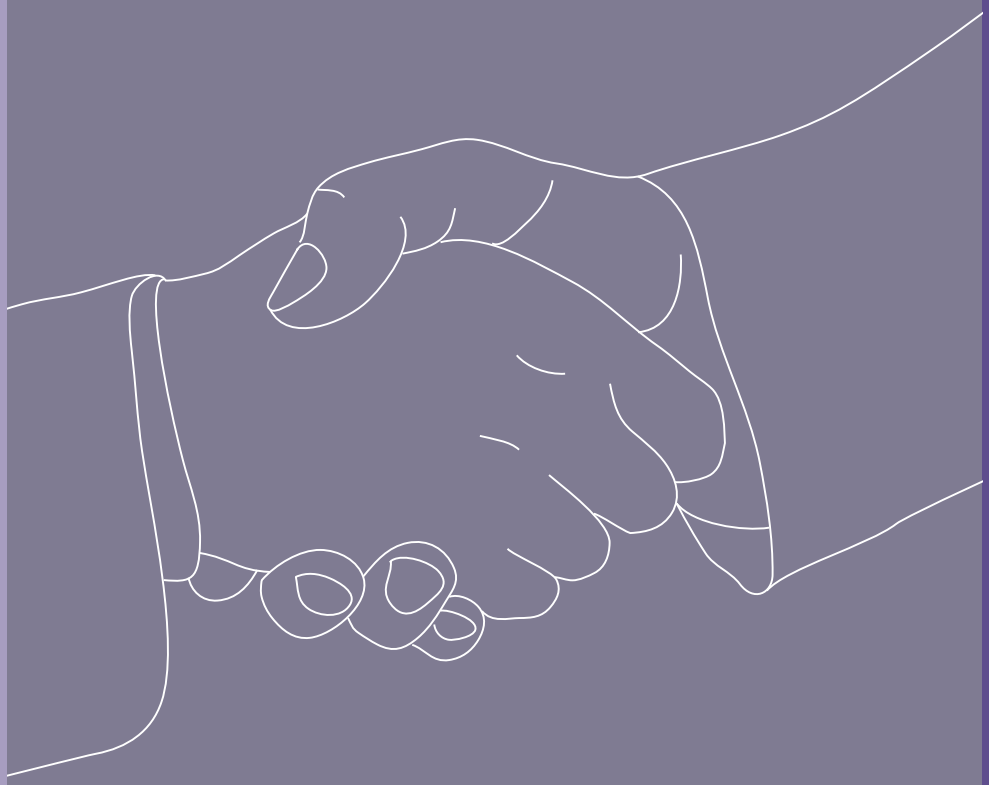
Australian Government

Private Health Insurance Ombudsman



ANNUAL REPORT

2005

contact details

PRINT AND PROJECT MANAGEMENT - NETPRINT PTY LTD. DESIGN DIRECTION AND ARTWORK - WARD WALKER DESIGN. TEXT PAGES PRINTED ON SPLENDORGEL SMOOTH 100GSM FROM SPICERS PAPER. SPLENDORGEL IS AN ENVIRONMENTALLY RESPONSIBLE STOCK BEING TOTALLY DERIVED FROM DESIGNATED SUSTAINABLE FOREST REGIONS. THE PULP IS BLEACHED USING PROCESSES THAT DO NOT USE ELEMENTAL CHLORINE. SPLENDORGEL IS PRODUCED AT MILLS THAT ARE ISO 14000/01 ACCREDITED - THE INTERNATIONAL STANDARD FOR ORGANISING AND ACHIEVING CONTINUAL IMPROVEMENT. SPLENDORGEL IS PH NEUTRAL FOR LONG LIFE. COVER PRINTED ON MONZA SATIN 350GSM, ALSO FROM SPICERS PAPER. MONZA IS PRODUCED USING 55% RECYCLED MATERIAL AND 45% OXYGEN BLEACHED VIRGIN FIBRE, IT IS ALSO FREE OF ELEMENTAL CHLORINE IN IT'S PRODUCTION.

COVER DESIGN - THE COVER GRAPHIC SYMBOLISES PHIO'S ONGOING ROLE; THE SUCCESSFULLY RESOLUTION OF ISSUES ARISING BETWEEN A VARIETY OF PARTIES WITHIN THE ARENA OF PRIVATE HEALTH INSURANCE.

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

STREET AND POSTAL ADDRESS

Private Health Insurance Ombudsman
Level 7, 362 Kent Street
SYDNEY NSW 2000

TELEPHONE, FAX AND E-MAIL

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

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

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

E-mail info@phio.org.au
Internet http://www.phio.org.au
Administration (02) 8235 8777
Facsimile (02) 8235 8778

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.

ISSN 1327-5305

contents

Australian Government
Private Health Insurance Ombudsman

The Hon Tony Abbott MP
Minister for Health and Ageing
Parliament House
CANBERRA ACT 2600

Dear Minister

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

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2004 to 30 June 2005.

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

John Powlay
OMBUDSMAN

26 September 2005

Level 7, 362 Kent St. Sydney NSW 2000
Complaints Hotline 1800 640 695
Phone: 02 8235 8777 **Fax** 02 8235 8778 **Email** info@phio.org.au **Web** www.phio.org.au
ABN 61 673 137 709

ombudsman's overview

DOES COMPLAINING EVER DO ANY GOOD?

One of the questions I'm often asked in casual conversation when I explain what I do in my job is, "Does complaining ever do any good?". By that most people simply mean "Does the decision being complained about get changed?"

Analysis of the outcomes of the complaints my office investigates (level 3 complaints) indicates that over 50 percent of complaint investigations result in some change of direct benefit to the complainant. In about 30 percent of cases the complainant receives an additional payment from their fund. In another 24 percent of complaints there is some other satisfactory outcome for the complainant. (This can indicate that a bill has been waived or reduced, a decision changed or some other change requested by the complainant has been made.) For most of the remaining cases, while the resolution sought by the complainant may not have been achieved, some additional explanation has been provided.

So my straightforward answer to the question "Does complaining ever do any good?" is "Yes it does, in fact, in most cases".

However simply answering the question in that way always leaves me with an uneasy feeling. Why?

There are two reasons:

1. Nearly 40% of the complaints my office receives are dealt with by referring the complainant to a contact point within the fund. This occurs in situations where my office considers that the fund has not been given an adequate opportunity to address the complaint. To date I have had no reliable information on the outcome of those referrals. *For those people we have referred in this way, did complaining do any good?*
2. The simple answer does not address whether anything happens beyond the resolution of the individual complaint. *Is the problem, error or action that led to the complaint identified, analysed and fixed or could it continue to occur?*

John Powlay, Ombudsman

Over the last year I have instituted some action aimed at addressing those additional questions.

Changes to referral procedures

Until last year, our procedure for referring complainants to their health fund to attempt to resolve their complaint was generally to advise the person to write to a contact person (or position) within the fund. After surveying a selection of complainants who had been referred in that way we found that many did not, in fact, pursue their complaint further. Many were put off by the requirement to put their complaint in writing. Others felt that our approach of referring them back to the fund indicated a lack of interest in their complaint and an unwillingness to assist them.

As a result, last year we altered our referral procedures. We now offer a range of options for contacting fund complaints staff; writing, phone, email. We also offer an option of "assisted referral" under which PHIO staff would contact the relevant person in the fund, provide the complainant's name and contact

details and request the fund staff to contact the complainant, within an agreed timeframe, to offer assistance with their complaint.

These new referral procedures appear to be working well for both complainants and fund complaints staff. Earlier this year PHIO conducted two workshops for health fund complaints staff at which these procedures were reviewed. The workshops identified further possible improvements, including greater use of assisted referrals and provision of information to PHIO from fund staff on the outcome of level 1 (referred) complaints. From next year I hope to be in a better position to report on the outcomes of complaints referred to the funds for resolution.

Promoting best practice complaint handling

Over the last two years my office has worked with the health funds to promote improved practices in complaint handling within the funds. In early 2004, I established a project to encourage funds to review their complaints handling by benchmarking their procedures against the emerging international standard for complaints management (ISO 10002). I engaged the consultant firm Listening Post Pty Ltd to manage this project and the cost of the project was met jointly by PHIO and the two health insurance industry associations; the Australian Health Insurance Association (AHIA) and the Health Insurance Restricted Membership Association of Australia (HIRMAA).

Each participating fund (33 of 40 funds participated) received a confidential report comparing their complaint procedures and outcomes against the international standard and recognised best practice. In addition all funds, the associations and PHIO received an industry wide report, identifying areas of good practice within the industry as well areas needing improvement.

Some of the key findings from the project were:

- A high rating across the industry against the guiding principles of the international standard and a significant level of compliance with the new standard;
- Commitment across the industry to treating complaints fairly and objectively;
- Positive attitudes by staff and management of the funds towards complaints – seeing them as an opportunity to identify ways of improving service;
- Scope to improve the visibility and accessibility of most funds' complaint handling processes; and
- A need to improve the management and resourcing of the complaints handling function in some funds.

In early 2005 PHIO also conducted workshops for health fund complaints staff that included training sessions in best practice complaints procedures. This training drew on the results of the Listening Post project to focus on areas identified as generally needing improvement across the industry. The training also stressed the need for analysis, follow up and correction of the cause of complaints.

INDUSTRY DEVELOPMENTS

Deregulation of rule changes

In last year's Annual Report, I noted a significant change to the regulation of private health insurance, giving health funds more flexibility to change their rules and benefits. From 1 July 2004 health funds were no longer required to submit proposals for such changes to the Department for consideration but simply needed to advise of the changes before they took effect.

Contrary to some fears and expectations, this change does not appear to have resulted in any increase in the incidence of benefit or rule changes implemented by the funds and, as yet there has been no significant change to the type or range of benefits offered by the funds. In fact fewer funds announced benefit and rule changes last year than in previous years. In this regard 2004/2005 seems to have been a period of stability and consolidation for most funds.

Increased Rebate for Older Australians

Following its re-election the Government implemented its promise to increase the private health insurance rebate for people aged over 65 (from 30 to 35 percent) and people aged over 70 (from 30 to 40 percent). The increased rebates took effect from 1 April 2005 (to coincide with the normal timing of any premium increases.

The implementation of the increased rebates (through reduced premiums) represented a significant challenge to the health funds, as some of the policy issues associated with the change were not able to be settled and communicated to the funds until shortly before implementation. Nonetheless, most funds were able to include the effect of the higher rebates in their advice to older members about their new premiums from 1 April.

A few funds were unable to do this and this caused confusion for some older members, and in some cases a possible delay for those members in getting the benefit of the lower rebates. Where these situations were brought to our attention we were able to make arrangements with the funds involved to ensure that those members did get the full benefit of the increased rebates from 1 April 2005.

We have also seen a few instances of older Australians joining private health insurance for the first time or rejoining after having dropped their cover previously. (For those aged 71 years or more, they can do so without incurring any lifetime health cover loading.) We have received a few complaints from people in this situation who have not fully understood the implications of the pre-existing waiting period.

People over 65 joining private health insurance are more likely than other new members to have pre-existing conditions or illnesses and are more likely to require hospital treatment in the first 12 months of their membership. It is therefore imperative that, on joining, they are given a full and clear explanation of the pre-existing ailment provisions.

Health fund benefits for podiatric surgery

During the year, legislative changes came into effect aimed at ensuring that health funds provide improved cover for their members who receive hospital treatment by accredited podiatric surgeons.

Hospital treatment by podiatric surgeons does not qualify for Medicare benefits. As a result, many funds did not provide any benefits towards the cost of hospitalisation associated with such treatment. The aim of the legislative change and the accreditation of podiatric surgeons is to ensure that people, with private health insurance, who choose to be treated by accredited podiatric surgeons, can have their hospital costs covered in a similar way to those treated by other surgeons.

More recent legislative change has given the Private Health Insurance Ombudsman a specific role in monitoring the funds' response to these legislative changes. I will be reviewing the funds' actions on this matter and intend to report on each fund's response and any issues in my next *State of the Health Funds Report.*

Funding the cost of prostheses

The Parliament has recently approved changes to legislation that will alter the arrangements

under which health funds provide benefits for the cost of prostheses and some medical devices used in hospital treatment (for example, artificial joints, heart valves etc).

At present health funds are required to provide benefits to cover the full cost of any prosthesis or medical device used as part of a hospital treatment if it is listed on a schedule approved by the Minister for Health. This schedule includes most prostheses and medical devices used in hospital treatment in Australia. Individual funds and suppliers negotiate the price/benefit to be paid. As a result most health members are unaware of the cost of prostheses that has been fully covered by their health insurance, even after having an operation involving the implantation of a very high cost item. Nonetheless the cost of prostheses has contributed significantly to health fund benefit costs and has been rising, making a small but significant contribution to rising premiums.

The changes to prostheses funding arrangements are intended to slow the growth in the cost of prostheses for health funds and reduce some of the pressure on health insurance premiums. The effect on premiums is likely to be quite small (increases should be a bit less than they might be otherwise) but consumers will welcome any contribution to lower premium rises.

