Australian Government

Private Health Insurance Ombudsman

Protecting the interests of people covered by private health insurance

ANNUAL REPORT 2008

Contact Details

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STREET AND POSTAL ADDRESS

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TELEPHONE, FAX AND E-MAIL

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

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

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

E-mail info@phio.org.au
Internet http://www.phio.org.au
Administration (02) 8235 8777
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FREECALL TELEPHONE HOURS OF OPERATION

9.00 am – 5.00 pm (Sydney time)
Monday – Friday

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

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

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Australian Government
Private Health Insurance Ombudsman

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

Dear Minister

Section 253-50 of the *Private Health Insurance Act 2007* requires me to provide a report of the Ombudsman's operations for each financial year.

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2007 to 30 June 2008.

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

Yours sincerely

Samantha Gavel

Samantha Gavel
Ombudsman
17 September 2008

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Ombudsman's Overview

Ombudsman's Overview

The *Private Health Insurance Act 2007* makes it clear that focus of the Private Health Insurance Ombudsman's activities is on protecting consumers' interests in relation to private health insurance. We carry out this role through our independent complaint handling service, producing the annual "State of the Health Funds Report" and other publications, the management of the consumer website www.privatehealth.gov.au and advice and recommendations to Government and industry.

Key activities and challenges for the office during the 2007-08 year have included the first year of operation of the *Private Health Insurance Act* and the consumer website, www.privatehealth.gov.au, as well as new corporate governance arrangements for the office. These are discussed in greater detail below.

Samantha Gavel – Ombudsman

Complaints

The Ombudsman received 2385 complaints in 2007-08, which was slightly more than the 2340 complaints received in 2006-07. The small increase in complaint levels occurred in the early part of 2008 and related to a number of issues that arose at that time, including fund rule changes and complaints relating to demutualisation issues and associated share and cash allocations.

There was a decline in the number of higher level (Level-3) complaints investigated by the Ombudsman during 2007-08. This was a reversal of the trend towards the office receiving higher numbers of more difficult complaints in recent years.

The Ombudsman was able to assist consumers to achieve a more satisfactory outcome to their complaint in around half of the higher level complaints that we investigated, and by providing a more detailed explanation to the member in the other half.

Complaints to the PHIO continue to be an important pointer to systemic problems within a particular fund or the industry generally. A notable increase occurred during the reporting period in complaints about service issues. Complaints in this category generally point to underlying problems in the fund's call centre and internal complaints handling processes.

Where complaints to the PHIO reveal particular problems within a fund or the industry more broadly, the office will take them up with the fund(s) in order to resolve the issues for consumers. The PHIO is also able to provide advice and recommendations to Government in relation to systemic issues across the industry.

Private Health Insurance Act 2007

It is now over a year since the *Private Health Insurance Act 2007* came into effect. The Act introduced a number of important reforms for consumers, including the legislative framework for broader health cover, and measures to provide better information to consumers about private health insurance.

The Ombudsman worked with the Department of Health and Ageing, consumers and the industry to monitor the impact of the new

legislation and provide advice and input into resolving the issues that arose. There were a number of areas that required clarification and amendment during the reporting period.

Funds were required to ensure their policies and rules were compliant with the Act by 1 July 2008. In some instances, this meant that funds had to remove benefits from some of their policies to ensure compliance with the Act.

This led to a number of complaints from consumers about the removal of benefits from their policies. In some cases, funds wrote to members advising that a number of benefits had been removed as a result of legislative changes.

While this was correct in some cases, investigation by the PHIO concluded that in others, the benefits being removed were still allowable under the new Act, or could have been retained if changes had been made to the policy to ensure compliance with the Act. In these cases, the information given to consumers about the reasons for the removal of benefits was not always accurate. Where the PHIO became aware of incorrect information being given to members, the funds were requested to provide clarification to members.

It was notable that the approach taken by individual funds determined the level of complaint by their members to the PHIO. Several funds consulted with the PHIO prior to introducing changes and carefully considered the impact of the changes on their members. They recognised that introducing detrimental changes, even though necessary to comply with the Act, could be a source of grievance to their members. In these cases, they substituted benefits for those being taken away and provided good information and lead times to their members. In these cases, there were no complaints to the office.

In one case, although the fund did take a more consumer focussed approach in removing a benefit, the popular nature of the benefit did mean there were complaints to the office and questions about the reason for its removal. In this instance, however, the fund responded quickly to request from the PHIO for the information to be corrected and the issue was quickly concluded.

In another case, the fund removed a popular benefit, citing the legislation as a reason. A number of aggrieved members questioned whether this information was correct. Investigation by the PHIO concluded the benefit was not incompatible with the Act.

In this instance, the fund did not move to resolve the matter and complainants remained highly aggrieved about the actions of the fund. This was unfortunate, because a more consumer focussed approach would have prevented this outcome.

The Act also provided the legislative framework for the introduction of broader health cover, which enables health insurers to cover hospital substitute, preventative health and chronic disease management programs. To date, the introduction of broader health initiatives has proceeded relatively slowly.

Some funds have been waiting for the Accreditation Rules under the Act to be finalised before implementing new programs. At the time of printing, these are now in effect and it is hoped they will give added impetus to funds to proceed with initiatives for their members in these areas.

Some thirty-three of the thirty-eight health funds had introduced broader health initiatives at the time of going to print. Figures reported by the industry regulator, the Private Health Insurance Administration Council (PHIAC) also reflected growth in payment of benefits in this area.

The Act also clarified that the waiting period for psychiatric, palliative care and rehabilitation treatment is two months. There were a small number of complaints to the office about insurers applying a longer waiting period.

These were quickly resolved in all cases. The PHIO will continue to monitor this issue to ensure consumers are not disadvantaged by insurers applying incorrect waiting periods to these services.

Consumer Website and Standard Information Statements

The PHIO is responsible for managing the www.privatehealth.gov.au website, which went "live" in April 2007. The website provides consumers with independent, reliable information about private health insurance. This includes a one page standard information statement for each health insurance policy sold by each of the thirty-eight funds. These Standard Information Statements (SISs) show the main features of each health insurance policy, including excesses, co-payments and benefit restrictions. They enable consumers to visit the website and download the SIS for their current policy, or compare SISs for policies they may be interested in purchasing.

Complaints to the PHIO and consumer focus testing confirm that private health insurance and the health system in general can be complex areas for consumers to navigate. It is therefore important for consumers to have access to independent information to assist them in making decisions about their private health insurance, so that they can choose policies that meet their individual needs.

Since the website's launch, the response from consumers and indeed the industry has generally been very positive.

The website received an award for the "Best Comparison Website" in March 2008. This was an unsolicited award, voted for by readers of "NetGuide" magazine, as well as an assessment of the technical aspects of the website including design, ease of navigation and presentation.

The website faced its biggest challenge yet on 1 April 2008, with the upload of new Standard Information Statements to replace those from the previous year. The process proceeded relatively smoothly, with some 16,000 Standard Information Statements replaced during the day.

The office will be undertaking a major review of the website in 2008/09. We will also be looking at more extensive marketing of its services. It is a source of independent information for consumers about health insurance and policies for all health insurers. It is therefore important that consumers are aware of its existence when they are searching for information about private health insurance on the internet.

This is particularly important given that a number of commercial website comparison sites for private health insurance were launched during the reporting period. As noted above, private health insurance is a complex area for consumers and these sites can assist them in making decisions about their health insurance.

It is of concern, however, that not all commercial sites are transparent about how they reach their recommendations on what policies to buy and any commercial arrangements they may have with industry. One site gives higher ratings to policies with restrictions, on the basis that they offer "value for money". Complaints to the PHIO show that policies with restrictions on certain procedures can cause problems for consumers if they need that procedure and find they are not covered.

The PHIO's advice to consumers is to take out the most comprehensive level of hospital cover they can afford and consider taking a higher level of excess, rather than a restriction on the policy.

Industry Developments

During the reporting period, NIB Health Funds converted to "for profit" status and was listed on the stock exchange, following a strong vote in favour of listing by its members. Members of MBF Australia also voted strongly in favour of a merger proposal with BUPA Australia and the

fund was converted to "for profit" status in June 2008.

The PHIO received a number of complaints from members of both NIB and MBF regarding the NIB share allocation and the MBF's cash allocation.

Issues relating to fund ownership and corporate structures are not strictly private health insurance arrangements. The PHIO's role is to protect consumers' interests regardless of the fund's ownership and corporate structure. There are significant consumer protections in the legislation, including community rating, legislated waiting periods and portability rights and the requirement for rigorous scrutiny of premium increases. All funds must comply with these, regardless of their ownership and corporate structure. In addition, all funds must manage the premium income they receive from their members in line with the prudential requirements overseen by the industry regulator, PHIAC.

In the case of both NIB and MBF, there were a number of processes and authorisations that had to be completed, followed by a vote of the membership, before any changes took place and share and cash allocations could be made. In voting for each proposal, the members of each fund were also voting for the proposed scheme for the allocation of shares (NIB) and cash (MBF).

