ASSETS		
GST receivable from the Australian Taxation Office	16,210	36,774
	16,210	36,774
Carrying amount of financial assets	16,210	36,774
FINANCIAL LIABILITIES		
Trade creditors	131,788	41,669
	131,788	41,669
Carrying amount of financial liabilities	131,788	41,669

NOTE 11B: CREDIT RISK

The Ombudsman's maximum exposure to credit risk at reporting date in relation to each class of recognised financial asest is the carrying amount of those assets as indicated in the Balance Sheet.

The Ombudsman has no significant concentration of credit risk.

All figures for credit risk referred to do not take into account the value of any collateral or other security.

NOTE 11C: LIQUIDITY RISK

The exposure to liquidity risk is based on the notion that the Ombudsman will encounter difficulty in meeting its obligations associated with financial liabilities. This is unlikely due to appropriations funding and mechanisms available to the Ombudsman and internal policies and procedures put in place to ensure there are appropriate resources to meet its financial obligations.

NOTE 11D: MARKET RISK

The Ombudsman holds basic financial instruments that do not expose the Ombudsman to certain market risks.

The Ombudsman is not exposed to currency risk or other price risk.

NOTE 12: APPROPRIATIONS

TABLE A – ACQUITTAL OF AUTHORITY TO DRAW CASH FROM THE CONSOLIDATED REVENUE FUND FOR ORDINARY ANNUAL SERVICES APPROPRIATIONS

PARTICULARS	DEPARTMENTAL OUTPUTS		TOTAL	
	2009 $	2008 $	2009 $	2008 $
Balance brought forward from previous period (Appropriation Acts)	2,021,682	-	2,021,682	-
Appropriation Act:				
Appropriation Act (No.1) 2008-2009 as passed	1,928,000	1,923,000	1,928,000	1,923,000
Appropriation Act (No.3) 2008-2009 as passed	34,000	34,000	34,000	34,000
FMA Act:				
Repayments to the Commonwealth *(FMA Act section 30)*	-	1,514,722	-	1,514,722
Appropriations to take account of re-coverable GST *(FMA Act section 30A)*	16,340	36,864	16,340	36,864
Relevant agency receipts *(FMA Act s 31)*	41,143	805	41,143	805
Total appropriation available for payments	4,041,165	3,509,391	4,041,165	3,509,391
Cash payments made during the year (GST inclusive)	1,738,586	1,487,709	1,738,586	1,487,709
Balance of authority to draw cash from the Consolidated Revenue Fund for ordinary annual services appropriations and as represented by:	2,302,579	2,021,682	2,302,579	2,021,682
Cash at bank and on hand	65,857	54,960	65,857	54,960
Departmental appropriations receivable	2,236,722	1,966,722	2,236,722	1,966,722
TOTAL AS AT 30 JUNE	2,302,579	2,021,682	2,302,579	2,021,682

Departmental and non-operating appropriations do not lapse at financial year-end. However, the responsible Minister may decide that part or all of a departmental or non-operating appropriation is not required and request the Finance Minister to reduce that appropriation. The reduction in the appropriation is effected by the Finance Minister's determination and is disallowable by Parliament.

NOTE 13: SPECIAL ACCOUNTS

The Ombudsman has a Special Account established with the name Services for Other Entities and Trust Moneys - Private Health Insurance Ombudsman Special Account. This account was established under section 20 of the Financial Management and Accountability Act 1997 (FMA Act). For the years ended 30 June 2008-09 the account had nil balances and there were no transactions debited or credited to it.

The purposes of the Services for Other Entities and Trust Money - Private Health Insurance Ombudsman Special Account, are to:

(a) disburse amounts temporarily held on trust or otherwise for the benefit of a person other than the Commonwealth;
(b) disbursing amounts in connection with services performed on behalf of other Governments and bodies that are not FMA Act agencies; and
(c) repay amounts where an Act or other law requires or permits the repayment of an amount received.

NOTE 14: REPORTING OF OUTCOMES

The Ombudsman is structured to meet one outcome, namely consumers and providers have confidence in the administration of private health insurance.

The following 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.

NOTE 14A: NET COST OF OUTCOME DELIVERY	OUTCOME 1	
	2009 $	2008 $
EXPENSES		
Departmental	1,738,136	1,484,273
Total expenses	1,738,136	1,484,273
OTHER EXTERNAL INCOME		
Departmental	54,343	11,805
Total other external income	54,343	11,805
NET COST / (CONTRIBUTION) OF OUTCOME	1,683,793	1,472,468

NOTE 14B: MAJOR CLASSES OF DEPARTMENTAL INCOME AND EXPENSES BY OUTPUT GROUPS AND OUTPUTS

OUTCOME 1	OUTPUT 1		OUTPUT 2		TOTAL	
	2009 $	2008 $	2009 $	2008 $	2009 $	2008 $
DEPARTMENTAL EXPENSES						
Employees benefits	215,452	187,110	629,981	545,239	845,433	732,349
Suppliers	176,086	151,594	514,876	441,743	690,962	593,337
Depreciation and amortisation	51,323	38,788	150,068	113,028	201,391	151,816
Write-down of assets	89	1,730	261	5,041	350	6,771
Total departmental expenses	442,950	379,222	1,295,186	1,105,051	1,738,136	1,484,273
FUNDED BY:						
DEPARTMENTAL INCOME						
Revenue from Government	500,000	500,000	1,462,000	1,457,000	1,962,000	1,957,000
Other revenue	13,849	3,016	40,494	8,789	54,343	11,805
Total departmental revenues	513,849	503,016	1,502,494	1,465,789	2,016,343	1,968,805

NOTE 14C: MAJOR CLASSES OF DEPARTMENTAL ASSETS AND LIABILITIES BY OUTCOMES

	OUTCOME 1	
	2009 $	2008 $
DEPARTMENTAL ASSETS		
Financial assets	2,318,789	2,058,456
Non-financial assets	880,371	730,542
Total departmental assets	3,199,160	2,788,998
DEPARTMENTAL LIABILITIES		
Payables	131,788	41,669
Provisions	194,592	152,756
Total departmental liabilities	326,380	194,425

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Protecting the interests of people covered by private health insurance