The changes, expected to take effect from November 2005, involve the negotiation of prices/benefits by industry committees (rather than individual funds and suppliers). A key feature of the new arrangements is that there will be at least one "no-gap prosthesis" for each type of treatment but there is a possibility that some brands of prosthesis or device may not be fully covered by health fund benefits. If a doctor chooses to use one of the brands that is not fully covered the patient may be liable for a "prosthesis gap" cost.

I have been consulted on the proposed implementation of this change and have been closely monitoring progress to date.
I am optimistic that the incidence of patient gap payments for prostheses will be rare. Nonetheless, the possibility of an extra gap for patients to meet as part of the cost of hospital treatment provides a further challenge for all parties (doctors, hospitals and funds) to ensure that patients are informed in advance of the likelihood of an extra gap cost and their options for avoiding such costs.

Health fund voluntary code of practice on advice giving

In July 2005 the Government approved a self-regulatory code for health funds dealing with the quality of advice provided to consumers. The code sets out minimum standards to be adhered to by health funds that become signatories to the code.
The health insurance industry associations (AHIA and HIRMAA) have responsibility for implementation of the code over the next year.

The full implementation of this voluntary code promises to be a very positive development for the industry. It includes obligations for funds as well as agents, brokers and other intermediaries acting on their behalf and sets out the expected standards for training of health fund staff and others responsible for advising consumers about health insurance products. It specifies the range of information that should be included in policy documents and endorses a plain English approach to consumer information.
It also requires funds to have documented and effective complaint handling procedures and to ensure that members are made aware of the availability of the Private Health Insurance Ombudsman. I look forward to working with the industry associations and individual funds to make sure that this excellent industry initiative achieves its objectives.

THE CONSUMER'S RIGHT TO BE INFORMED

Virtually all complaints to my office about health fund benefits for hospital treatment concern unexpected gaps in the coverage of benefits and, as a result, unexpected bills for health fund members.

These gaps can arise because of the provisions of particular health insurance products (which may limit the benefits paid for particular treatments), because the particular hospital does not have an agreement with the person's fund (which usually means the hospital's charges are not fully covered by the fund's benefits), or because the fund's benefits have not fully covered their doctor's fees (and the doctor has chosen not to use the fund's gap cover scheme).

While some complainants are made aware of these gaps in advance and are simply aggrieved about the existence of the gaps and the amount, most complaints would not have arisen if the person was properly advised in advance of the likely cost of the procedure and had the opportunity to consider options to avoid that cost.

Funds, hospitals and doctors all have a role in ensuring that consumers are adequately informed.

Funds should provide clear explanations to their members about the limitations of the cover they have purchased. They should also educate their members about how gaps can arise, what can be done to avoid them and what information they should obtain from their doctor and hospital before agreeing to treatment.

Hospitals play a key role in informing consumers about the cost implications of a particular treatment, given their health insurance coverage. The procedures adopted by funds and private hospitals, to ensure that fund members can be given this advice before treatment, are well established and generally work very effectively. However, there are still examples of breakdown of procedures or miscommunication that mean that the hospital charges are not fully covered by the fund and there is potential for the patient to receive a large unexpected bill. In such cases, too often, hospitals simply bill the patient without acknowledging the error that has led to the unexpected bill and without considering whether a reduction in the bill or offer of terms to pay may be appropriate.

There are no established procedures between doctors and health funds to ensure that patients are fully aware of the doctor's fees and how much of it might be covered by their fund. The approach taken by individual doctors varies. In most cases this at least extends to indicating either that the doctor will use the fund gap cover scheme (and the gap allowed under that scheme) or an indication of the likely fee with advice to check with the fund to see how much of it will be covered.

During the last year the Australian Medical Association has developed and distributed a standard form to be used by doctors in providing for a patient's *informed financial consent*.

I was consulted in development of this form, as were key health consumer and industry bodies. The adoption of the AMA's recommended procedure and form for *informed financial consent* should ensure that a patient's right to be informed is properly acknowledged and that consumers are protected against unexpected bills. I will be encouraging all sectors of the private health industry to promote the use of the AMA form and procedures.

HEALTH INSURANCE COVER IN EMERGENCY SITUATIONS

Some of the most difficult cases my office deals with involve health fund members who have large unexpected bills following emergency (often life saving) treatment in a private hospital. In such situations it is normally impracticable (because of the urgency or seriousness of the situation or the condition of the patient) to provide for *informed financial consent.*

A large unexpected bill can arise in these situations because the person's health insurance product has only limited cover for the type of treatment involved. A common example is products providing only limited benefits for cardiac surgery.

The Private Health Insurance Ombudsman has consistently argued that products should not include exclusions or restrictions on treatment for life threatening conditions such as heart surgery. Nonetheless such products persist. Consumers can be attracted to them by their lower premiums. However, it is clear that despite the efforts of the funds to improve their information products many people who purchase these products are unaware of the implications of the restrictions particularly in emergency situations.

There are provisions in the *National Health Act 1953* to ensure that health fund members admitted to a private hospital in an emergency situation are covered at fund agreement rates, even where the fund may not have an agreement with the particular hospital.

If funds are to continue to offer products that exclude or restrict benefits for treatments such as cardiac surgery, consideration should be given to implementing similar safeguards for people with such products who are treated in an emergency situation.

PORTABILITY AND BENEFIT LIMITATION PERIODS

In my last annual report I commented on the implications of a contracting dispute between BUPA health funds and the Healthscope hospital group. I noted that the impact of the dispute on other funds had led some funds to question the application of portability policy in such situations. I expressed the view that the concerns of the various parties ought to be addressed through discussions and agreement across the industry on the appropriate conduct of funds and private hospitals in such situations (contract disputes). Unfortunately while a number of discussions have taken place over the year the matter has not been settled through those discussions. Nonetheless, with the exception of one particular issue, this has not emerged as an actual problem for consumers and there have not been any examples of funds failing to comply with portability requirements.

The one exception mentioned above has been the practice of two funds to impose benefit limitation periods on transferring members.

Benefit limitation periods are periods (generally one year or more) during which only limited benefits are paid for certain identified treatments. Most open membership funds include benefit limitation periods as a feature of some of their products. They are a way of reducing the cost of hospital cover and have advantages over ongoing exclusions and restrictions, in that eventually (following the expiration of the benefit limitation period) members gain access to full cover without the limitation on benefits.

Until recently all funds (other than BUPA) have waived the benefit limitation periods for transferring members if they have already had the appropriate period of membership with another fund. In April 2004 Australian Unity

introduced a change to its rules to apply benefit limitations on all its products for psychiatric and rehabilitation treatment including for members transferring from other funds. This rule change was intended to protect Australian Unity (and its existing members) from the costs of benefits for transferring members, in particular BUPA members, requiring psychiatric treatment who may wish to transfer because of the restrictive nature of BUPA's agreements with Healthscope in relation to Victorian private psychiatric hospitals.

Healthscope hospitals provide a significant proportion of private psychiatric hospital service in Victoria. BUPA's agreements with Healthscope significantly limit the benefit paid for BUPA members treated in Healthscope's psychiatric hospitals, other than in situations of emergency. This leaves BUPA members who are treated in these Healthscope psychiatric hospitals with substantial out-of-pocket costs for their treatment. The Australian Unity benefit limitation period policy means that BUPA members who seek to transfer to Australian Unity do not gain the benefit of Australian Unity's agreements with Healthscope psychiatric hospitals and are limited to a basic level of benefit (slightly less than they would receive under the BUPA/Healthscope arrangements).

The Australian Unity changes have been criticised by hospital groups, clinicians and mental health advocacy groups because they undermine portability and because they disadvantage potential members with mental illnesses. There has also been concern that other funds might follow suit and implement similar barriers to transfer.

I am opposed to the use of benefit limitation periods in transfer situations because they undermine the portability of health insurance for the particular treatments targeted by the limitation periods. Nonetheless, I acknowledge that the rules of both BUPA and Australian Unity have not been disallowed and are apparently in accordance with the requirements of the legislation (if not the spirit).

I have had only a few initial enquiries and complaints about the Australian Unity change and no complaints from members who have actually been affected by the limitations. It would appear that the Australian Unity change has had the (intended) effect of discouraging members with mental illness from transferring to that fund. The impact of the Australian Unity changes does not appear to have unduly disadvantaged individual consumers requiring psychiatric treatment but instead, appears to be resulting in additional costs for other funds. No other funds have implemented similar rules and are accepting transferring BUPA members with full portability rights.

STATE OF THE HEALTH FUNDS REPORT

In February of this year I published the first *State of the Health Funds Report*. The report provides comparative information on the performance of health funds on some indicators likely to be of interest to consumers; service delivery arrangements, service performance (including level of complaints to the PHIO), financial information and some general information about product coverage.

The report was generally well received by consumers and industry stakeholders. Inevitably there was some criticism of the choice of some indicators and the simplified ratings approach that was adopted in the report. (All funds were rated from A to D against the chosen indicators.)

My aim is to continually improve and refine the content and format of the report over time taking account of feedback and following appropriate consultation.

I distributed state based summaries of the report – *Consumer Guides* to many consumers on request, and to any complainants who sought advice on changing health funds. A subsequent survey of a sample of consumers who received the report indicated that 65 percent of respondents reported they found the publication helpful for their purposes.

COMPLAINTS WORKLOAD

There has been a further decline in the total number of complaints received and dealt with by my office compared to last year. Once again the workload impact of this reduction has been offset by an increase in the number of complaints requiring investigation (level 3 complaints).

This may indicate an increased likelihood that members will take up a complaint with their fund before bringing the matter to my office and more effective resolution of complaints by the funds. If so this is a positive outcome for the industry and it is hoped that some of the measures taken by health funds over the last year (to further improve their own complaint handling procedures) will lead to a continuation of this trend.

John Powlay
Private Health Insurance Ombudsman

role and function

INTRODUCTION

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

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

FUNCTIONS

The main role of the Ombudsman is to deal with complaints about private health insurance arrangements. The full functions of the Ombudsman, as provided by section 82ZRC of the *National Health Act 1953,* are to:

- Deal with complaints and conduct investigations;
- Publish aggregate data about complaints;
- Publish the State of the Health Funds Report
- Make recommendations to the Minister or Department of Health and Ageing;
- Make available and publicise the existence of the Private Patients' Hospital Charter; and
- Promote an understanding of the Ombudsman's functions.

Samantha Gavel, Director of Policy & Compliance

WHO CAN MAKE A COMPLAINT?

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

- Health fund members;
- Doctors and some dentists;
- Hospitals and day hospital facilities;
- Health funds; and
- Persons acting on behalf of any of the above, including a family member, a lawyer or friend.

WHAT CAN THE OMBUDSMAN DO WITH A COMPLAINT?

The Ombudsman is able to deal with complaints by:

- Mediation;
- Referring the complaint to the health fund, hospital or provider, with a request to report to the Ombudsman with its findings and any action it proposes to take. If the Ombudsman is not satisfied with the explanation or proposed action, the Ombudsman may further investigate the complaint and make a formal recommendation;
- Referring the complaint to the Australian Competition and Consumer Commission; and
- Referring the complaint to any other appropriate body.

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

WHAT HAPPENS AT THE END OF A COMPLAINT OR INVESTIGATION?

The Ombudsman is able to recommend that:

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

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

Section 82ZSG of the *National Health Act 1953* provides various grounds for the Ombudsman to decide not to deal with a complaint. These include if the complaint is:

- Trivial, vexatious or frivolous;
- If the complainant has not taken reasonable steps to negotiate a settlement;
- If the complainant does not have a sufficient interest in the subject matter of the complaint; or
- If another organisation is dealing adequately with the complaint.

HOW STAFF RESOLVE COMPLAINTS

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

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

Staff 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.

Standing: (L to R) Jacqueline Power, David McGregor, Ursula Schappi, Ramy Bakhos, Kaylie Blyton, Hilary Bassingthwaighte and Richard Van Der Male. Seated: (L to R) Taran Sahdeva, John Powlay and Samantha Gavel

OUTPUT PERFORMANCE MEASURES

The 2004/2005 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 2004/2005.

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

Quality indicator: High level of satisfaction with the relevance, quality and timeliness of advice and submissions.
Measurement: No formal mechanism has been established to assess the satisfaction of key stakeholders. Reporting relies on informal discussion.
Performance result: Overall high level of satisfaction achieved against the three measures – relevance, quality and timeliness.

Quantity indicator: Advisory services commensurate with the funds allocated to produce a range of products, including 11-15 submissions and public presentations.
Measurement: Count of submissions, other written advice and public presentations.
Performance result: 9 submissions, 21 items of written advice, 17 public presentations. (Further details are provided in the General Issues section of this report.)