In both cases, there were review processes available to members who believed their allocation was incorrect. These had strict guidelines and once the review had been completed, there were no other avenues available to members who were still unhappy with their allocation.

The PHIO was able to record complaints and assist members in seeking a review of their allocation. Members who were unsuccessful in having their allocation increased through the review process were, however, aggrieved that the PHIO was not able to assist them in appealing the matter further. Complaints about this issue will be analysed and information provided to stakeholders to inform decisions about any similar offers that may be are made to members in future.

Corporate Governance

PHIO became a prescribed statutory agency under the *Financial Management and Accountability Act 1997* on 1 July 2007. At the same time, all staff became Commonwealth employees under the *Public Service Act 1999*. All governance and reporting requirements under both of these Acts were met during the reporting period. As part of the change in the office's corporate governance arrangements, a dedicated Financial Officer was employed and Mr Neill Buck was appointed as the independent Chair of the PHIO Audit Committee from 1 December 2007.

The Year Ahead

The office has a number of priorities for 2008/09, including a review of the www.privatehealth.gov.au website; a focus on improving the office's corporate planning and public communication strategies; and ensuring our complaints handling service continues to meet best practice and the needs and expectations of consumers.

Role and Function

Introduction

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

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

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

Who can make a complaint?

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

Persons against whom a complaint may be made

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

What can the Ombudsman do with a complaint?

The Ombudsman is able to deal with complaints by:

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

The Ombudsman is also able to investigate the practices and procedures of health insurers, health care providers and health insurance brokers and the Minister is able to request the Ombudsman to undertake such an investigation.

What happens at the end of a complaint or investigation?

The Ombudsman is able to recommend that:

- Health insurers, health care providers and health insurance brokers take a specific course of action in relation to a complaint; and

PHIO Staff (left to right) – Richard Van Der Male, Alison Leung, Joanna Wong, David McGregor, Samantha Gavel, Ursula Schappi, Hilary Bassingthwaighte, Kaylie Blyton, Tanya Snowden

- A health insurer changes its rules or practices.

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

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

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

How the Ombudsman's staff resolve complaints

The Ombudsman deals with most complaints by telephone, fax and e-mail. Where complainants have not made a sufficient attempt to resolve their complaint with their health insurer or provider, staff will usually refer complainants back to these parties in the first instance. Staff will often refer the complaint themselves in order to provide a faster and more convenient service to the complainant.

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

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

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

Output performance measures

The 2007/2008 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 2007/2008.

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

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

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

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

Quality indicator: Efficient complaints handling service.
Measurement: Complaints received during the year finalised.
Performance result: 94% complaints received during the year finalised.

Quantity indicator: Accessible, effective and timely complaints handling service.
Measurement: Consumer satisfaction survey.
Performance result: 78% respondents satisfied or very satisfied.

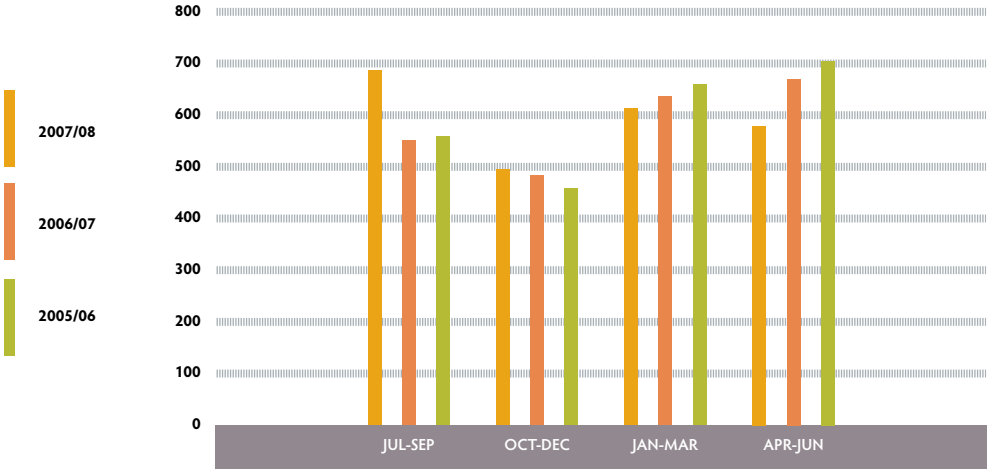
Quantity indicator: Improved fund or industry practices as a result of PHIO investigation recommendations.
Measurement: Proportion of recommendations that have resulted in changes to fund or industry practices.
Performance result: There were no formal recommendations to change fund or industry practices during the reporting period.

Quantity indicator: Information products produced are useful and informative for consumers.
Measurement:. Client satisfaction survey
Performance result: 87% respondents found PHIO written information easy to understand.

Quantity indicator: Timeliness of complaint resolution.
Measurement: Percentage of complaints finalised within one month of receipt and a reduction in the average time taken to finalise Level-3 disputes.
Performance result: 87% complaints finalised in one month compared to 84% the previous year. Average time taken to finalise Level-3 disputes reduced.

Quantity indicator: Quality, accurate information about private health insurance
Measurement: Publication of the State of the Health Funds Report by 31 March 2008, www.privatehealth.gov.au website accessible to consumers.
Performance result: State of the Health Funds Report released on 31 March 2008, First review of website completed and site updated by June 2008.

Figure 1 **Total Complaints Received per Quarter**



Performance

The Ombudsman received 2385 complaints during 2007/08. This was 45 (1.9%) more complaints than the previous year.

There were 723 Level-3 complaints received during the year, 70 (8.8%) less than the year before. Level-3 complaints are categorised as those where the Ombudsman's staff contacts the health fund or other body and requests a report which is reviewed and either closed as a satisfactory response or investigated further.

Some Level-3 communications involve several communications between the Ombudsman's office and other bodies as well as escalation within the office. Most Level-3 complaints that haven't received a satisfactory response are reviewed by all staff within the office during weekly case assessment meetings.

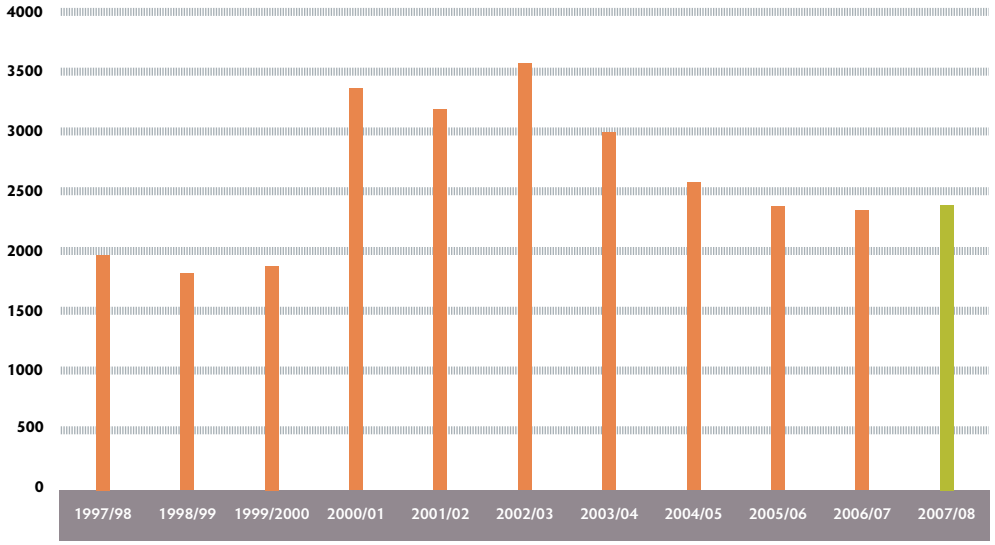
The Ombudsman also received 193 phone, email and online enquiries in relation to the consumer website www.privatehealth.gov.au.

Figure 1 shows the distribution of complaints throughout the four quarters of the 2007/2008 financial year.

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

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

Figure 2 **Total Complaints Received per Year**



Recording and categorisation of complaints

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

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

Often staff will refer a complaint directly on behalf of the complainant, as this ensures a quicker turnaround time and it enables the correct person within an organisation to assist them. The Ombudsman's client satisfaction survey indicates that complainants are more often satisfied with the office if assistance is provided by staff members in this way.

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

Complaint Level-2 (Grievances):
Moderate level of complaint resolved without requiring a report from the subject of the complaint
Level-2 complaints are dealt with by staff of the Ombudsman investigating the complainant's grievance directly and providing additional information or a clearer explanation. Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy they have purchased, including concerns about service levels provided by the insurer or provider, price increases, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

Complaint Level-3 (Disputes):
Highest level of complaint where significant intervention is required
Level-3 complaints are dealt with by contacting the health insurer, health care provider or health insurance broker 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 include pre-existing ailments, informed financial consent, benefits available on transfer of membership, benefits not in accordance with brochure descriptions and contribution errors.

The 2385 complaints recorded in 2007/08 consisted of 723 Level-3 complaints, 531 Level-2 complaints and 1131 Level-1 complaints. Figures 3 shows this ratio and shows a small increase in Level-1 complaints and a small reduction in Level-3 complaints.

Changing Complaint Categories

During the year approximately one quarter of Level-3 complaints that were initially recorded as Level-1 complaints were re-classified as Level-3 complaints. This occurs either because the complainant or the Ombudsman staff member finds that the fund's initial response is inadequate or because the complaint record is corrected in audit.

During the Ombudsman's complaint audit a senior member of staff reviews details of

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

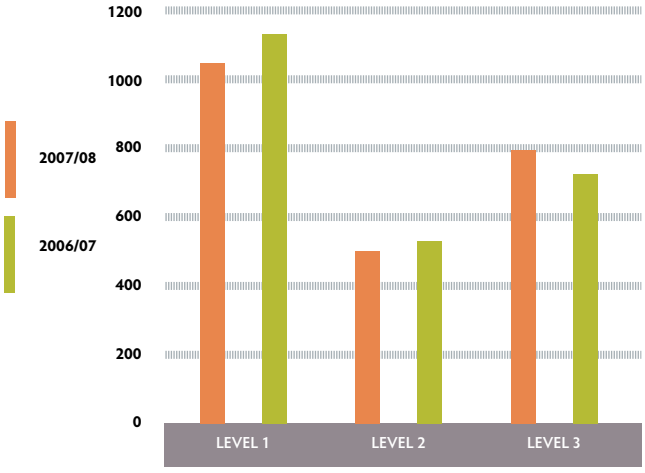
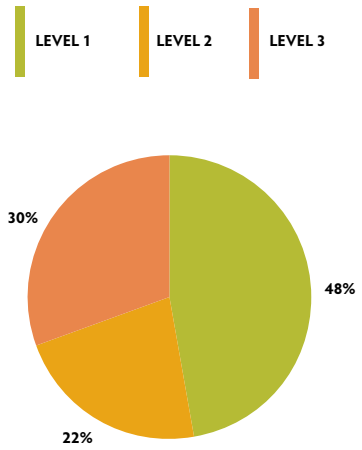


Figure 4 **Complaints Category, Percentage**



a complaint to ensure the complainant's concerns were addressed and that the categorisation of complaints is consistent. If the audit shows, for example, that a complaint initially thought to be a simple (assisted referral) complaint turned outv to be complex it is reclassified as a Level-3 complaint.

Overall, however, the number of Level-3 complaints recorded has decreased at the same time that Level-1 complaints have increased which indicates that health funds are improving in responding to complaints referred directly to them by the Ombudsman's staff.

Complaints handling procedures

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

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

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

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

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

Hilary Bassingthwaighte – Director Policy and Compliance

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

Figure 5 **Steps in Handling Approaches to the Ombudsman**

LEVEL 3 [DISPUTE]

Timeframe
Depends on the nature and complexity of matter and responses from health fund and provider

Action
PHIO contacts health fund or provider to obtain a report, then mediates the dispute between the parties or investigates the matter further

Outcomes
Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal recommendation by Ombudsman

LEVEL 2 [GRIEVANCE]

Timeframe
Usually within 24 hours

Action
Complainant provided with explanation or information to resolve matter, or if there is no avenue for the Ombudsman to take up the matter

Outcomes
Detailed information provided which appropriately resolves the issue

LEVEL 1 [PROBLEM]

Timeframe
Immediate

Action
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
Referral to health fund or provider

Workload

The office received 2385 complaints (Levels 1, 2 & 3) in 2007/08, an average of 199 per month compared with 195 complaints per month in the previous year.

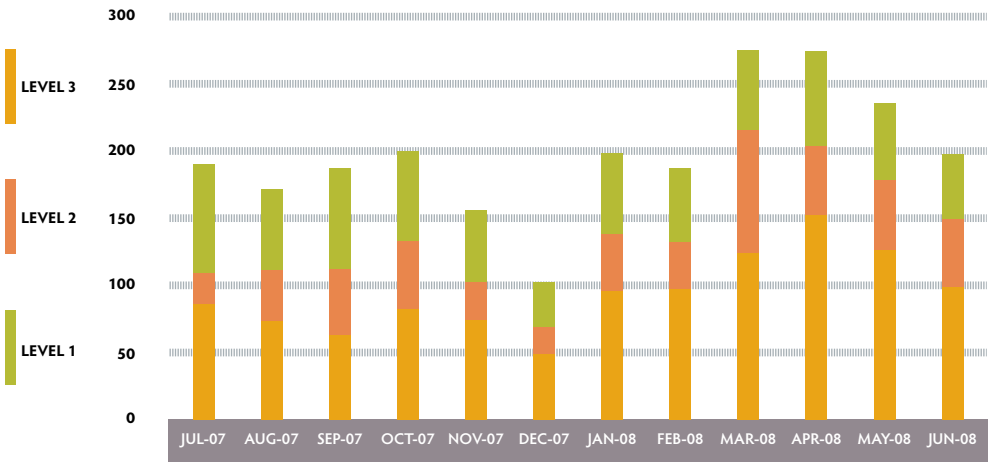
The office finalised 2355 complaints during the year; an average of 197 per month which is the same as the previous year.

The office finalised 711 complaint investigations (Level-3 complaints) during the year, compared to 815 in the previous year.

The Ombudsman also received 193 phone, email and internet lodged enquiries relating to the consumer website www.privatehealth.gov.au.

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 Ombudsman received almost three times more complaints in March or April than in December.

Figure 6 **Total Complaints Received by Month**



Time taken to resolve complaints

Figures 7 and 8 provide information on the time taken to resolve complaints this year compared to last year. There has been a small improvement in the timeliness of handling complaints. 87% of complaints were handled within one month compared to 84% the previous year.

Who was complained about

Most complaints were made about registered health insurers (2267), followed by hospitals (133) and practitioners (56). The Ombudsman also received 55 complaints from people holding overseas health cover (these are not counted as registered health insurer complaints) and 23 complaints about health insurance brokers.

Some complaints concerned one or more health insurers, or a health insurer as well as a health care provider. Consequently, the total number of organisations or people that were complained about (2534) adds up to more than the total number of individual complainants contacting the Ombudsman (2385).

Figure 7 **Time Taken to Finalise Complaints**

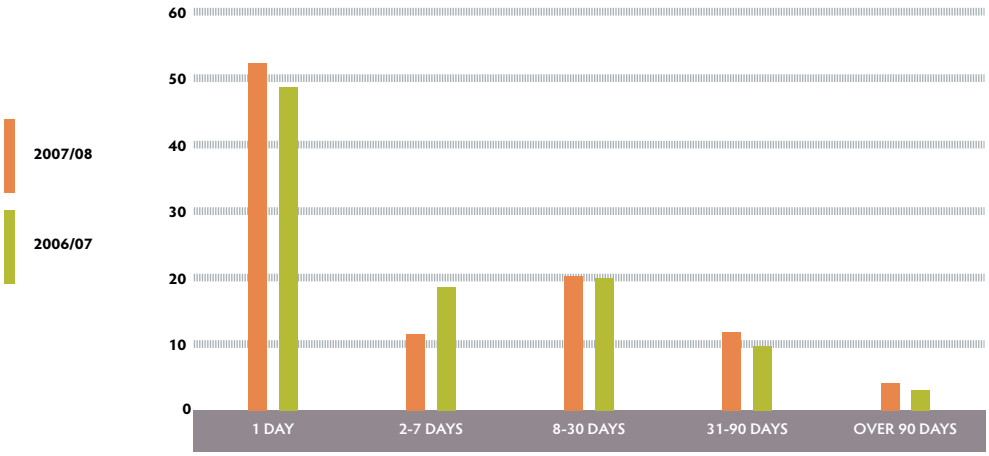
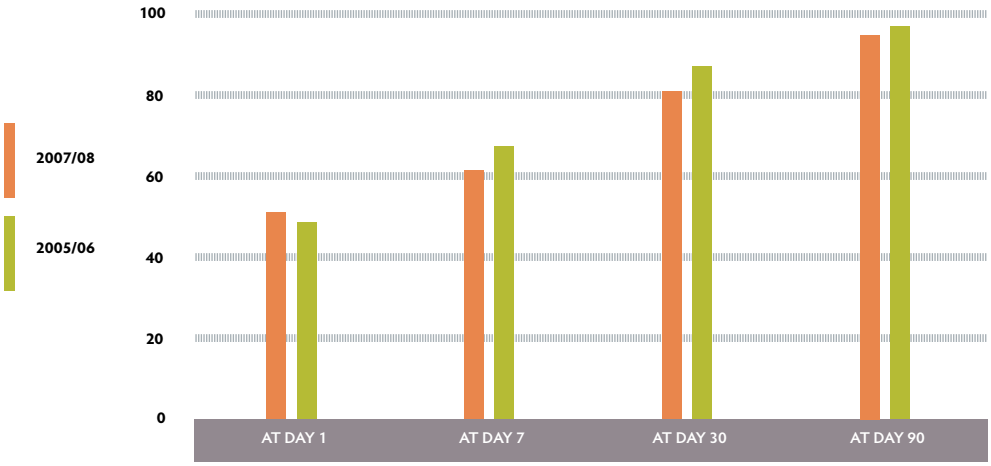


Figure 8 **Complaints Completed Since Day of Lodgement**



Complaints about registered health insurers

Figure 9 (following page) provides a summary of all complaints (Levels 1, 2 & 3) for individual health insurers compared with their market share. This data is also presented for the higher category "Level-3" complaints. Analysing the information at this further level of detail provides a more realistic picture of the way 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 hospitals

During the year, there were 133 complaints about hospitals; this was 8 less than the previous year. Most complaints about hospitals concerned inadequate *informed financial consent (IFC)* being sought from patients before a hospitalisation. Patients have contacted the Ombudsman after receiving unexpected hospital bills; either because the hospital did not perform a check of their likely benefits, or because a mistake had been made in advising them of out-of-pocket expenses.