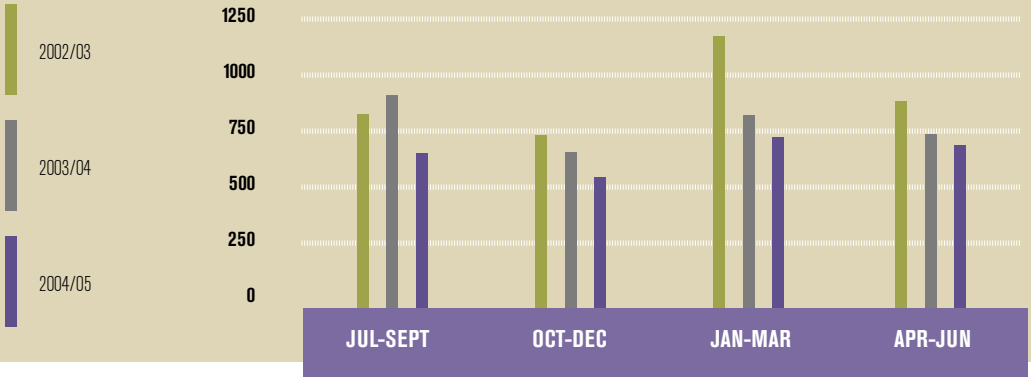
Output group 2 – Direct delivery of services (information and dispute resolution service)

Quality indicator: Information provided and complaints dealt with accurately and in a timely manner.
Measurement: Analysis of PHIO complaints recording database, client satisfaction survey.
Performance result: Quality meets the standard indicated. (Further details are provided in the following discussion of complaints performance and in the report of the client satisfaction survey included in the General Issues section of this report.)

Quantity indicator: 75% of complaints resolved within one month.
Measurement: Analysis of PHIO complaints recording database.
Performance result: 83% of complaints resolved within one month (86% last year).

Quantity indicator: Number of complaints received.
Measurement: Analysis of PHIO complaints recording database
Performance result: 2571 complaints received.

Figure 1 Total Complaints Received Per Quarter



DECREASE OVERALL IN COMPLAINTS RECEIVED

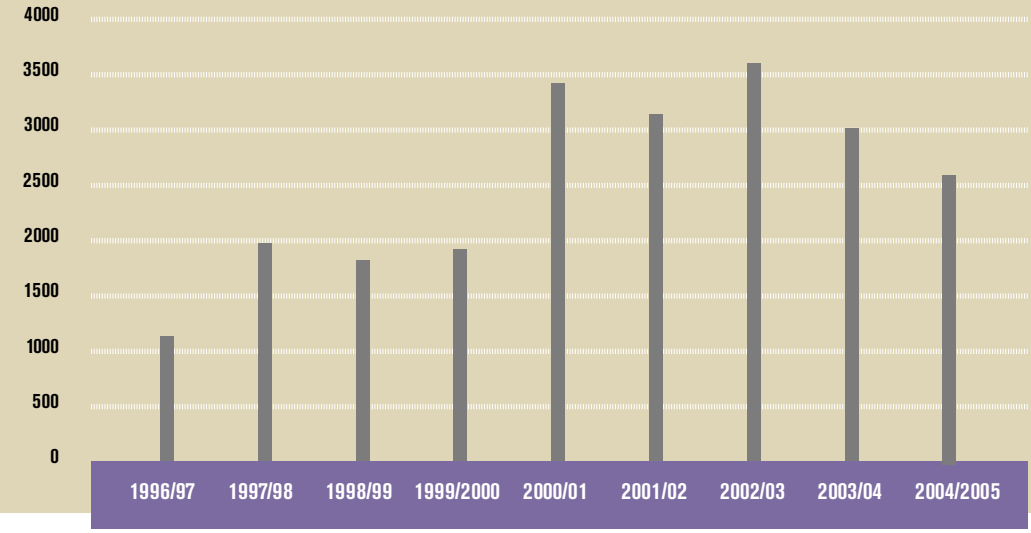
The Ombudsman received 2571 complaints during 2004/05, this is a decrease of 421 complaints (14%) from the previous year. This is the lowest number of complaints the office has received in the last 5 years.

Despite the overall drop in complaints received, the number of level 3 complaints (those requiring a health fund report or investigation) increased slightly compared to the previous year. The office received 706 Level-3 Complaints during 2004/05, this is an increase of 94 Level-3 complaints (15%).

Figure 1 shows the distribution of complaints through the four quarters of the 2003/2004 financial year.

Figure 2 shows the total number of complaints received per year for the last 9 years. The jump in the number of complaints in the 2000/2001 year was associated with a large increase in the numbers of Australians covered by private health insurance as a result of the Government's introduction of the 30% health insurance rebate, Lifetime Health Cover and other Private Health Insurance Initiatives.

Figure 2 Total Complaints by 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 *National Health Act 1953*. A complaint must be:

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

Complaints are categorised by the degree of effort needed for their resolution.

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 fund, hospital, doctor or dentist. This occurs where, in the view of the Ombudsman, the complainant has not made an adequate attempt to resolve the problem or the Ombudsman is able to suggest to the complainant other ways to approach the problem with the health fund, hospital, doctor or dentist. Issues within this category can be across the whole complaint range of product description, benefits paid, informed financial consent, pre-existing ailments and service quality. The Ombudsman's staff empower the consumer to try and resolve the complaint directly and if they are not successful, they return and reactivate the complaint.

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 product they have purchased, concerns with service levels provided by the fund or provider, price increase, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

Complaint level 3 (Disputes):

Highest level of complaint where significant intervention is required

Level 3 complaints are dealt with by contacting the health fund, hospital, doctor or dentist about the matter. Issues in this category will have previously been the subject of dispute between the complainant and the respondent and not have been resolved. The Ombudsman attempts resolution through conciliation by telephone or in writing. Common complaints in this category would include pre-existing ailments, informed financial consent, benefits available on portability of membership, benefits not in accordance with brochure descriptions and contribution errors.

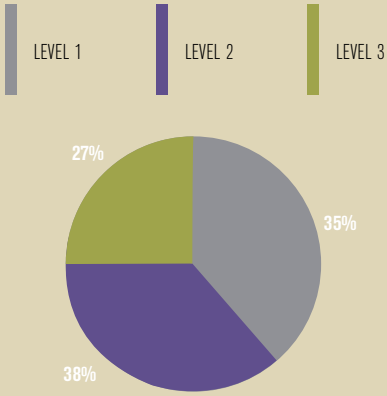
The 2571 complaints recorded in 2004/05 consisted of 706 Level-3 complaints, 968 Level-2 complaints and 897 Level-1 complaints. Figures 3 and 4 show these ratios and indicate a significant reduction in the number of Level 1 and 2 complaints. This is a trend that occurred in the previous year as well. There was, however, a significant increase in Level-3 Complaints, from 612 in 2003/04 to 706 in 2004/05.

The proportion of Level-3 complaints increased from 20% in 2003/04 to 27% in 2004/05.

Ursula Schappi, Dispute Resolution Officer

Figure 3 Complaints Received per Year by Category

Figure 4 Complaints Category, Percentage



COMPLAINTS HANDLING PROCEDURES

The process and timeframes for handling the different categories of complaint are depicted in Figure 5 (see over).

The majority of complaints handled are from fund members about their own fund. However, there are instances where a complaint needs to be recorded against both the health fund and a provider. This occurs, for example, where the complaint involves contradictory advice about how much of a hospital bill will be paid by a health fund.

Fund members also lodge complaints about a:

- Hospital, (generally about inadequate information to enable informed financial consent);
- Doctor (almost always relating to either the gap between charges and benefits paid through Medicare and the fund, and the failure to inform of the discrepancy before proceeding); or
- Other practitioners (generally about the gap between the charges and the benefit paid through ancillary tables).

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

Hospitals and some providers can also lodge complaints against health funds. 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 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
ACTIONS PHIO contacts health fund or provider to obtain a report, then mediate the dispute between the parties or investigate the matter further	**ACTIONS** Complainant provided with explanation or information to resolve matter, or if there is no avenue for the Ombudsman to take up the matter	**ACTIONS** If complainant has made insufficient effort to resolve the matter with fund or provider, empower them with detail enabling them to take up the issue at an appropriate level
OUTCOMES 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

WORKLOAD

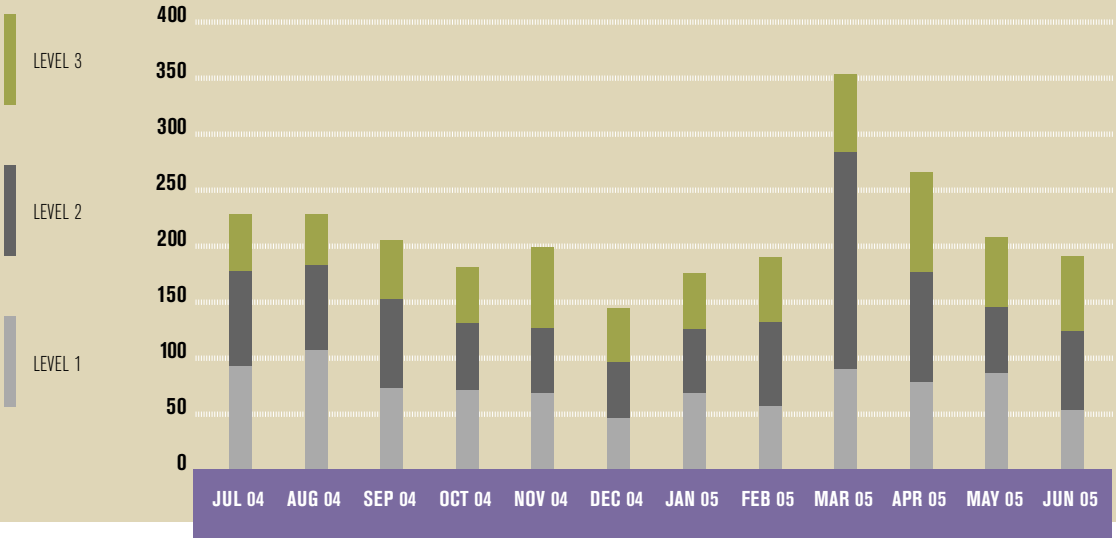
The office received 2571 complaints (Levels 1, 2 & 3) in 2004/05, an average of 214 per month compared with 249 complaints per month in the previous year.

The office finalised 2602 complaints during the year; an average of 217 per month, compared with an average 251 complaints finalised per month in the previous year.

The office finalised 729 complaint investigations (Level 3 complaints) during the year.

Figure 6 shows the number of complaints received in each month of the year, indicating changes in workload over the year in the various complaint categories. The workload peak in

Figure 6 Total Complaints Received by Month



March 2005 was associated with health fund premium increases; though this peak was similar to last year's and only half that which occurred following 2003's health fund premium increases.

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 marginal decline

Figure 7 Time Taken to Finalise Complaints

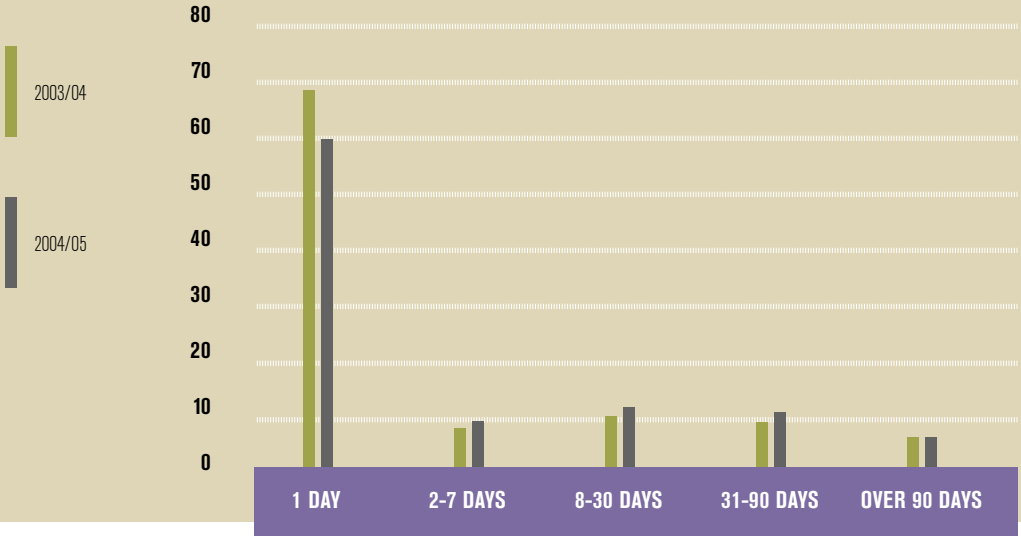
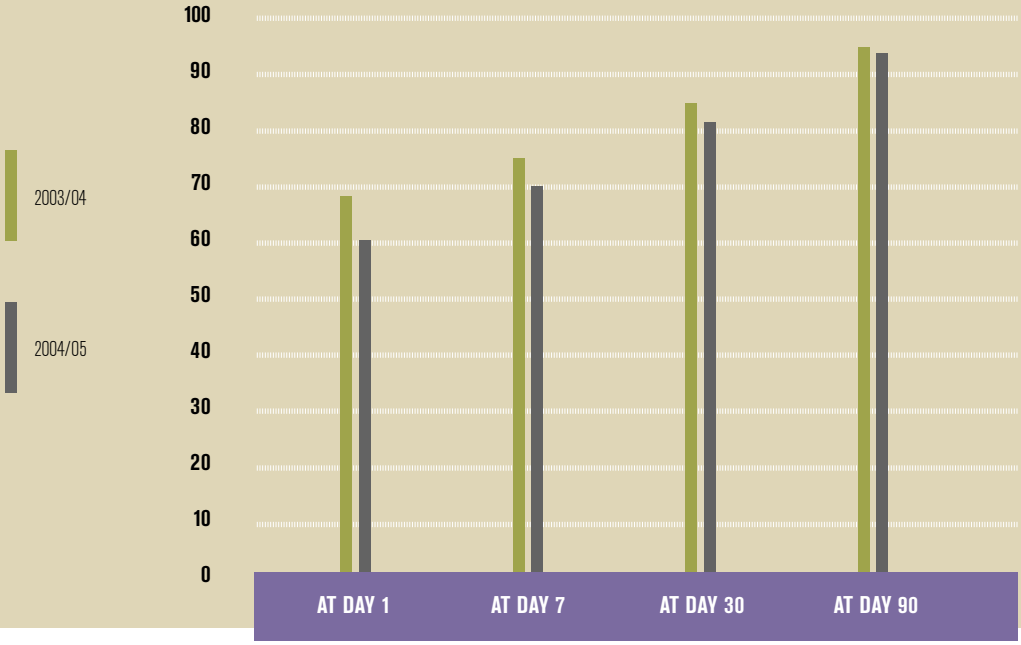


Figure 8 Complaints Completed Since Day of Lodgement



in the timeliness of complaints processing. This is attributable to the increase in the more complex and work intensive Level 3 complaints (from 20% of all complaints to 27%)

Despite an increase in the amount of time taken to close complaints, the office recorded a higher level of satisfaction expressed by complainants with the time taken in handling their complaints.