The number of complaints about IFC is small when compared to the number of private patient hospital admissions in a year which indicates that in most cases, IFC is being appropriately sought by hospitals.

Complaints about practitioners

Most complaints about doctors and practitioners concerned medical gap issues and/or a lack of *informed financial consent (IFC)*. During 2007/08 year the office received 76 complaints about medical gap issues, 39 fewer complaints than the previous year. The office registered 56 complaints against practitioners, which is 38 less than last year.

Over the last few years practitioners have improved their advice to consumers and their efficiency in seeking *informed financial consent (IFC)* from patients. The number of complaints regarding IFC and medical gaps is now lower than at any time since the Ombudsman's office was established.

Resolving complaints

36% of complaints were resolved by the Ombudsman's office providing an independent and impartial explanation of the health insurer member's complaint.

45% of complaints were referred back to the health insurer or other agency. Most of these complainants were referred with the assistance of the Ombudsman's staff and on the understanding that they could request a review of the complaint if they remain unsatisfied. Alternatively, the Ombudsman was generally able to suggest ways for the complainant to pursue the matter with the health insurer themselves.

9% of complaints (25% 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 insurer agreeing that a 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 insurer.

An additional 9% of complaints (27% of the Level-3 complaint category) were resolved by taking other remedial action, such as re-instating a membership or confirming that a health insurance record had been corrected.

0.4% of complaints, which met the criteria for complaint contained in the *Private Health Insurance Act 2007*, 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

Figure 9 Complaints by Health Insurer Market Share (01 July 2007 - 30 June 2008)

NAME OF FUND	COMPLAINTS (1)	PERCENTAGE OF COMPLAINTS	LEVEL-3 COMPLAINTS (2)	PERCENTAGE OF LEVEL-3 COMPLAINTS	MARKET SHARE (3)
ACA Health Benefits	2	0.1	0	0.0	<0.1
AHM	86	3.8	31	4.5	2.7
Australian Unity	138	6.1	51	7.5	3.4
BUPA (HBA)	167	7.4	45	6.6	9.8
CBHS	11	0.5	2	0.3	1.2
CDH (Cesasnock District Health)	3	0.1	1	0.1	<0.1
CUA Health	4	0.2	0	0.0	0.4
Defence Health	25	1.1	7	1.0	1.4
Doctors' Health Fund	1	0.0	0	0.0	0.1
Druids Victoria	16	0.7	3	0.4	0.1
GMHBA	17	0.7	6	0.9	1.5
Grand United Corporate Health	6	0.3	1	0.1	0.3
HBF Health	55	2.4	19	2.8	7.6
HCF (Hospitals Cont. Fund)	146	6.4	32	4.7	8.8
Health Care Insurance	2	0.1	1	0.1	0.1
Health Insurance Fund of W.A.	14	0.6	6	0.9	0.4
Healthguard	5	0.2	1	0.1	0.5
Health-Partners	8	0.4	2	0.3	1.1
Latrobe Health	4	0.2	1	0.1	0.6
Manchester Unity	63	2.8	24	3.5	1.6
MBF Alliances	106	4.7	34	5.0	2.1
MBF Australia Limited	644	28.4	163	23.9	15.9
Medibank Private	498	22.0	150	22.0	28.6
Mildura District Hospital Fund	0	0.0	0	0.0	0.3
National Health Benefits Aust.	1	0.0	1	0.1	<0.1
N.I.B. Health	165	7.3	68	10.0	6.6
Navy Health	1	0.0	0	0.0	0.3
Peoplecare	1	0.0	0	0.0	0.3
Phoenix Health Fund	0	0.0	0	0.0	0.1
Police Health	4	0.2	2	0.3	0.2
Queensland Country Health	3	0.1	2	0.3	0.2
Railway & Transport Health	14	0.6	6	0.9	0.3
Reserve Bank Health	1	0.0	0	0.0	<0.1
St Lukes Health	6	0.3	2	0.3	0.4
Teacher Federation Health	26	1.1	10	1.5	1.7
Teachers Union Health	12	0.5	4	0.6	0.4
Transport Health	0	0.0	0	0.0	0.1
Westfund	12	0.5	7	1.0	0.7
Total for Health Insurers	**2267**	**100**	**682**	**100**	**100**

1. Number of Complaints (Levels 1, 2 & 3) from those holding registered health fund policies.
2. Level 3 Complaints required the intervention of the Ombudsman and the health fund.
3. Source: PHIAC, Market Share, All Policies, 30 June 2007

Samantha Gavel, Ombudsman & David McGregor, Senior Project Officer

department of fair trading and a small number were referred to the ACCC. 0.5% of complaints were withdrawn by the complainant or required no further action.

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

Who complained?

The *Private Health Insurance Act 2007* allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. Overwhelmingly, complaints were made by health insurance members (2332), followed by practitioners (24) and hospitals (10).

Figure 10 **Outcomes of Finalised Complaints**

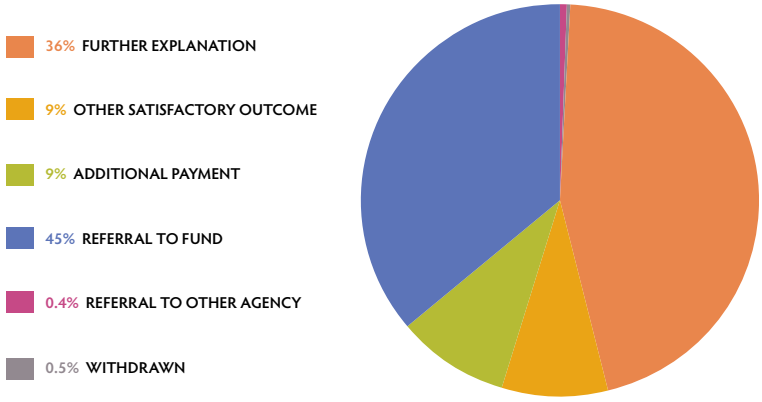
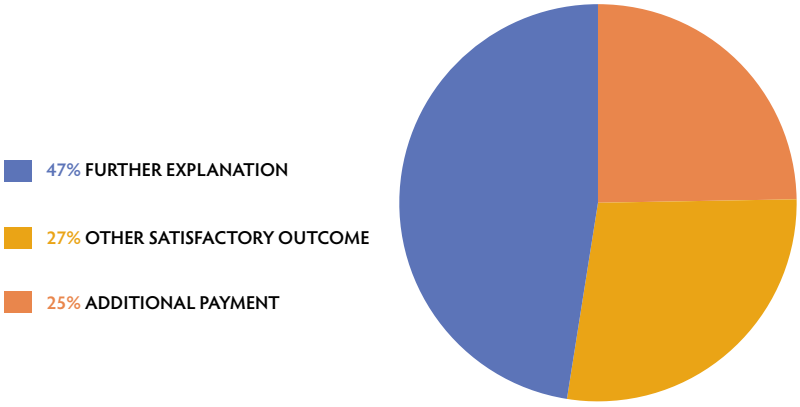


Figure 11 **Outcomes of Finalised Disputes**



How complaints were made

73% of complaints were made initially by telephone, 20% were lodged by the internet or by email, 6% by letter and less than 1% by fax. The remainder were made by personal visit, or by parliamentary representation.

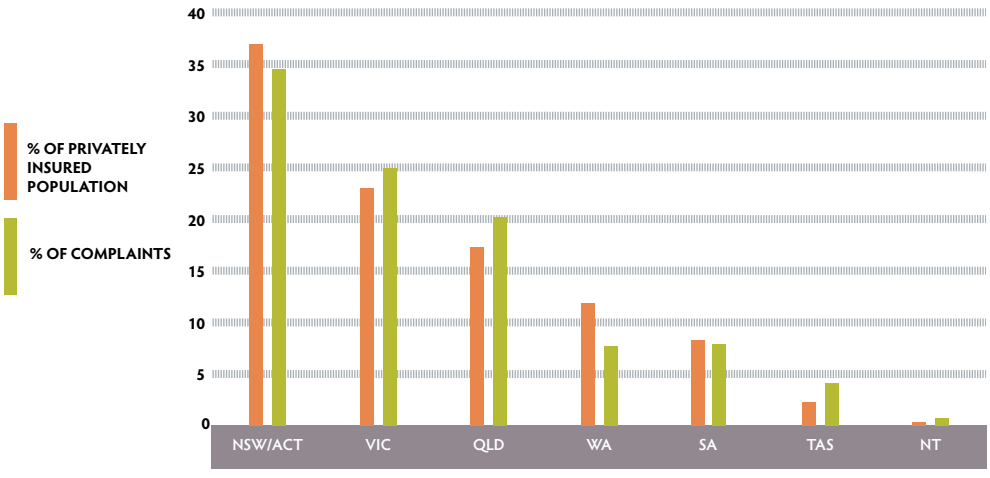
Complaints by State/Territory

Figure 12 identifies, on a state-by-state basis, where complaints originate. This data is shown by state and territory, against the percentage of people who have private health insurance coverage. Generally, health insurance members in Queensland, Victoria and Tasmania have a great tendency to complain to the Ombudsman.

Investigations

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

Figure 12 **Complaints by Population Covered by State & Territory**



Introduction

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

Figures 13 and 14 illustrate the proportion of complaints corresponding to each issue type.

Figure 13 **Complaints Issues - Percentage of Each Issue**

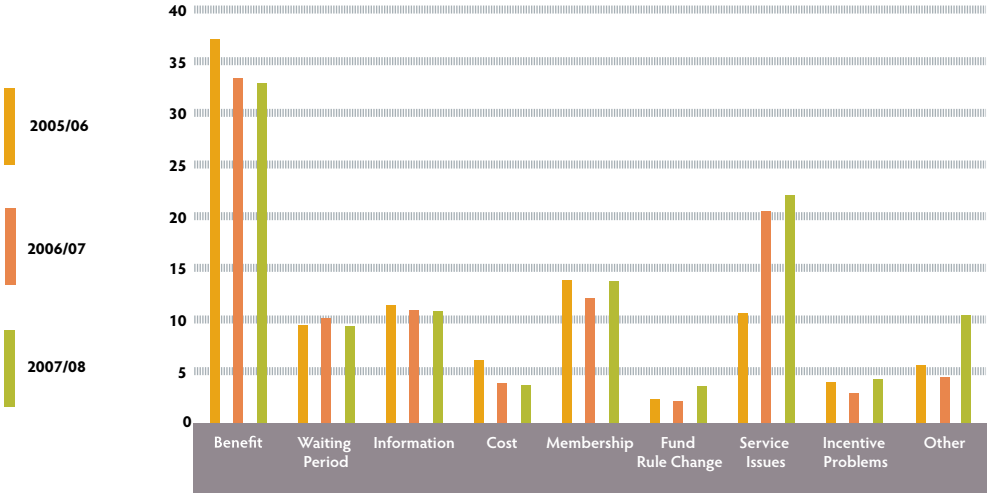
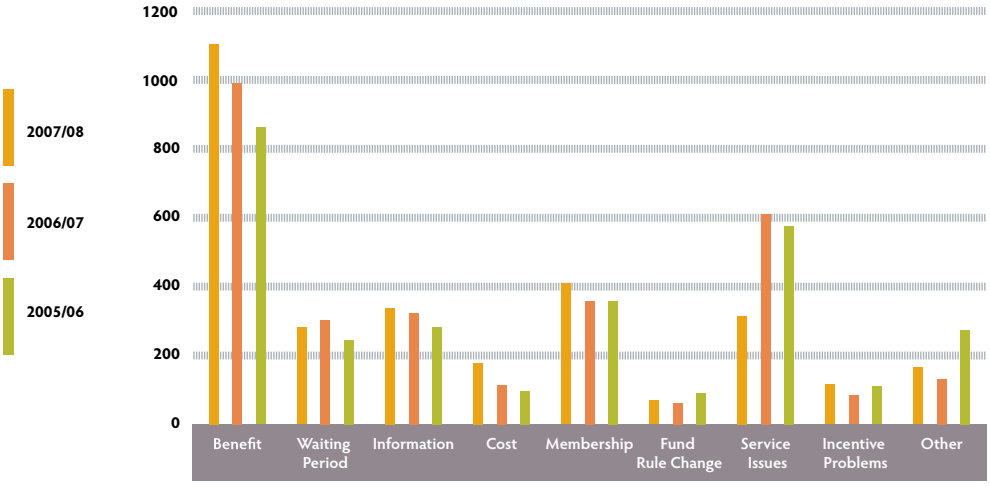


Figure 14 **Complaints Issues - Numbers of Matters Registered**



Benefit Issues

The Ombudsman received 850 complaints concerning a wide range of benefit issues; this was 143 less than last year. The most significant concerns for consumers were delays in benefit payments, levels of cover not paying specific benefits, benefit amounts being inadequate and providers not being recognised.

Service & Payment Related Issues

The Ombudsman received 333 complaints regarding general service issues with health insurers. This was 10 fewer than last year but still 300% more than recorded in 2005/06. Similarly, the office continued to receive a large number of complaints concerned premium payment problems, mostly associated with direct debit computer systems. During the year, 236 complaints were made about premium payment problems, compared to 266 in the previous year and still one third more than received in 2005/06.

Membership Issues

The Ombudsman received 350 matters about membership issues, which is similar to previous years. The more common membership issues raised with the Ombudsman are related to cancellation and transferring memberships and problems with membership payment arrears.

Information Issues

The office received 283 complaints recorded as relating to information. Of these187 concerned oral information and the remainder concerned printed material from health insurers.

Health Fund Premium Increases

During 2007/08 the Ombudsman received 96 complaints regarding health insurance premiums. This was 37 more than the previous year but still the second lowest number of premium complaints since the Ombudsman's office was established.

Overseas Visitors Health Cover

The Ombudsman assisted 55 consumers with complaints concerning *overseas visitors cover* (for visitors to Australia). This type of insurance is required to be taken out to comply with visa requirements in some circumstances. Overseas visitor cover is not a registered health insurance product and is consequently not counted in Figure 9 "Complaints by Health Insurer Market Share".

Overseas visitors health cover

Unlike Australian residents, overseas visitors to Australia who hold temporary visas aren't eligible for Medicare benefits. Some visitors from countries with which Australia has a Reciprocal Health Care Agreement do receive emergency treatment in public hospitals free of charge, but aren't otherwise entitled to Medicare benefits. This means that when overseas visitors need medical attention, whether that takes the form of a visit to their local GP or an extended hospital stay, they can find themselves responsible for the full cost of treatment unless they hold an appropriate level of insurance.

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

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

The most common types of complaint investigated by the office in relation to OVHC concerns the pre-existing ailment waiting period. These cases tend to be complicated because medical information about a person's history before joining a health fund is held overseas. Sometimes fund members aren't unaware that they aren't covered for pre-existing ailments for periods of up to 12 months or more, and with some funds not at all.

Overseas visitors should note that most OVHC products have limited cover for pharmaceuticals. Overseas visitors may face significant out of pocket costs if they need pharmaceutical treatment, particularly oncology (cancer treatment).

If a person insured on OVHC has any change to their visa status or Medicare eligibility, they should inform their health fund as soon as possible. In the year following the date that a person becomes eligible for full Medicare benefits, they are able to switch over to Australian residents' cover at base rates. If they decide to switch at a later date, they may find they have to pay a Lifetime Health Cover penalty for each year they have delayed.

Tips

- Make sure you're aware of the waiting periods which apply to your policy.
- Check the restrictions and exclusions on the policy. If you need treatment for any item which isn't fully covered, you will become responsible for some or all of the cost of treatment.
- If your visa status or Medicare eligibility changes, inform your fund.
- If you're expecting upcoming treatment, contact your fund to find out whether you will be covered.
- If you need treatment which isn't covered by your fund, ask the service provider to find out how much you will need to pay out of your own pocket.

Who to contact?

To purchase Overseas Visitors Health Cover, contact one of the funds listed above. You can find their contact details on www.privatehealth.gov.au.

If you have a complaint about your cover and you aren't able to resolve the issue directly with your fund, you can contact the Private Health Insurance Ombudsman on 1800 640 695 or www.phio.org.au.

To check your Medicare eligibility, contact Medicare on 132 011, www.medicareaustralia.gov.au or your local office.

Problems with Policy Restrictions

Most health funds offer a range of policies, designed to appeal to people at different life stages. Less expensive policies tend to have restrictions on a number of procedures including plastic and reconstructive surgery.

The Ombudsman's complaints experience shows that restrictions on plastic and reconstructive surgery can be problematic for members. The majority of consumers associate the term "plastic surgery" with cosmetic procedures and believe they can safely take a policy that doesn't cover cosmetic procedures. Restrictions on plastic and reconstructive surgery, however, do not relate to cosmetic surgery; they cover all of the plastic and reconstructive item numbers in the Medicare Schedule and are medically necessary procedures.