78% of complainants whose cases lasted longer than 7-days indicated they were happy with the time taken to resolve their complaint, which is an increase from 68% in the previous year.

WHO WAS COMPLAINED ABOUT

Most complaints were made about registered health funds (2433), followed by hospitals (191) and practitioners (doctors and dentists) 123. The Ombudsman also received 42 complaints from people holding overseas health cover (these are not counted as registered health fund complaints)

Some complaints concerned one or more health funds, or a health fund as well as a hospital, doctor or dentist. Consequently, the total number of organisations or people being complained about (2792) adds up to more than the total number of individual complainants contacting the Ombudsman (2571).

COMPLAINTS ABOUT HOSPITALS

During the year, there were 191 complaints registered against hospitals, this is a significantly lower number of complaints than the previous year (277 in 2003/05). Of these complaints 107 were Level-3 complaints. Those Level-3 complaints, which required investigation, were likely to result in a hospital accepting a reduced payment for an outstanding hospital account.

Complaints to the Ombudsman about hospitals usually related to inadequate *informed financial consent* (IFC) being sought from a patient prior to a hospital admission. This occurred either because a check of a patient's health fund membership was not performed, or because of a mistake in communicating the level of out-of-pocket expenses which a membership verification should have indicated.

Most of the complaints about inadequate IFC were in relation to hospitals which held *Hospital Purchaser Provider Agreements* (HPPAs). The hospital and health fund have a contractual relationship, with the HPPA setting the basis of their contract. All such agreements are required to include a requirement that the hospital provide, wherever possible, adequate advance notice to the health fund member of likely out of pocket costs. In effect, when dealing with many of these complaints, we are engaged in requiring either the hospital or fund to comply with their own contractual obligations. This should not be necessary.

Figure 9 Complaints by Health Fund Market Share

NAME OF FUND	TOTAL NUMBER OF COMPLAINTS (1)	% OF TOTAL COMPLAINTS	TOTAL NUMBER OF LEVEL-3 COMPLAINTS (2)	% OF TOTAL LEVEL-3 COMPLAINTS	MARKET SHARE (3)
ACA Health Benefits	2	0.1	1	0.1	0.1
AMA Health Fund	3	0.1	0	0	0.1
AHMG	71	2.9	22	3.3	2.4
Australian Unity	80	3.3	31	4.6	3.2
BUPA (HBA)	284	11.7	80	11.9	9.9
CBHS	12	0.5	2	0.3	1.1
CDH (Cessnock District Health)	0	0	0	0	<0.1
Credicare	13	0.5	4	0.6	0.4
Defence Health	50	2.1	13	1.9	1.4
Druids NSW	1	0	0	0	<0.1
Druids Victoria	2	0.1	0	0	0.1
Federation Health	2	0.1	0	0	0.2
GMHBA	41	1.7	15	2.2	1.5
Grand United Corporate Health	14	0.6	8	1.2	0.3
Grand United Health	36	1.5	13	1.9	0.4
HBF Health	76	3.1	23	3.4	7.9
HCF (Hospitals Cont. Fund)	151	6.2	47	7.0	8.8
Health Care Insurance	1	0	0	0	0.1
Health Insurance Fund of W.A.	10	0.4	4	0.6	0.4
Healthguard	21	0.9	5	0.7	0.6
Health-Partners	12	0.5	2	0.3	0.7
Latrobe Health	3	0.1	3	0.4	0.4
Lysaght Peoplecare	8	0.3	0	0	0.3
Manchester Unity	67	2.8	20	3.0	1.4
MBF Australia Limited	370	15.2	79	11.7	16.7
MBF Alliances	90	3.7	14	2.1	2.2
Medibank Private	700	28.8	213	31.6	28.7
Mildura District Hospital Fund	1	0.0	0	0	0.3
N.I.B. Health	212	8.7	53	7.9	6.2
Navy Health	1	0	1	0.1	0.3
Phoenix Health Fund	0	0	0	0	0.1
Police Health	1	0	0	0	0.2
Queensland Country Health	19	0.8	4	0.6	0.2
Railway & Transport Health	2	0.1	0	0	0.3
Reserve Bank Health	0	0	0	0	<0.1
St Lukes Health	5	0.2	0	0	0.4
Teacher Federation Health	19	0.8	2	0.3	1.6
Teachers Union Health	14	0.6	2	0.3	0.4
Transport Health	0	0	0	0	0.1
Westfund	39	1.6	12	1.8	0.7
TOTAL FOR REGISTERED FUNDS	**2819**	**100.0**	**574**	**100.0**	**100.0**

Note 1. Complaints (Levels 1,2 & 3) from those holding registered health fund policies.
Note 2. Level 3 Complaints required the intervention of the Ombudsman and the health fund.
Note 3. Market share data provided by PHIAC as at 30 June 2005.

COMPLAINTS ABOUT REGISTERED HEALTH FUNDS

Figure 9 provides a summary of all complaints (Levels 1, 2 & 3) for individual health funds 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 funds respond to their members' complaints. Higher Level 3 complaint to market share ratios are a pointer to a less than adequate internal disputes resolution process for complex issues within the fund.

COMPLAINTS ABOUT PRACTITIONERS

Most complaints about doctors and practitioners concerned medical gap issues and/or the lack of *informed financial consent.* During 2004/05 year the office received 137 complaints about medical gap issues, 60 less complaints than the previous year. The office registered 123 complaints against practitioners, 54 less complaints than the previous year.

RESOLVING COMPLAINTS

46% of complaints were resolved by the Ombudsman's office providing an independent and impartial explanation of the health fund member's complaint.

34% of complaints were referred back to the health fund. Many of these complainants were referred with the assistance of the Ombudsman's staff. Alternatively, the Ombudsman was generally able to suggest ways for the complainant to pursue the matter with the health fund themselves.

9% of complaints (29% of the Level-3 complaint category) were resolved following payments by health funds or the *writing-off* of accounts by hospitals. These payments by health funds usually followed an investigation by the Ombudsman and then the health fund agreeing that a health fund member was entitled to a benefit payment or some other payment. In some cases, payment is made by health funds on an *ex gratia* basis, for instance, where the fund accepts that the member relied on incorrect advice from the fund. Accounts written off by hospitals are usually the result of hospitals accepting responsibility for their failure to adequately inform patients of their costs.

An additional 7% of complaints (24% of the Level-3 complaint category) were resolved by taking other remedial action, such as re-instating a membership or allowing the back payment of contributions where a membership had lapsed.

1% of complaints, which met the criteria for complaint contained in the National Health Act 1953, were referred to another agency such as a hospital's patient liaison office, a state based health complaints handling body, the Privacy Commissioner, a state department of fair trading and a small number were referred to the ACCC). 2% of complaints were withdrawn or required no further action.

Summarised information about the resolution of complaints and Level-3 complaints is provided in Figures 10 and 11.

David McGregor, Project and Research Officer

Figure 10 Outcomes of Finalised Complaints

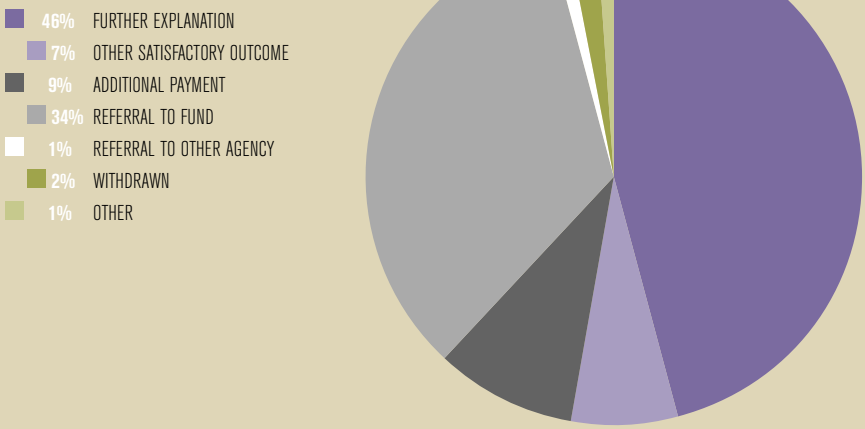
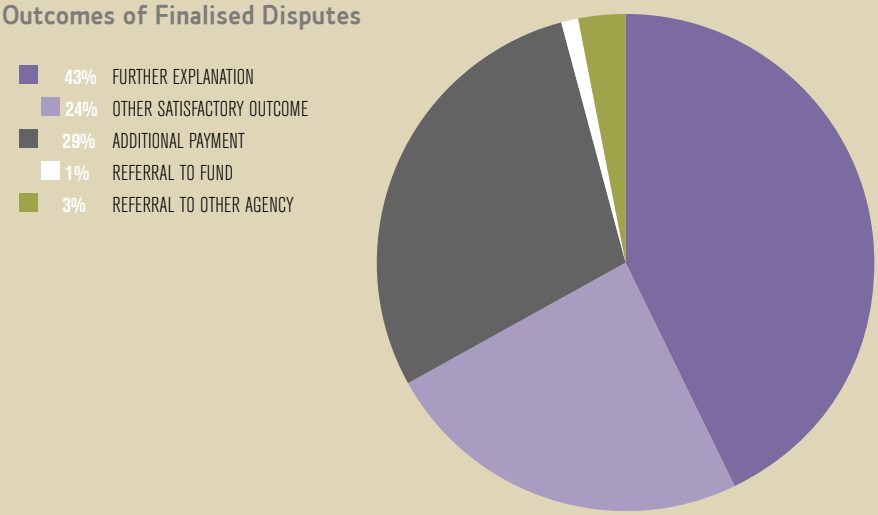


Figure 11 Outcomes of Finalised Disputes



Our client survey for this year asked respondents to indicate if they took any other action following their (level-2) complaint about premium rises receiving a response from the Ombudsman. This year no respondents indicated that they had dropped out of private health insurance. This compares with 5% reporting having taken that action in 2003/04.

A lower proportion of respondents reported changing health funds (13%) compared to 21% in 2003/04. This year a much higher proportion of respondents (27%) reported changing their cover but remaining with the same fund. The majority of respondents (60%) said they'd decided to take no action or were still considering their options.

WHO COMPLAINED?

The *National Health Act 1953* allows health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf to lodge complaints. Overwhelmingly, complaints were made by health fund members (2536), followed by practitioners (23), hospitals/day hospitals (11) and a health fund.

HOW COMPLAINTS WERE MADE

85% of complaints were made initially by telephone. 7% were received by letter, almost 7% were lodged by email. The remainder were made by fax, personal visit, or by Parliamentary Representation.

COMPLAINTS BY STATE/TERRITORY

Figure 12 identifies, on a state-by-state basis, where complaints originate. This data is shown by State, against the percentage of people who have private health insurance coverage.

Generally, there was a greater proportion of complaints coming members in Victoria, South Australia, Queensland and Tasmania. These state based differences significantly change from year to year.

INVESTIGATIONS INTO HEALTH FUND PRACTICES AND PROCEDURES

During 2004/05 the Ombudsman initiated one investigation into health fund practices and procedures under section 82ZT of the National Health Act 1953. This investigation related to the administration of ambulance cover by BUPA health funds.

An investigation into health fund practices relating to the portability of hospital insurance under section 82ZT, which was commenced in 2003/04, continued into 2004/05.