The following case illustrates the problems that can occur with this type of restriction.

Mr J had been with his health fund for some fifteen years. During that time, he had held a medium level of cover with a number of restrictions, including plastic and reconstructive surgery.

Mr J sustained severe lacerations to his forearm as a result of an accident and was rushed to the Accident and Emergency section of his local public hospital. The hospital did not have a surgeon available to treat Mr J, but was able to locate a surgeon with visiting rights at a nearby private hospital who could operate immediately. Mr J was transferred to this hospital later that day and underwent surgery within hours of being admitted. He was discharged the following morning.

Following his discharge, Mr J received an account from the hospital for $6,500. This was because the item number used for his surgery was a plastic and reconstructive item number and therefore restricted under his policy. The fund paid only a basic accommodation benefit, leaving Mr J to pay the most expensive portion of the account himself.

There are a number of measures in place to protect consumers from this type of unexpected account. All private hospitals will conduct a membership eligibility check prior to or on admission with the member's health fund, to ensure they are covered for the procedure. If the patient is not covered for any reason, the hospital can advise them of their out of pockets costs prior to surgery, giving them the opportunity to consent to incurring these costs, or discuss other treatment options with their doctor.

Unfortunately, however, in Mr J's case, it was an unplanned admission requiring surgery at very short notice. By the time he was transferred from the public hospital, it was after 5.30pm. Twenty-four hour electronic checking was not available between this particular hospital and his health fund.

The patient did not make inquiries with his fund due to the nature of his injuries. In addition, he is did not realise that this type of surgery would be classed as "plastic and reconstructive" surgery and be restricted under his policy.

Members are now sent a Standard Information Statement (SIS) every year, outlining any restrictions on cover, but again, this is not an area the member would be aware would trigger their restriction.

In this case, PHIO recommended a three way split of the outstanding account between the patient, fund and hospital. This seemed to be the fairest way to resolve the matter, given that all parties had some responsibility for the situation of the member being admitted on a restricted cover without full informed financial consent.

Restrictions on Cover for Pregnancy

Australia's birth rate is currently higher than it has been for many years, which appears to be having an impact on the claims experience of funds. Several funds opted to remove benefits for pregnancy from some levels of cover during the year citing increased costs and the need to keep premiums competitive.

Mrs V contacted the office to complain about a letter she had received from her fund. The letter indicated that pregnancy benefits would be removed from her policy with effect from 1 January 2009. If she wanted to be covered for pregnancy in future, she would need to upgrade to a new level of cover with a higher premium.

Mrs V wanted advice on whether the fund could remove pregnancy benefits from her level of cover and whether she had any other options, apart from upgrading and paying a higher premium. PHIO staff explained that the fund could remove a benefit from her policy, providing they gave her adequate notice and options for upgrading to ensure she remained covered at her previous level of cover without waiting periods. PHIO also suggested she check www.privatehealth.gov.au to see if there was a policy that would better meet her needs and confirmed that providing she took a new cover before the change took effect (ie in January 2009) she could transfer to a similar level of cover without waiting periods.

Funds can change or remove benefits, providing they give sufficient advance notice and facilitate an upgrade for members who wish to member to retain the same level of cover. PHIO's experience with the removal of benefits, however, is that there will always be some consumers who, for any number of reasons, are unaware of the change and can be disadvantaged in future if they need to claim for the service that has been removed.

Where a significant detrimental change is made to a policy, such as the removal of benefits for pregnancy services, we recommend a personal letter to the member outlining the change on page one in a way that draws people's attention to it. There also needs to be follow up information sent and a campaign to remind people about the change through the fund call centre and website.

Forced Cover Migration

The Ks had been with their health fund for nearly ten years when it was taken over by another fund. The new fund did not initially make any changes to the K's health insurance policy. This policy paid full private hospital benefits, but limited those benefits to only 4 days in a private hospital in any calendar year.

Late last year, the Ks received a letter from their new fund telling them their old policy would no longer be available and they would be transferred to a new policy. This policy was going to cost them an extra $60 a month, because it provided more comprehensive cover that did not limit the number of days the member could stay in a private hospital.

Mrs K phoned the fund to complain because she didn't think they could afford the higher premium for the new cover. The health fund staff member suggested she consider downgrading their cover to reduce premiums. The policy suggested was significantly lower than her previous cover, with restrictions on most expensive types of surgery.

Shortly after downgrading the policy, Mr K became ill and needed an urgent admission to hospital. He was admitted on a Sunday evening and hospital staff could not check his health insurance eligibility at that time.

Hospital staff contacted the fund the next morning to check that Mr K's admission would be covered. The health fund responded with written advice that Mr K would be covered and that there were no restrictions on his policy. This advice was incorrect.

Fund staff realised the mistake later that same day and contacted the hospital to warn that the procedure was restricted under Mr K's new policy. This meant the fund would only pay a small portion of the hospital account. Unfortunately, Mr K had already undergone surgery by the time this advice was received. Mr K was informed by hospital staff on discharge that he would need to contribute some $3000 towards the hospital account.

After discharge, Mr K received the account for $3000 and this caused some distress because he could not afford to pay the account. In response, the hospital sent numerous demands for payment and later, sent the account to a debt collector.

The Ks complained to their fund about the outstanding account, but the fund took the view that the Ks had chosen to downgrade their cover and were only entitled to receive a minimum benefit, because the hospitalisation was for a procedure restricted under the policy.

The Ks approached the Ombudsman for assistance. The Ombudsman's view was that they would never have chosen to downgrade their level of cover if the fund hadn't withdrawn their original policy and required them to migrate to a new level of cover. If the fund hadn't made any changes to their policy, this procedure would have been fully covered by the fund.

In addition, the incorrect information provided by the fund to the hospital during the eligibility check meant that the Ks were not given the right to be informed of the $3000 bill they were incurring by consenting to the hospital admission.

Following the Ombudsman's investigation, the health fund agreed to pay the outstanding hospital account. This was in recognition that the fund's actions had led to the Ks taking a restricted level of cover and that incorrect information had been given to the hospital.

Health Fund Membership History.

Ms A recently transferred to a new fund. On joining, the new fund told Ms A that she would need to pay a 14% Lifetime Health Cover (LHC) loading on her policy. Under LHC legislation people who join private hospital cover for the first time when they're over 31 years old, or who rejoin after an extended break in cover, are required to pay a higher premium based on their age.

The advice given by Ms A's new fund was based on the clearance (transfer) certificate they'd received from her previous fund which confirmed she had paid a 14% loading on her last policy. However, Ms A believed she had held continuous private hospital insurance since 1998 and didn't understand why she should have to pay a LHC loading at all.

On looking into the issue, PHIO found that Ms A had actually transferred hospital funds six times since 1998. She had been in contact with a health insurance broker almost annually and each time she changed to a new fund if she could lower her premiums. At some point during those six transfers, some with companies which are no longer in business, she had accidentally acquired a Lifetime Health Cover loading.

Ms A's situation was further complicated because she had relied on a health insurance broker to complete each of the transfers but when she asked her broker for advice on correcting the error, they were unable to assist her.

The role of our office in this complaint was to approach each of Ms A's previous funds, including those that had been absorbed by other companies, to find out when the error had occurred. The case officer eventually found that the age loading had been added in error in 2004, three funds prior to her current fund. Each of the funds which had subsequently over-charged Ms A was required to provide her

with a refund and to issue her with a corrected clearance certificate which verified she had zero LHC loading.

Ms A's insurer in 2004 assumed she had joined private health insurance for the first time and automatically charged her an age loading of 14% based on her age in 2004. However, had the fund or Ms A's broker looked further into the issue, they could have confirmed with her previous fund that zero loading applied.

Ms A's situation was an extreme example of the difficulties encountered by consumers when they transfer between funds. PHIO's intervention as a central point of contact is often necessary in complex cases such as these where a mistake needs to be corrected across several funds or brokers.

Health Appliance Benefits

Mr J lives in a regional area. In December 2007 he was required to undergo a sleep study test in a medical clinic in the nearest town. Following the study, Mr J was diagnosed with sleep apnoea.

To assist with Mr J's breathing, his doctor recommended buying a Continual Positive Airway Pressure (CPAP) machine. Mr J purchased a machine for a cost of $1900.

On contacting his health fund, Mr J was advised that no benefit was payable for the CPAP machine and the reason given was that he had not been admitted to hospital for the test which led to diagnosis. However, had he been admitted to hospital for the test, then the fund would have paid towards the machine.

The Ombudsman's office receives a number of complaints each year similar to Mr J's. In general, benefits for medical appliances have restrictions which many consumers aren't aware of and they feel aggrieved when they are unable to claim based on what they see as a technicality.

Mr J felt he was being disadvantaged because there were no local hospitals in his area which could have performed the study, and contacted our office for assistance. He felt it was unfair that he had the same medical appliance, cover and condition as another member of the fund but he was unable to claim because of where he lived.

On reviewing the situation the fund agreed with Mr J's argument and decided to pay a $500 ex gratia benefit towards Mr J's CPAP machine, which was equivalent to the benefit other members of the fund received.

Customer Service: Benefit Quotes

Mr D was expecting dental treatment from a periodontist and visited one of his fund's retail centres for a quote. In a conversation with a staff member, he listed the dental item numbers he had been quoted for the treatment and was given a verbal estimate of benefits for each item.

Based on this advice, Mr D believed he would receive over $2000 in benefits and proceeded with the treatment. However, on submitting the claim to the fund, he found his total benefits were only $36.70. Mr D contacted the fund and asked for a review of the claim because he felt a mistake had been made.

The fund reviewed the claim but explained the benefit of $36.70 was correct because he had not completed his waiting periods. He had commenced dental cover June 2007 and received the treatment in October 2007.

The waiting period for major dental benefits, such as periodontal treatment, is 12 months, so he would not have been entitled to any benefits for the treatment until June 2008. Also, the fund claims officer explained that even after completing the waiting period, Mr D could not have claimed $2000 on his cover as the maximum benefit for major dental was $1000. Mr D felt the fund should honour the quote he was given prior to treatment and contacted the Ombudsman's office to lodge a complaint.

On examining the records, the Ombudsman was unable to determine exactly what Mr D was advised. Also, Mr D was unable to provide firm evidence for his view that he would receive $2000 in benefits.

In such cases, the Ombudsman's office reviews the procedure of the fund to ascertain what should be showing on the records and in Mr D's case a record should have been made that he was told he was subject to a waiting period of 12-months and that the maximum possible benefit for dental treatment was $1000.

The Ombudsman's office felt that it was likely Mr D wasn't warned that he was still within a waiting period, but at the same time there wasn't sufficient evidence to suggest he was quoted exactly $2000. In reviewing the case, the Ombudsman believed the most appropriate resolution to this complaint was for the fund to pay a benefit similar to what other members of the fund, who have served the waiting period, would receive. The fund agreed and paid an additional $1000 to Mr D.

Access and Public Awareness

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

To raise awareness of the services provided by the Ombudsman, the following strategies were employed during 2007/08:

- Details of the Ombudsman's services are referenced in various Government publications and in publications produced by other agencies and consumer bodies.
- Health insurers provide information about the availability of the Ombudsman's services and contact details in brochures, publications and in some correspondence to their members. These details are also included on health insurers' internet sites.
- The Ombudsman produces and distributes a range of brochures on health insurance issues.
- The Ombudsman participated in a number of media interviews during the year.
- The Ombudsman also contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites.
- The Ombudsman publishes a regular quarterly report which is distributed in both printed format and on the PHIO website.
- The Ombudsman 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, internet complaint form, e-mail or by post.

People who are deaf, hearing or speech impaired can contact the office through the National Relay Service by telephoning 13 36 77.

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

Relations with Stakeholders

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

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

Client Survey

About the Survey

In May 2008, the office carried out a postal survey of 225 randomly selected complainants who had lodged complaints during the period November 2007 to May 2008. 77 clients responded to the survey (34%) which is a high participation rate for a postal survey.

The aim of the survey was to gauge the degree to which PHIO was meeting its clients' needs and to identify areas where improvements could be made. This year's survey has shown

a reduction in client satisfaction compared to the previous year. 78% of clients were satisfied or very satisfied with the overall handling of their complaint, which is a reduction from 88% the previous year. An analysis of the responses reveals a number of reasons for this result. In particular, some complainants felt aggrieved that the office was unable to assist them in obtaining a higher cash allocation following the MBF merger with BUPA Australia. (More information about this issue is provided in the Ombudsman's Overview.)

In 2008/09 the office will conduct a review of its procedures and update its service charter in response to the issues identified and suggestions from health insurance consumers. One of the main problems expressed by clients was the length of time taken in finalising complaints. The Ombudsman will consider measures to better meet client expectations to have complaints resolved more quickly, particularly for the 13% of clients who waited more than 30 days to have their complaints resolved. Some clients waiting more than 30 days tended to express strong dissatisfaction about all areas of their complaint and for this reason improving their satisfaction will be a priority for the Ombudsman's office in 2008/09.

In summary, of the respondents to the survey:

87% said that staff listened to their concerns, compared to 95% the year before.

82% said that staff explained what sort of assistance we could provide, compared to 91% last year.

87% said that staff were easy to understand, a decrease from 92% the previous year.

75% said that they were satisfied or mostly satisfied with the manner in which staff handled their complaint, this was a reduction from 88% the year before.

65% said that we had resolved their complaint or provided an adequate explanation, a decrease from 86% last year.

80% reported that PHIO was independent in dealing with their complaint, compared to 88% the previous year.

76% said that they would recommend PHIO to others, a reduction from 90% the year before.

74% of those whose cases lasted more than a week said that they were happy with the time taken resolving their complaint. This was a decrease from 92% last year.

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:

- Continued participation in the development of policies and procedures for providing for informed financial consent by medical providers.
- Submission to the ACCC's Report to the Senate on *Anti-competitive and other practices by health funds and providers in relation to private health insurance.*
- Submission to the ACCC regarding the demutualisation and sale of MBF.

Corporate Governance

Being a small office with duties specified by the *Private Health Insurance Act 2007*, the business of the Ombudsman's office is well defined. In accomplishing the tasks envisaged under the Act, there is a need for procedures to be in place to monitor both performance and process, together with the appropriate management and staff policies.

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

Management of Human Resources

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

The ability within a small organisation to accomplish these tasks places a significant reliance on all staff to work as a team and to fully understand the fundamentals associated with the whole private health industry. Dispute resolution staff are responsible for the day to day management of individual complaints and for bringing potential and actual issues which require broader investigation to the attention of the Ombudsman and the Director of Policy and Compliance. Dispute resolution staff need to be highly trained and sourced from such disciplines as Law, Commerce or Nursing.

Staff Details

As at 30 June 2008, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman	1	-
Director, Policy & Compliance (acting)	1	-
Senior Project Officer		1
Financial Officer	1	-
Dispute Resolution Officers	4	-
Administrative Assistant	-	1
Customer Service Officer – Website	1	-
Total	8	2

Statutory Positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

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

Staff Development and Training

During the 2007/08 financial year, $35 291 was spent directly on PHIO staff attending training courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff.

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. 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 2008.

Occupational Group	Women	Men	Total Staff	NESB1
SES	1	0	1	-
Other	8	2	11	3
Total	**9**	**2**	**11***	**3**

Note: SES Senior Executive Service, Acting Ombudsman

Other All other staff - temporary and permanent

NESB1 Non-English speaking background, 1st Generation

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

Performance Appraisal

The Ombudsman has a performance appraisal system 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 2007/08 Portfolio Budget Statement indicates that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 9, *Private Health.*

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

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

Consultants Engaged

The Ombudsman engaged Complete GST Solutions as a consultant during the financial year.

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

Interaction Consulting Group was engaged to provide advice on staffing issues under the Public Service Act and Resolution Consulting Services was engaged to provide advice on finances under the Financial Management and Accountability Act.

Human Solutions continued to maintain and develop the www.privatehealth.gov.au website under the contract awarded in the previous year.

Information Systems

The Ombudsman's information system is based upon a Windows 2000 Network Server and the Microsoft Office 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. PHIO's Internet service is maintained by Nicols Price (Business ADSL).

Payroll Services

The Ombudsman continues to engage Australian Payroll Management Services to provide a payroll processing service.

Fraud Control

Staff are trained in fraud awareness and procedures, which are in place to notify the Australian Federal Police and/or the Director of Public Prosecutions if loss occurs as a result of fraud. A formal fraud procedure manual has been produced and all staff made aware of their obligations and responsibilities. No cases of fraud were detected during the year.

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 of 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 2009.

Establishment

The Private Health Insurance Ombudsman (the Ombudsman) is established under the *Private Health Insurance Act 2007* to resolve complaints about any matter arising out of, in or connection with a private health insurance arrangement. The Ombudsman is an independent statutory 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 brochure "Waiting Periods"
- A brochure "Health Insurance Choice"
- A booklet and brochure "Private Patients' Hospital Charter"
- "The State of The Health Funds Report"
- Individual Summaries for each fund of "The State of the Health Funds Report".

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

Access to documents

People may obtain documents:

- from the office of the Ombudsman located at Level 7,
  362 Kent Street,
  Sydney, NSW 2000
- by telephoning (02) 8235 8777 or 1800 640 695 (Free-call)
- by fax on (02) 8235 8778
- by e-mail to info@phio.org.au
- from the web site http://www.phio.org.au

Information and procedures for Freedom of Information Act requests

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 enquiries 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 Australian Government agencies, the Ombudsman has a Service Charter which was last reviewed in 2006. In 2008/09 The Charter will be updated in response to consumer feedback provided through the Client Satisfaction Survey.