There were no investigations undertaken under section 82ZTA of the National Health Act 1953.

complaints issues

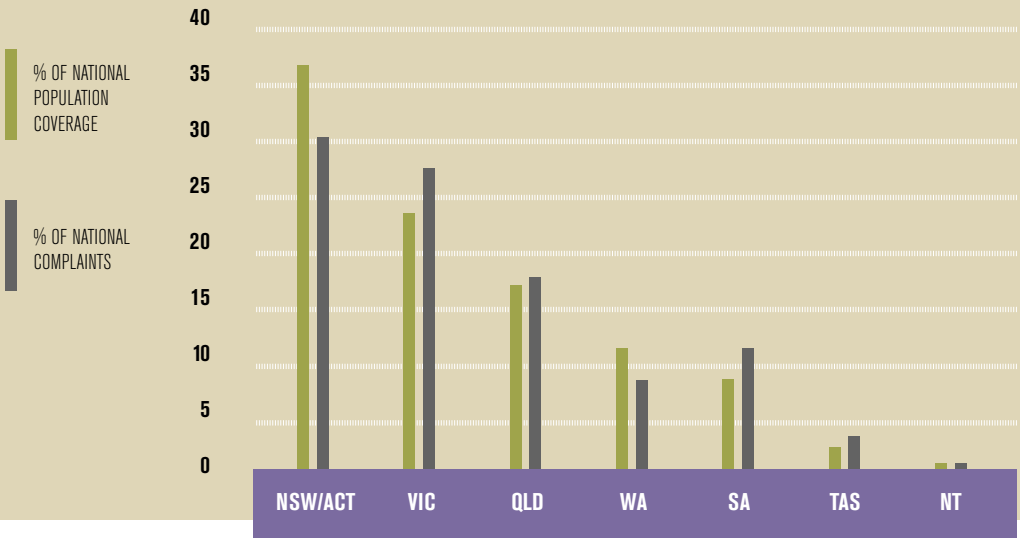
INTRODUCTION

Complaints to the Ombudsman must first meet the requirements of the Section 82Z of the *National Health Act 1953*. 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.

about a person's history before joining a health fund is held overseas.

The office also received a small number of complaints about other types of issues such as difficulties obtaining membership refunds after cancelling policies that were paid in advance and problems with oral advice provided by funds and hospitals.

Figure 12 Complaints by Population Covered by State & Territory



OVERSEAS VISITORS HEALTH COVER

The Ombudsman assisted 42 consumers with complaints concerning *overseas visitors cover* (for visitors to Australia). This type of health insurance is not a registered health insurance product and is consequently not counted in the list of complaints against health funds.

The most common types of complaints investigated by the office were those concerning the *pre-existing ailment* waiting period. Some of these cases tended to be complicated because medical information

HEALTH FUND PREMIUM INCREASES

During the year, the Ombudsman received 230 complaints concerning premium increases, which is a reduction of 14 on the previous year and significantly lower than the 2002/3 year.
The percentage of average premium increases for each fund for 2005 are detailed in figure 15 (see over).

Figure 13 Reported Private Health Insurance Premium Increases 2005

NAME OF FUND	AVERAGE INCREASE ACROSS THE FUND
ACA Health Benefits	11.60%
AMA Health Fund	8.35%
AHMG	5.22%
Australian Unity	7.85%
BUPA (HBA)	7.40%
CBHS	8.41%
CDH (Cessnock District Health)	5.20%
Credicare	13.29%
Defence Health	13.63%
Druids NSW	34.42%
Druids Victoria	6.49%
Federation Health	4.82%
GMHBA	11.38%
Grand United Corporate Health	16.78%
Grand United Health	8.51%
HBF Health	4.17%
HCF (Hospitals Cont. Fund)	5.71%
Health Care Insurance	5.92%
Health Insurance Fund of W.A.	9.03%
Healthguard	5.42%
Health-Partners	8.32%
Latrobe Health	3.61%
Lysaght Peoplecare	13.11%
Manchester Unity	7.47%
MBF Australia Limited	7.74%
MBF Alliances	8.38%
Medibank Private	7.94%
Mildura District Hospital Fund	2.27%
N.I.B. Health	13.86%
Navy Health	5.36%
Phoenix Health Fund	10.00%
Police Health	7.18%
Queensland Country Health	30.05%
Railway & Transport Health	10.57%
Reserve Bank Health	10.01%
St Lukes Health	9.82%
Teacher Federation Health	7.75%
Teachers Union Health	7.87%
Transport Health	8.18%
Westfund	12.57%

Source: Prepared by the Department of Health & Ageing in accordance with Section 78(8) of the National Health Act 1953 and tabled in the Senate on 21 June 2005

CASE STUDIES

Membership Issues

Complaints about membership issues increased in 2004/05. Membership issues include problems with cancellation and suspension of membership, continuity and inter fund transfers. The introduction of lifetime health and the Medicare levy surcharge have made membership issues even more important than they were previously, because any loss of continuity can affect a member's lifetime health status and may result in them incurring the Medicare levy surcharge

Under legislation, a fund cannot cancel a membership unless it is more than two months in arrears. After this time, a fund is permitted to cancel the membership, but the fund has discretion to accept arrears and provide continuity if they believe there are special circumstances.

Members have a responsibility to ensure their premiums are up to date. If a member has opted to use a direct debit facility, they are responsible for ensuring the payments are being debited each month. Where a direct debit fails, some members believe the fund should provide continuity without requiring payment of arrears. In most cases, however, it is not unreasonable for the fund to require payment of arrears in return for continuity. PHIO would only recommend waiving of some portion of the arrears if it were evident that the fund had been at fault in the matter.

COMPLAINTS ISSUES

Figure 14a Complaints Issues - Percentage of Each Issue

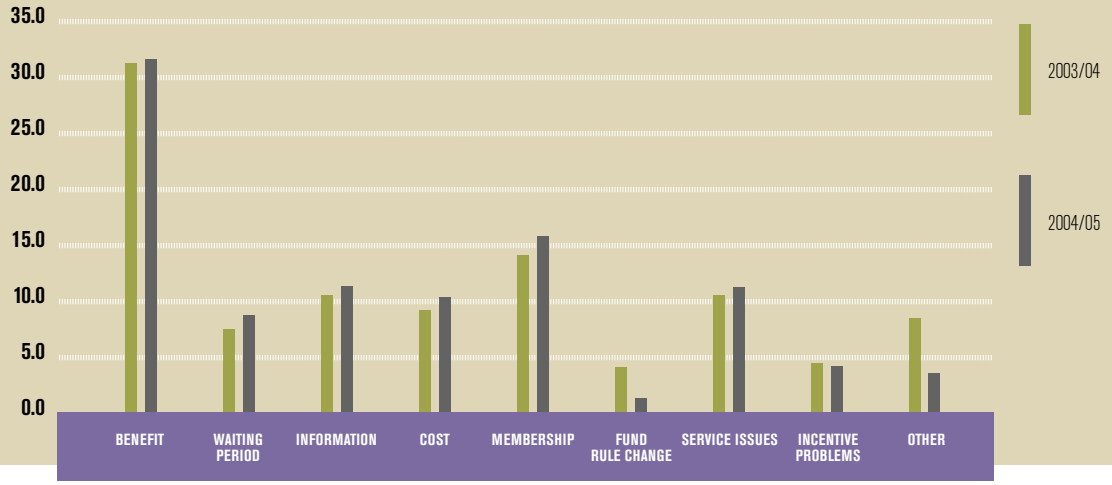
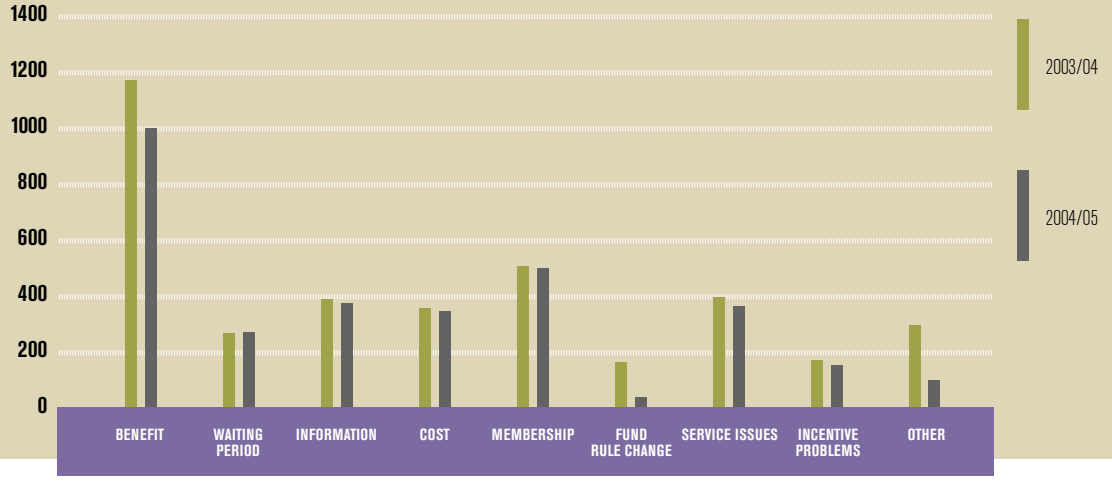


Figure 14b Complaints Issues - Numbers of Matters Registered



Mrs Rosella was an elderly lady who had been living in a nursing home for some years. She fell and broke her hip and was admitted to hospital. On admission, the hospital conducted a membership eligibility check which revealed the member had not made her annual premium payment, due some nine months earlier. As a result, her membership had been cancelled by the fund and she was no longer covered.

The member's son had power of attorney to act on her behalf and he had been dealing with her affairs since she had been admitted to the nursing home. He did not recall receiving a reminder notice about the premium payment being due, or any follow up mail indicating the membership was about to be, or had been cancelled. After attempting unsuccessfully to resolve the matter with the fund, Mrs Rosella's son contacted PHIO for assistance.

The fund's records indicated that a number of letters were sent to Mrs Rosella advising her that her annual premium was due. Two of these letters had been returned to the fund by the post office because the address was invalid. The fund's view at this point was that the member or those acting on her behalf had a responsibility to advise them of any change of address and this had not been done.

Mrs Rosella's son explained that the postal address for his mother's mail had not changed, but the house had been demolished so a new one could be built. The mailbox had been left in place, but some mail had been stolen or lost. Mr Rosella was able to provide evidence that he had formally taken the issue of the missing post up with the post office at the time it occurred. The post office had a record of returning some items from this address to the senders.

PHIO advised the fund of this. In addition, Mrs Rosella was a long term member of the fund who had never been in arrears before.

After taking account of Mrs Rosella's long term membership and the information provided by Mrs Rosella's son, the fund agreed to accept payment to cover the period when the membership was in arrears and to provide full continuity of cover to Mrs Rosella.

PROBLEMS WITH INTER-FUND TRANSFERS

The Ombudsman received 163 complaints about problems with inter fund transfers. The ability to transfer between funds is an important consumer right. In the majority of cases, inter fund transfers occur without major problems. Unfortunately, however, when things go wrong, it can result in continuity problems for the member, as well as the frustration of trying to resolve the problem with two funds.

Mrs Corella had held a basic cover with her health fund for six years. She decided to transfer to another fund on a higher level of hospital and ancillary cover. Before transferring, she e-mailed the new fund to ask about whether she would need to serve waiting periods again if she transferred. The fund e-mailed back to advise (correctly) that she would receive continuity for any completed waiting periods and entitlements. The fund also advised that they needed a clearance certificate from her old fund to be able to confirm her entitlements and any new waiting periods under her new cover.

Mrs Corella proceeded to cancel her membership with her old fund and joined the new fund. She filled out a form which authorised her new fund to seek a copy of her clearance certificate directly from her old fund. The new fund posted this authorisation to the old fund on the same day the membership commenced.

Unfortunately, the old fund did not receive the clearance certificate request. Mrs Corella spent a number of frustrating weeks chasing it up with both funds. Mrs Corella had been with the new fund for two months before they finally received the clearance certificate. It was only at this point that they were able to advise her that she needed to serve a twelve month waiting period for major dental, because this was not covered under her old cover.

Mrs Corella was very dissatisfied with the length of time it had taken for her entitlements under her new cover to be confirmed. She was also dissatisfied that she would have to serve a waiting period for the higher dental cover (although the Ombudsman confirmed that the new fund was entitled to apply this waiting period). She therefore decided to cancel her cover with the new fund and requested the old fund to re-instate her membership, backdated to the time she had cancelled it. The old fund agreed to do this. The new fund, however, refused to refund Mrs Corella's premiums as she requested.

After investigating the matter, the Ombudsman was unable to conclude that either of the funds were at fault in relation to the late clearance certificate; records showed the new fund had requested it from the old fund, but it appears the initial request was never received. The Ombudsman believed, however, that the member should not be out of pocket as a result of her attempt to transfer funds and requested the funds concerned resolve the matter between themselves so the member was not left out of pocket. The funds agreed to this course of action.

INTERFUND TRANSFERS 2

Mrs Electus transferred to a new fund over the telephone in 2002. Staff at the new fund explained to her that she needed to complete an application form and send it back to them to formalise the membership. Staff also advised her that they would organise for the cancellation of her membership with her old fund if she filled out the section of the form giving them authority to do this. Unfortunately, Mrs Electus neglected to fill out this part of the application form.

This meant the new fund could not confirm her entitlements or her lifetime health status. A 54% penalty loading was applied to Mrs Electus's new cover, even though she had locked in her lifetime health status and was not liable for the loading. The new fund sent her lifetime health statements for three years indicating she was paying this loading, but these failed to alert Mrs Electus to the problem.

Mrs Electus was also unaware that because she hadn't authorised the new fund to cancel her membership of the old fund, she was still paying premiums for her old membership as well. She only became aware of this when her bank contacted her to advise that a direct debit payment to the old fund had been dishonoured because there was not enough money in her bank account to cover it. Mrs Electus contacted the Ombudsman when she found herself unable to resolve the problem with either fund.

The Ombudsman's investigation revealed that Mrs Electus's old fund had also been sending her correspondence and lifetime health statements, but because she believed she was no longer a member, she was throwing out this correspondence. The mail was never returned

to the old fund and so they did not realise there was a problem with the membership.

The Ombudsman concluded Mrs Electus had contributed to the problem by not reading her mail and not checking her bank statements. However, the Ombudsman did not believe it was reasonable for Mrs Electus to be liable for two health fund memberships. The Ombudsman was eventually able to resolve the matter by negotiating a resolution between the funds which did not leave Mrs Electus out of pocket.

PROBLEMS WITH COVER FOR NEWBORN BABIES

If a mother holds a single hospital cover when her baby is born, the baby is not covered if it needs to be formally admitted to hospital. In most cases, newborn babies do not need to be formally admitted to hospital. If a baby requires admission and is not covered, however, the member can incur substantial out of pocket costs. All funds have different rules about when a mother needs to take out family cover to ensure the baby is covered, so it is important to check with the fund well in advance of the birth.

Mrs Regent was pregnant and due to give birth in two months' time, when she went into her fund branch to inquire about ensuring her baby was covered when it was born. Fund staff told her she needed to change her membership from a single to a family cover to ensure the baby was covered if it needed admission to hospital. Fund staff advised her to fill out an application form for family cover and put her due date as the date the cover would commence. Fund staff advised that if the baby came early, all she needed to do was ring the fund and have the commencement date of the new cover adjusted.

Some weeks later, Mrs Regent was admitted to hospital and required an emergency caesarian section which meant her baby was born one month prematurely and before the date her family cover would commence. The baby was immediately admitted to the hospital's intensive care unit. Later that day, Mrs Regent rang the fund and requested her family cover commence that same day to ensure the baby was covered. Fund staff advised a new application form would be sent to her to sign and return in fourteen days. Unfortunately, the signed application form reached the fund a few days after the fourteen day deadline and the fund denied benefits for the baby's admission.

After investigating the matter, the Ombudsman concluded that fund staff should have advised Mrs Regent to upgrade her single cover to family cover from the date she went into the branch. If this had happened, the baby's admission would have been covered.

The Ombudsman negotiated a resolution of the matter between the fund and hospital which did not leave Mrs Regent out of pocket.

MISTAKEN NAMES

Mr Lorikeet was due to have his wisdom teeth removed. Before arranging treatment, he asked his dental surgeon how much would be charged and where the surgery would take place. His dental surgeon advised that he operated at a couple of facilities, so he chose the most convenient one for his needs. This was Mr Lorikeet's first operation, so he walked into his local health fund office to ask about how much he was covered for. At the same time, he made a claim for his dental surgeon's consultation fee.

The health fund confirmed that the day surgery that Mr Lorikeet wanted to go to was covered because it was an agreement facility. Health fund memberships usually entitle members to be fully covered (less any agreed excess) for a range of hospitals that hold agreements with the fund. Both the facilities that Mr Lorikeet's dental surgeon offered to use were covered, so he chose the more convenient one.

On the day of the admission, the day surgery facility asked Mr Lorikeet to pay $1300 as an upfront payment on his credit card. He thought this was unusual at the time, however he was too nervous about having his first operation to contact the fund right away and so he agreed to pay the amount. He was sure the fund would reimburse him $900 (he knew he had to pay a $400 excess) later on.

On attempting to make a claim for the $900, the health fund paid him only $55. He asked why the benefit was so low and was told it was a default benefit as he attended a non-agreement hospital. If a facility chosen by a health fund member is not an agreement facility, Mr Lorikeet's health fund pays only a default benefit which is equivalent to what a public hospital would charge for a private admission. The fund denied that it had provided advice that the day hospital was covered as an agreement hospital at the time he says he visited the branch.

Mr Lorikeet contacted the Ombudsman who asked the fund about the advice given at the time he visited the branch. The fund initially responded that it held no record that Mr Lorikeet had visited its office on the day he claimed he was misadvised. However, the Ombudsman tended to favour Mr Lorikeet's version of events because it could clearly be established that he had visited the fund's office on that day because he made a cash claim at the time. Also, it made sense that he would query the fund covering the hospital at the time of this visit because his doctor had advised him in writing to do so.

Additionally, it seemed that the name of the hospital that Mr Lorikeet attended was the same as another day surgery facility; the difference between the two was that one was a stand-alone facility and the other a private facility in the grounds of a public hospital (the one in the public hospital was the one that wasn't covered). A staff member could easily mistake the two if he or she didn't double check the address details.

After reviewing the matter, the Ombudsman formed the opinion that it was more than likely that Mr Lorikeet was misadvised about benefits during his visit. The fund agreed and paid a further $900.

ACCESS AND PUBLIC AWARENESS

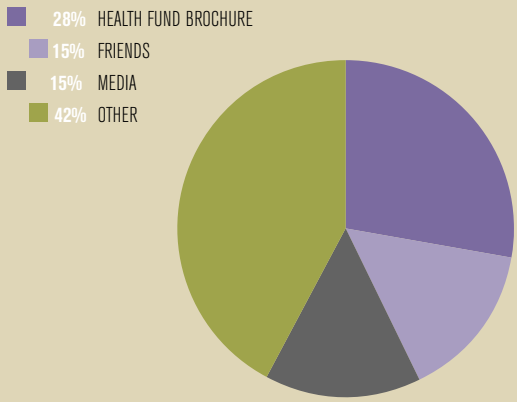
Because the Private Health Insurance Ombudsman was established primarily for the benefit of health fund members, it is important that they know about their right to approach the Ombudsman for assistance. The 2005 Client Satisfaction survey asked complainants to indicate how they found out about PHIO.

To further raise awareness of the service provided by the Ombudsman, the following strategies were employed during 2004/05:

- Details of the Ombudsman's services are referenced in various Government publications and in publications produced by other agencies and consumer bodies.
- Health funds provide information about the availability of the Ombudsman's services and contact details in brochures, publications and on some correspondence to fund members. These details are also included on health fund internet sites.
- The Ombudsman produces and distributes a range of brochures on health insurance issues.
- The Ombudsman participated in a number of radio and television interviews during the year. This year there was additional press and media coverage of the Ombudsman's role as part of reporting on the State of the Health Funds Report.
- The Ombudsman also contributed 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 written format and available on the PHIO website.
- The Ombudsman hosts an internet site where consumers can access a range of brochures, recent Ombudsman Quarterly Bulletins and Annual Reports. The site enables consumers to make inquiries, lodge complaints and request printed copies of brochures. 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 inquires can be made from anywhere in Australia on a free-call hotline, 1800 640 695. Complaints may be lodged by telephone, fax, e-mail or by post.

Figure 15 How did you find out about PHIO?



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 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 funds, hospitals and others who specifically request the printed version. The Bulletin is released simultaneously in electronic form on the PHIO website.

The Ombudsman sponsored a project, with the support of the Australian Health Insurance Association (AHIA) and the Health Insurance Restricted Membership Association of Australia (HIRMAA), to assess the effectiveness of complaints management within the Private Health Insurance industry. The project identified strengths and weaknesses of current processes and reported on improvement strategies that are relevant to the industry.

Kaylie Blyton, Dispute Resolution Officer

The Ombudsman maintains regular contact with health fund, hospital and consumer organisations. During the last year the Ombudsman gave presentations to seventeen industry conferences or meetings of industry associations.

The Ombudsman also provided comments and advice to health funds, consumer groups and other regulatory bodies on proposed consumer communication products on health insurance, on request.

CLIENT SURVEY

About the Survey

In July 2005, the office carried out a mail survey of a randomly selected 300 complainants who had lodged completed complaints during the period October 2004 to May 2005. 119 (40%) clients responded to the survey.

The aim of the survey was to gauge the degree to which PHIO was meeting its clients' needs and to identify any areas where improvements could be made. Regular consultation with clients through such surveys is an important element of the Federal Government's program of implementing and reporting on Service Charters for Commonwealth Government Departments and Statutory Authorities.

Maintaining Similar Levels of Client Satisfaction

Overall, 87% of clients indicated that they were satisfied with the office's overall handling of their complaint. This is the same result as the 2004 Annual Survey.

Last year's survey showed a significant improvement in client satisfaction; the 2005 survey indicated that the Ombudsman had either maintained these improvements or even improved on them in some areas.

In Summary;

- 98% of respondents indicated staff listened to their concerns; an increase from 92% last year.
- 91% of respondents said we explained what sort of assistance we can provide, this is an increase from 85% in 2004.
- 90% of respondents said that we were easy to understand, this is an increase from 87% in 2004.
- 87% of respondents said they were satisfied or mostly satisfied with the manner in which staff handled their complaint, this is an increase from 84% in 2004.
- 70% of respondents said that we had resolved their complaint or provided an adequate explanation; this was the same result as in 2004.
- 83% of respondents indicated that the Ombudsman was independent in dealing with their complaint, this is an increase from 79% in 2004.
- 83% of respondents said that they would use the Ombudsman's services again or recommend us to others, this is a decrease from 89% in 2004.
- 78% of respondents who had a case that lasted over 1-week indicated that they were happy with the time taken in resolving their complaint. This is an increase from 68% in 2004.

Figure 17 Are you satisfied with the manner in which staff handled your complaint?

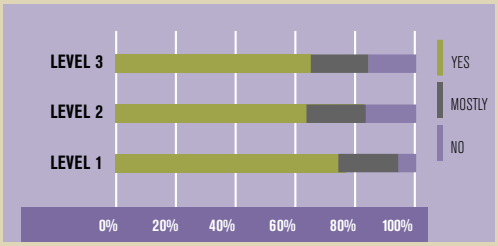
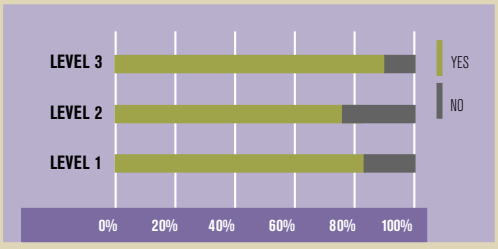


Figure 18 In your view, was the Ombudsman independent?



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 the compliance with established rules and laws. Some significant activities included:

- Membership of the Informed Financial Consent Taskforce – to advise the Minister on strategies to improve the incidence of genuine financial consent to in-hospital medical procedures;
- Work with the Australian Medical Association and Australian Society of Anaesthetists on development or review of policies and procedures for providing for informed financial consent.
- Comment on proposed legislation to establish new arrangements for funding the prostheses and medical devices used in private hospital treatment.
- Circulation of proposed guidelines on transitional measures and communication protocols when hospital/ health fund agreements are terminated.
- Providing statistics on complaint issues for inclusion in the ACCC's Report to the Senate on *Anti-competitive and other practices by health funds and providers in relation to private health insurance.*

The Ombudsman continued to support and contribute to the work of the Australasian Council of Health Care Complaints Commissioners.

statutory reporting information

CORPORATE GOVERNANCE

Hilary Bassingthwaighte, Senior DRO and Office Administrator.

Being a small office with duties specified by the National Health Act 1953, the business of the Ombudsman's office is well defined. In accomplishing the tasks envisaged under the Act, there is a need for procedures to be in place to monitor both performance and process, together with the appropriate management and staff policies.

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

MANAGEMENT OF HUMAN RESOURCES

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

The ability within a small organisation to accomplish these 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 to bring to the attention of the Ombudsman and the Director of Policy and Compliance, potential and actual issues, which require broader attention.

Dispute resolution staff need to be highly trained and sourced from such disciplines as Law, Commerce or Nursing. The activity of the office is very intense and staff retention as a consequence is a significant problem.

STAFF DETAILS

As at 30 June 2005, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman		1
Director, Policy & Compliance	1	
Projects and Research Officer		1
Senior Dispute Resolution Officer	1	
Dispute Resolution Officers	3	1
Administrative Assistant		1
Total	**5**	**4**

STATUTORY POSITIONS

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry Date
Mr J Powlay	Ombudsman	3 years	November 2005

Mr Powlay was appointed as Private Health Insurance Ombudsman in November 2002. The Ombudsman's remuneration is determined by the Remuneration Tribunal.

STAFF DEVELOPMENT AND TRAINING

During the 2004/05 financial year $12 060 was spent directly on PHIO staff attending training courses, conferences and seminars. During the financial year the Ombudsman continued its internal staff development and training program for dispute resolution staff.

In June and July 2005 the Ombudsman's Office conducted 2 complaints workshops for health fund complaints handling staff. These

workshops were partially funded by the Ombudsman's office costing $5158.

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

STAFF EMPLOYMENT STATUS

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

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

The following table shows the numbers and status of staff who were employed on 30 June 2005.

Occupational Group	Women	Men	Total Staff	NESB1
SES		1	1	
Other	5	3	8	1
Total	**5**	**4**	**9***	**1**

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

*Includes part time employees. Actual EFT = 8.5

This year the Ombudsman, in consultation with staff undertook a review of the terms and conditions for staff working in the Ombudsman's office. The review was undertaken with the assistance of a Human Resources consultant, Marana Consulting of Sydney. The review resulted in a more complete documentation of terms and conditions and revisions to provisions for probation, performance review, personal and maternity leave and for extending the hours of operation of the complaints hotline.

PERFORMANCE APPRAISAL

The Ombudsman has a performance appraisal system in place that is used to measure staff performance. This tool is used to assist the Ombudsman with general staff management and annual salary reviews. All staff are subject to 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's Audit Committee, which comprises PHIO staff, Hall Chadwick Accountants and the National Audit Office, held appropriate discussions during the financial year.

OUTCOMES AND OUTPUTS

The 2004/05 Portfolio Budget Statement indicates that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 8, *Choice Through Private Health.*

The Ombudsman provides regular advice and makes recommendations about the private health insurance industry. 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.

For 2005/06 the Private Health Insurance Ombudsman a separate agency outcome is specified for the Ombudsman's activities – Consumers and providers have confidence in the administration of private health insurance. From next year the Ombudsman will be reporting on achievements towards this outcome and a revised set of performance indicators.

CONSULTANTS ENGAGED

The Ombudsman continued to engage Complete GST Solutions as a consultant during the financial year to assume responsibility for regular in-house accounting functions. The office continues to engage specialised IT staff to assist with maintaining the complaints management and reporting system, and PT and A Health as a medical referee on cases requiring a detailed medical opinion. Both of these latter consultants are engaged on an ad-hoc basis.

During the 2004/05 year the Ombudsman also engaged Listening Post Pty Ltd to facilitate a review of complaints management within the Health Insurance industry, analyse the results of the review and prepare individual fund and industry wide reports. The Australian Health Insurance Association and The Health Insurance Restricted Membership Association of Australia contributed to the cost of this consultancy.

Neill Buck & Associates (booked through SAI Global) were engaged to conduct sessions at the Ombudsman's complaints handling workshops in June and July 2005.

Hall & Chadwick (accountants) and Banki Haddock Fiori (lawyers) were consulted during the year by the Ombudsman.

Marana Consulting Group Limited were engaged to assist in updating the Ombudsman's staff terms and conditions.

INFORMATION SYSTEMS

The Ombudsman's information system is based upon a Windows 2000 Network Server and the Microsoft Office 2000 suite. Accounting software used is *Mind Your Own Business (MYOB) Accounting and Asset Manager.* Additionally, the Ombudsman has a purpose built *Complaints Management and Reporting* system on-site. The Ombudsman's Internet network and network security is maintained by Alpha Dot Net.

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.

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. It was

updated in early 2005 and issued under the office's "About Our Service" brochure.

OCCUPATIONAL HEALTH AND SAFETY

Responsibility for the safety and health of all staff rests with the Ombudsman, who is required to be aware of all dangers to health and safety in the workplace. The Director, Policy and Compliance is the Ombudsman's First Aid and *Occupational Health and Safety Officer.*

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

No reportable incidents occurred during the year.

EQUAL EMPLOYMENT OPPORTUNITY

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

freedom of information statement

This statement is published to meet the requirements of Section 8 of the *Freedom of Information Act 1982* (FOI Act). It is correct as at 30 June 2005.

ESTABLISHMENT

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

PUBLIC INFORMATION

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

REQUESTS

The Ombudsman received many requests for information about its activities during the reporting year, but no requests were received for information under the FOI Act during the reporting period.

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

DOCUMENTS HELD BY THE OMBUDSMAN

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

- A series of consumer brochures produced by the Office
- A booklet and brochure "Private Patients' Hospital Charter"
- Complaints Register and Complaints files
- 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 booklet and brochure "Private Patients' Hospital Charter"
- "The State of The Health Funds Report"
- State & Territory Summaries of "The State of the Health Funds Report" – titled "Consumer Guide"

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.)

FREEDOM OF INFORMATION STATEMENT

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

Requests under the FOI Act should be made in writing and accompanied by a $30.00 application fee, as required by the Act, and directed to:

Director, Policy and Compliance
Private Health Insurance Ombudsman
Level 7
362 Kent Street
SYDNEY NSW 2000

Initial enquires about access to documents may be made in person or by telephone. The office is open for business between 9.00 am and 5.00 pm on weekdays.

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 Commonwealth Government agencies, the Ombudsman introduced a Service Charter in June 1998 which was reviewed in 2005.

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

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 AUDIT REPORT

To the Minister for Health and Ageing

Scope

The financial statements and Ombudsman's responsibility

The financial statements comprise:

- Statement by Ombudsman;
- Statements of Financial Performance, Financial Position and Cash Flows;
- Schedules of Commitments and Contingencies; and
- Notes to and forming part of the Financial Statements

of the Private Health Insurance Ombudsman for the year ended 30 June 2005.

The Ombudsman is responsible for preparing the financial statements that give a true and fair view of the financial position and performance of the Private Health Insurance Ombudsman and that comply with Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997,* accounting standards and other mandatory financial reporting requirements in Australia. The Ombudsman is also responsible for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial statements.

Audit approach

I have conducted an independent audit of the financial statements in order to express an opinion on them to you. My audit has been conducted in accordance with Australian National Audit Office Auditing Standards, which incorporate Australian Auditing and Assurance Standards, in order to provide reasonable assurance as to whether the financial statements are free of material misstatement. The nature of an audit is influenced by factors such as the use of professional judgement, selective testing, the inherent limitations of internal control, and the availability of persuasive, rather than conclusive, evidence. Therefore, an audit cannot guarantee that all material misstatements have been detected.

While the effectiveness of management's internal controls over financial reporting was considered when determining the nature and extent of audit procedures, the audit was not designed to provide assurance on internal controls.

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

I have performed procedures to assess whether, in all material respects, the financial statements present fairly, in accordance with Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, including accounting standards and other mandatory financial reporting requirements in Australia, a view which is consistent with my understanding of the Private Health Insurance Ombudsman's financial position, and of its performance as represented by the statements of financial performance and cash flows.

The audit opinion is formed on the basis of these procedures, which included:

- examining, on a test basis, information to provide evidence supporting the amounts and disclosures in the financial statements; and
- assessing the appropriateness of the accounting policies and disclosures used, and the reasonableness of significant accounting estimates made by the Ombudsman.

Independence

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

Audit 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 *Commonwealth Authorities and Companies Act 1997;* and

(b) give a true and fair view of the Private Health Insurance Ombudsman's financial position as at 30 June 2005 and of its performance and cash flows for the year then ended, in accordance with:

  (i) the matters required by the Finance Minister's Orders; and
  (ii) applicable accounting standards and other mandatory financial reporting requirements in Australia.

Australian National Audit Office

P Hinchey
Senior Director

Delegate of the Auditor-General
Sydney
15 September 2005

PRIVATE HEALTH INSURANCE OMBUDSMAN
STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2005 have been prepared 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 *Commonwealth Authorities and Companies Act 1997.*

In my opinion, at the date of this statement, there are reasonable grounds to believe that the Private Health Insurance Ombudsman will be able to pay its debts as and when they become due and payable.

Signed.....
John Powlay
Ombudsman

14 September 2005

PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 2005

	Note	2005 $	2004 $
REVENUE			
Revenues from ordinary activities			
Revenue from Government	**3A**	**1,165,000**	965,000
Interest	**4A**	**33,485**	26,477
Other	**4B**	**14,049**	23,910
Revenue from sale of assets	**4C**	**404**	600
Revenues from ordinary activities		**1,212,938**	1,015,988
Expenses from ordinary activities			
Suppliers	**5A**	**308,168**	326,875
Employees	**5B**	**695,285**	611,958
Depreciation and amortisation	**5C**	**24,438**	20,196
Write down of assets	**5D**	**93**	3,680
Expenses from ordinary activities		**1,027,984**	962,709
Operating surplus from ordinary activities		**184,954**	53,277
Net credit (debit) to asset revaluation reserve		**(4,299)**	-
Total revenues, expenses and valuation adjustments recognised directly in equity		**(4,299)**	-
Total changes in equity other than those resulting from transactions with the Australian Government as owner		**180,655**	53,277

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

PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF FINANCIAL POSITION

As at 30 June 2005

	Note	2005 $	2004 $
ASSETS			
Financial assets			
Cash	**6A**	**140,443**	98,466
Other Investments	**6B**	**500,000**	300,000
Receivables		**-**	6,460
Total financial assets		**640,443**	404,926
Non-financial assets			
Infrastructure, plant & equipment	**7A,B,D,E**	**59,636**	69,040
Intangibles	**7C**	**-**	740
Prepayments	**7F**	**-**	4,105
Total non-financial assets		**59,636**	73,885
Total assets		**700,079**	**478,811**
LIABILITIES			
Payables			
Suppliers	**8A**	**20,512**	9,645
Total payables		**20,512**	9,645
Provisions			
Employees	**8B**	**175,350**	145,603
Total provisions		**175,350**	145,603
Total liabilities		**195,862**	155,248
EQUITY			
Reserves	**9**	**-**	4,299
Accumulated surplus	**9**	**504,217**	**319,264**
Total equity		**504,217**	323,563
Current liabilities		**76,760**	50,043
Non-current liabilities		**119,102**	105,205
Current Assets		**640,443**	409,031
Non-current assets		**59,636**	69,780

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

PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF CASH FLOWS

For the year ended 30 June 2005

	Note	2005 $	2004 $
OPERATING ACTIVITIES			
Cash Received			
Appropriations		**1,165,00**	965,000
Interest		**33,485**	26,477
Other		**14,453**	18,052
Total cash received		**1,212,938**	1,009,529
Cash Used			
Suppliers		**(286,830)**	(348,100)
Employees		**(665,539)**	(622,650)
Total cash used		**(952,369)**	(970,750)
Net cash from operating activities	**15**	**260,569**	38,779
INVESTING ACTIVITIES			
Cash used			
Purchase of investment		**(200,000)**	-
Purchase of property, plant and equipment		**(18,592)**	(58,010)
Total cash used		**(218,592)**	(58,010)
Net cash used by investing activities		**(218,592)**	(58,010)
Net increase/(decrease) in cash held		**41,977**	(19,231)
Cash at the beginning of the reporting period		**98,466**	117,697
Cash at the end of the reporting period	**6A**	**140,443**	98,467

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

PRIVATE HEALTH INSURANCE OMBUDSMAN SCHEDULE OF COMMITMENTS

As at 30 June 2005

	2005 $	2004 $
BY TYPE		
Other commitments		
Operating Leases	**101,060**	165,194
Total other commitments	**101,060**	165,194
Commitments receivable	**(9,187)**	(15,017)
Net commitments	**91,873**	150,177
BY MATURITY		
Operating lease commitments		
One year or less	**60,636**	58,304
From one to five years	**40,424**	106,890
	101,060	165,194
Commitments receivable	**(9,187)**	(15,017)
Net commitments	**91,873**	150,177

The lease is for office accommodation and is subject to annual increase of 4%.
The lease is current for 1 years with an option to renew for a further 3 years.

PRIVATE HEALTH INSURANCE OMBUDSMAN SCHEDULE OF CONTINGENCIES

As at 30 June 2005

There were no contingent losses or gains as at 30 June 2005.

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

PRIVATE HEALTH INSURANCE OMBUDSMAN NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the year ended 30 June 2005

PRIVATE HEALTH INSURANCE OMBUDSMAN NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the year ended 30 June 2005

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Basis of Accounting

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

The statements have been prepared in accordance with:

- Finance Minister's Orders (being the *Commonwealth Authorities and Companies (Financial Statements for reporting periods ending on or after 30 June 2005));*
- Australian Accounting Standards and Accounting Interpretations issued by the Australian Accounting Standards Board; and
- Urgent Issues Group Abstracts.

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

Assets and liabilities are recognised in the Statement of Financial Position when and only when it is probable that future economic benefits will flow and the amounts of the assets or liabilities can be reliably measured. Assets and liabilities arising under agreements equally proportionately unperformed are however 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.

Revenues and expenses are recognised in the Statement of Financial Performance when and only when the flow or consumption or loss of economic benefits has occurred and can be reliably measured.

1.2 Changes in Accounting Policy

The accounting policies used in the preparation of these financial statements are consistent with those used in 2003-04.

1.3 Revenue

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

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

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

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

1.4 Employee Entitlements

Benefits

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

Liabilities for wages and salaries (including non-monetary benefits) and annual leave, are measured at their nominal amounts. Other employee benefits expected settled within 12 months of their reporting date are also measured at their nominal amounts.

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

All other employee benefit liabilities are measured as 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, including the employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

Superannuation

Employees of the Ombudsman are members of the Commonwealth Superannuation Scheme and the Public Sector Superannuation Scheme. The liability for their Superannuation benefits is recognised in the financial statements of the Commonwealth and is settled by the Commonwealth in due course.

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

1.5 Leases

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

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

The Ombudsman has no finance leases.

1.6 Cash

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

1.7 Financial Instruments

Accounting policies for financial instruments are stated at Note 16.

1.8 Property, Plant and Equipment

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the Statement of Financial Position, except for purchases costing less than $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

Buildings, infrastructure, plant and equipment are carried at valuation.

Frequency

Infrastructure, plant and equipment assets were previously revalued progressively in successive three-year cycles, so that no asset has a value greater than three years old.

The Finance Minister's Orders require that all property, plant and equipment assets be measured at up-to-date fair values from 30 June 2005 onwards..

In the move to adopt the Australian Equivalents to International Financial Reporting Standards, the Council has revalued all its assets at 30th June 2005, with all asset groups being valued at fair value.

Depreciation and Amortisation

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

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

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

	2005	2004
Leasehold improvements	**Lease term**	Lease term
Plant and equipment	**4 to 9 years**	3 to 7 years

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 5C.

1.9 Intangibles

The Ombudsmans's intangibles comprise internally-developed software for internal use. The asset is carried at cost.

All software assets were assessed for impairment as at 30 June 2005. None were found to be impaired.

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

	2005	2004
Useful lives are: Internally developed software	**7 years**	7 years

1.10 Taxation

The Ombudsman is exempt from all forms of taxation except fringe benefits tax and the goods and services tax.

1.11 Insurance

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

1.12 Comparative Figures

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

Note 2: Adoption of Australian Equivalents to International Financial Reporting Standards from 2005-2006

The Australian Accounting Standards Board has issued replacement Australian Accounting Standards to apply from 2005-06. The new standards are the Australian Equivalents to International Financial Reporting Standards (AIFRS).
The International Financial Reporting Standards (IFRS) are issued by the International Accounting Standards Board. The new standards cannot be adopted early.

The Australian Equivalents contain certain additional provisions which will apply to not-for-profit entities, including PHIO. Some of these provisions are in conflict with the IFRS's and therefore PHIO will only be able to assert compliance with the AIFRSs.

Management of the transition to Australian Equivalents to International Financial Reporting Standards

PHIO has taken the following steps for the preparation towards the implementation of AIFRS:

(i) Identification of all major accounting policy differences between current Australian standards and the AIFRS progressively to 30 June 2004.

(ii) Identification of system changes necessary to be able to report under the AIFRS, including those necessary to enable capture of data under both sets of rules for 2004-05, and the testing and implementation of those changes

(iii) A Transitional balance sheet as at 1 July 2004 under AIFRS was completed.

(iv) An AIFRS compliant balance sheet was also prepared during the preparation of the 2004-05 statutory financial reports.

No significant accounting and disclosure differences have been identified.

	2005 $	2004 $
3 OPERATING REVENUES		
3A Revenues from Government		
Appropriation for outputs	**1,165,000**	965,000
Total revenue from government	**1,165,000**	965,000
4 REVENUES FROM INDEPENDENT SOURCES		
4A Interest revenue		
Interest on Deposits	**33,485**	26,477
Total Interest revenue	**33,485**	26,477
4B Other Revenue		
Seminar Income	**7,230**	23,000
Other	**6,819**	910
Total Other revenue	**14,049**	23,910
4C Net gain from Sale of Assets		
Property Plant and Equipment:		
Proceeds from disposal	**404**	600
Net book value at sale	**-**	-
Net gain from disposal of property, plant & equipment	**404**	600
4 OPERATING EXPENSES		
5A Suppliers expenses		
Supply of Goods and Services - all external	**251,561**	227,666
Operating Lease Rentals	**56,607**	99,209
Total suppliers expenses	**308,168**	326,875
5B Employee expenses		
Wages and Salaries	**534,027**	499,592
Superannuation	**97,602**	90,941
Leave and other entitlements	**60,274**	18,706
Other employee expenses	**3,382**	2,719
Total employee expenses	**695,285**	611,958
5C Depreciation and Amortisation		
Depreciation of property, plant and equipment	**24,438**	19,627
Amortisation - Lease Fitout	**-**	569
Total depreciation and amortisation expense	**24,438**	20,196
5D Write-Down of Assets		
Plant & equipment written down	**93**	3,680
Total Write-Down of Assets	**93**	3,680

	2005 $	2004 $
6 FINANCIAL ASSETS		
6A Cash		
Cash at Bank and on Hand	**140,443**	98,466
Total cash	**140,443**	98,466
6B Investments		
Term Deposits	**500,000**	300,000
Total Investments	**500,000**	300,000
7 NON FINANCIAL ASSETS		
7A Buildings		
Lease Fitout at Cost	**-**	5,531
Accumulated Amortisation	**-**	(194)
Leasehold Fitout at valuation	**4,915**	-
Accumulated Amortisation	**(561)**	-
Total Building	**4,354**	5,337
7B Infrastructure, Plant and Equipment		
Plant and Equipment		
at cost	-	61,476
Accumulated depreciation	**-**	(5,454)
	-	56,022
at 2002 valuation	**-**	32,238
Accumulated depreciation	**-**	(24,557)
	-	7,681
at 2005 valuation (fair value)	**55,282**	-
Accumulated depreciation	**-**	-
Total Infrastructure, Plant and Equipment	**55,282**	63,703
7C Intangibles - at cost	**17,412**	17,412
Accumulated depreciation	**(17,412)**	(16,672)
Total intangibles	**-**	740

7D Analysis of Property, Plant, Equipment and Intangibles

Item	Leasehold Improvements $	Plant & Equipment $	Intangibles $	Total $
As at 1 July 2004				
Gross Book Value	5,531	93,714	17,412	116,657
Accumulated Depreciation/amortisation	(194)	(30,011)	(16,672)	(46,877)
Net Book Value	**5,337**	**63,703**	**740**	**69,780**
Addition by purchase	-	18,593	-	18,593
Net revaluation increment/decrement	(100)	(4,199)	-	(4,299)
Depreciation/amortisation expense	(883)	(22,815)	(740)	(24,438)
As at 30 June 2005				
Gross Book Value	4,915	55,282	17,412	77,609
Accumulated Depreciation/amortisation	(561)	0	(17,412)	(17,973)
Net Book Value	**4,354**	**55,282**	**-**	**59,636**

7E Assets At Valuation

	Leasehold $	Plant & equip. $
As at 30 June 2005		
Gross Value	4,915	55,282
Accumulated depreciation/amortisation	(561)	-
Net Book Value	4,354	55,282
As at 30 June 2004		
Gross Value	-	32,238
Accumulated depreciation/amortisation	-	(24,557)
Net Book Value	-	7,681

	2005 $	2004 $
7F Other Non-Financial Assets		
Prepayments - current	-	4,105
Total non-financial assets	-	4,105

8 PROVISIONS AND PAYABLES

8A Supplier Payables		
Trade creditors - current	**16,226**	4,745
Accruals - current	**4,286**	4,900
Total supplier payables	**20,512**	9,645
8B Employee Provisions		
Salaries and Wages	**2,133**	575
Annual Leave	**54,115**	39,823
Long Service Leave	**119,102**	105,205
Aggregate Employee Benefit Liability	**175,350**	145,603
Current	**56,248**	40,398
Non-Current	**119,102**	105,205

NOTE 9: EQUITY

9A Analysis of Equity

Item	Accumulated Results		Asset Revaluation Reserve		Total	
	2005 $	2004 $	2005 $	2004 $	2005 $	2004 $
Opening balance at 1 July	319,263	265,986	4,299	4,299	323,562	270,285
Net surplus	184,954	53,277		-	184,954	53,277
Net revaluation (decrement)			(4,299)	-	(4,299)	-
Closing balance at 30 June 2005	**504,217**	**319,263**	**-**	**4,299**	**504,217**	**323,562**

	2005 $	2004 $

10 REMUNERATION OF OFFICERS

The number of officers who received or were due to receive total remuneration of $100,000 or more:	**Number**	Number
$170,000 - $179,999	**-**	1
$180,000 - $189,999	**1**	-
TOTAL	**1**	1
The aggregate amount of total remuneration of officers shown above.	**183,018**	178,710

11 REMUNERATION OF AUDITORS

Remuneration to the Auditor-General for Auditing the Financial Statements	**6,000**	5,000

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

12 SUPERANNUATION

The Ombudsman's office contributes to the Commonwealth Superannuation (CSS) and the Public Sector (PSS) superannuation schemes which provide retirement, death and disability benefits to employees. Contributions to the scheme are at rates calculated to cover existing and emerging obligations. Current contribution rates are 25.3% of salary (CSS) and 12.4% of salary (PSS). An additional amount of up to 3% is contributed for employer productivity benefits. Casual staff can choose to be a member of any approved superannuation fund and receive employer benefits at the Superannuation Guarantee Charge rate, currently 9%.

13 ECONOMIC DEPENDENCY

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

14 SEGMENT REPORTING

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

	2005 $	2004 $
15 CASH FLOW RECONCILIATION		
Reconciliation of operating surplus to net cash from operating activities:		
Operating Surplus	**184,954**	53,277
Non-cash items		
Depreciation and amortisation	**24,438**	20,196
Net write down of non-financial assets	**93**	3,680
Changes in Assets and Liabilities		
(Increase)/decrease in Other Debtors	**6,460**	(6,460)
Increase/(decrease) in Suppliers	**10,772**	(16,765)
(Increase)/decrease in Other Prepayment	**4,105**	(4,105)
Increase/(decrease) in employee provisions	**29,747**	(11,045)
Net Cash provided by operating activities	**260,569**	38,779

16 FINANCIAL INSTRUMENTS

a) Terms, Conditions and accounting policies

Financial Instruments	Accounting Policies and methods (including recognition criteria and measurement basis)	Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows)
Financial Assets	Financial assets are recognised when control over future economic benefits is established and the amount of the benefits can be reliably measured.	
Other Debtors	These receivables are recognised at the nominal amounts due less any provision for bad and doubtful debts. Provisions are made when collection of the debt is judged to be less rather than more likely.	Credit terms are net 14 days (2003-04: 14 days)
Financial Liabilities	Financial Liabilities are recognised when a present obligation to another party is entered into and the amount of the liability can be reliably measured.	
Trade Creditors	Creditors and accruals are recognised at their nominal amounts, being the amounts at which the liabilities will be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of being invoiced).	Settlement is usually made net 30 days.

b) Interest rate risk

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

Financial Instruments	Notes	Floating Interest Rate		Non-Interest Bearing		Total		Weighted Average Effective Interest Rate	
		2005 $	2004 $	**2005 $**	2004 $	**2005 $**	2004 $	**2005 %**	2004 %
Financial Assets									
Cash	6A	**140,443**	98,466	**-**	-	**140,443**	98,466	**4.95**	4.65
Investments	6B	**500,000**	300,000	**-**	-	**500,000**	300,000	**5.25**	4.95
Receivables		**-**	-	**-**	6,460	**0**	6,460	**n/a**	n/a
Total		**640,443**	398,466	**-**	6,460	**640,443**	404,926		
Total Assets						**700,079**	478,811		
Financial Liabilities									
Trade & other Creditors	8A	**-**	-	**20,512**	9,645	**20,512**	9,645	**n/a**	n/a
Total		**-**	-	**20,512**	9,645	**20,512**	9,645	**n/a**	n/a
Total Liabilities						**195,862**	155,248		

c) Credit Risk

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

The Ombudsman has no significant concentration of credit risk.

d) Net Fair Values

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

17 APPROPRIATIONS

Particulars	Department Outputs	
	2005	2004
	$	$
Year ended 30 June 2004		
Balance carried forward from previous year	**-**	-
Appropriation Acts 1 and 3	**1,165,000**	965,000
Available for payment of CRF	**1,165,000**	965,000
Payments made out of CRF	**1,165,000**	965,000
Balance carried forward to next year	**-**	-

18 STAFFING LEVELS

	2005	2004
The average staffing levels for the Authority during the year were:	**9**	9

19 REPORTING OF OUTCOMES

The Ombudsman is structured to meet one outcome, namely Choice Through Private Health.

Two output groups support the outcome:
Output 1: To provide advice and recommendations about the Private Health Services Industry.
Output 2: To facilitate direct delivery of services.

19A NET COST OF OUTCOME DELIVERY

	Outcome 1	
	2005	2004
Departmental expenses	1,027,984	962,710
Total expenses	**1,027,984**	**962,710**
Other external revenues		
Interest	33,485	26,477
Other	14,049	23,910
Revenue from sale of assets	404	600
Total other external revenues	**47,938**	**50,988**
Net cost of outcome	**980,046**	**911,722**

19B DEPARTMENTAL REVENUES AND EXPENSES BY OUTPUT GROUPS AND OUTPUTS

PHIO's revenues, expenses, assets and liabilities are attributable to two outputs.

	OUTCOME 1				TOTAL	
	Output 1		Output 2			
	2005	2004	**2005**	2004	**2005**	2004
	$	$	**$**	$	**$**	$
Operating Expenses						
Employees	**141,625**	124,877	**553,405**	487,081	**695,285**	611,958
Suppliers	**62,885**	66,703	**245,283**	260,172	**308,168**	326,876
Depreciation and amortisation	**4,887**	4,121	**19,551**	16,075	**24,438**	20,196
Write-down of assets	**19**	751	**74**	2,929	**93**	3,680
Total operating expenses	**209,416**	196,452	**818,312**	766,256	**1,027,984**	962,709
Funded by:						
Revenues from Government	**237,731**	196,919	**927,269**	768,081	**1,165,000**	965,000
Interest	**6,833**	5,403	**26,652**	21,074	**33,485**	26,477
Other	**2,867**	4,879	**11,181**	19,031	**14,049**	23,910
Revenue from sale of assets	**82**	122	**323**	478	**404**	600
Total operating revenues	**247,513**	207,324	**965,425**	808,664	**1,212,938**	1,015,988

index