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 (in the brochure "About our Service").

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

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

Financial Information

Australian National
Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Ageing

Scope

We have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2008, which comprise: a statement by the Ombudsman; income statement; balance sheet; statement of changes in equity; cash flow statement; schedules of commitments and contingencies; a summary of significant accounting policies; and other explanatory notes.

The Responsibility of the Ombudsman for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error.

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Level 6
130 Elizabeth Street SYDNEY NSW 2000
Phone (02) 9367 7100 Fax (02) 9367 7102

In making those risk assessments, the auditor considers internal control relevant to the Private Health Insurance Ombudsman's preparation and fair presentation of the financial statements to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Private Health Insurance Ombudsman's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Ombudsman, as well as evaluating the overall presentation of the financial statements.

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

Independence

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

Auditor's Opinion

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

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

(b) give a true and fair view of the matters required by the Finance Minister's Orders including the Private Health Insurance Ombudsman's financial position as at 30 June 2008 and its financial performance and its cash flows for the year then ended.

Australian National Audit Office

P Hinchey
Senior Director
Delegate of the Auditor-General

Sydney
21 August 2008

PRIVATE HEALTH INSURANCE OMBUDSMAN

STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2008 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, as amended.

Signed....Samantha Gavel

Samantha Gavel
Ombudsman

21 August 2008

Private Health Insurance Ombudsman **Income Statement**
FOR THE PERIOD ENDED 30 JUNE 2008

	NOTES	2008 $
INCOME		
Revenue		
Revenue from Government	2A	1,957,000
Other revenue	2B	11,805
Total revenue		1,968,805
TOTAL INCOME		1,968,805
EXPENSES		
Employee benefits	3A	732,349
Suppliers	3B	593,337
Depreciation and amortisation	3C	151,816
Losses from asset disposals	3D	6,771
TOTAL EXPENSES		1,484,273
SURPLUS		484,532

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

Private Health Insurance Ombudsman **Balance Sheet**

AS AT 30 JUNE 2008

	NOTES	2008 $
ASSETS		
Financial Assets		
Cash and cash equivalents	4A	54,960
Trade and other receivables	4B	2,003,496
Total financial assets		2,058,456
Non-Financial Assets		
Land and buildings	5A	2,992
Infrastructure, plant and equipment	5B,C	65,700
Intangibles	5D	661,850
Total non-financial assets		730,542
TOTAL ASSETS		2,788,998
LIABILITIES		
Payables		
Suppliers	6A	41,669
Total payables		41,669
Provisions		
Employee provisions	7A	152,756
Total provisions		152,756
TOTAL LIABILITIES		194,425
Net Assets		2,594,573
EQUITY		
Retained earnings		2,594,573
TOTAL EQUITY		2,594,573
Current Assets		2,058,456
Non-Current Assets		730,542
Current Liabilities		128,349
Non-Current Liabilities		66,076

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

Private Health Insurance Ombudsman Cash Flow Statement
FOR THE PERIOD ENDED 30 JUNE 2008

	NOTES	2008 $
OPERATING ACTIVITIES		
Cash received		
Appropriations		1,505,000
GST received from ATO		28,425
Other cash received		805
Total cash received		1,534,230
Cash used		
Employees		(682,396)
Suppliers		(540,274)
Total cash used		(1,222,670)
Net cash flows from operating activities	8	311,560
INVESTING ACTIVITIES		
Cash received		
Other cash received		-
Total cash received		-
Cash used		
Purchase of infrastructure, plant and equipment		(26,350)
Purchase of intangibles		(170,443)
Total cash used		(196,793)
Net cash flows used by investing activities		(196,793)
FINANCING ACTIVITIES		
Cash received		
Contributed equity		1,454,915
Total cash received		1,454,915
Cash used		
Transfer to the Official Public Account		(1,514,722)
Total cash used		(1,514,722)
Net cash flows used by financing activities		(59,807)
Net increase in cash held		54,960
Cash & cash equivalents at the start of the reporting period		-
Cash & cash equivalents at the end of the reporting period	4A	54,960

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

Private Health Insurance Ombudsman Statement of Changes in Equity
AS AT 30 JUNE 2008

	RETAINED EARNINGS 2008 $	CONTRIBUTED EQUITY 2008 $	TOTAL EQUITY 2008 $
OPENING BALANCE			
Balance carried forward from previous period	-	-	-
INCOME AND EXPENSES			
Surplus for the period	484,532	-	484,532
Contributions by owners restructuring	-	2,110,041	2,110,041
CLOSING BALANCE AT 30 JUNE	484,532	2,110,041	2,594,573

Private Health Insurance Ombudsman Schedule of Commitments
AS AT 30 JUNE 2008

There were no commitments as at 30 June 2008.

Private Health Insurance Ombudsman Schedule of Contingencies
AS AT 30 JUNE 2008

There were no contingent losses or gains as at 30 June 2008.

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

NOTE 1:
SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Objectives of Private Health Insurance Ombudsman

The Ombudsman is an Australian Public Service organisation. The objective of the Ombudsman is to be an independent body which resolves complaints about private health insurance, and act as the umpire in dispute resolution at all levels within the private health industry.

The Ombudsman is structured to meet one outcome:

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

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

Departmental activities are identified under two Outputs. Both outputs support Outcome 1.

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

1.2 Basis of Preparation of the Financial Report

The Financial Statements and notes are required by section 49 of the Financial Management and Accountability Act 1997 and are a General Purpose Financial Report.

The Financial Statements and notes have been prepared in accordance with:

- Finance Minister's Orders (or FMOs) or reporting periods ending on or after 1 July 2007; and
- Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

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

The Financial Report is presented in Australian dollars.

Unless an alternative treatment is specifically required by an Accounting Standard or the FMOs, assets and liabilities are recognised in the Balance Sheet when and only when it is probable that future economic benefits will flow to the Entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under agreements equally proportionately unperformed are not recognised unless required by an Accounting Standard. Liabilities and assets that are unrealised are reported in the Schedule of Commitments and the Schedule of Contingencies.

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

1.3 Changing from reporting under the CAC Act to reporting under the FMA Act

Effective 1 July 2007, as a part of the former Government's response to the Uhrig Report, the Ombudsman to which the *Commonwealth Authorities and Companies Act 1997* (CAC Act) applied became a prescribed agency under the Financial Management and

Accountability Act 1997 (FMA Act).

Body corporate ceases to exist

Unless legislation provides otherwise, where a body corporate ceases to exist and a new entity is created to carry out functions of the previous Commonwealth authority, the changes must be accounted for as a restructure in accordance with the Finance Minister's Orders and the accounting standards. The assets and liabilities of the old authority, to the extent transferred to the new agency, should be recognised as direct net credits to equity in the new agency. The opening balances of the new entity are zero and no prior year comparative figures exist.

The Private Health Insurance Ombudsman has been identified as a newly created FMA Agency and is no longer a body corporate from 1 July 2007.

1.4 Significant Accounting Judgements and Estimates

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

1.5 Statement of Compliance

Adoption of new Australian Accounting Standard requirements

No accounting standard has been adopted earlier than the application date as stated in the standard. The following new standards are applicable to the current reporting period:

Financial instrument disclosure

AASB 7 *Financial Instruments: Disclosures* is effective for reporting periods beginning on or after 1 January 2007 (the 2007-08 financial year) and amends the disclosure requirements for financial instruments. In general AASB 7 requires greater disclosure than that previously required. Associated with the introduction of AASB 7 a number of accounting standards were amended to reference the new standard or remove the present disclosure requirements through 2005-10 Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]. These changes have no financial impact but will effect the disclosure presented in future financial reports.

The following new standards, amendments to standards or interpretations for the current financial year have no material financial impact on the Ombudsman.

- AASB 101 Presentations of Financial Statements (reissued October 2006);
- AASB 1048 Presentations and Application of Standards (reissued September 2007);
- 2007-04 Amendments to Australian Accounting Standards arising from ED 151 and Other Amendments and Erratum: Proportionate Consolidation;
- 2007-05 Amendments to Australian Accounting Standard – Inventories Held for Distribution by Not-for-Profit Entities [AASB 102];
- 2007-07 Amendments to Australian Accounting Standards [AASB 1, AASB 2, AASB 4, AASB 5, AASB 107 & AASB 128];
- AASB interpretation 10 Interim Financial Reporting and Impairment;
- AASB Interpretation 11 AASB 2 – Group and Treasury Share Transactions and 2007-1 Amendments to Australian Accounting Standards arising from AASB

Interpretation 11;

- AASB Interpretation 1003 Australian Petroleum Resource Rent Tax.

Future Australian Accounting Standard requirements

The following new standards, amendments to standards or interpretations have been issued by the Australian Accounting Standards Board but are effective for future reporting periods. It is estimated that the impact of adopting these pronouncements when effective will have no material financial impact on future reporting periods.

- AASB 3 Business Combinations;
- AASB 8 Operating Segments and 2007-3 Amendments to Australian Accounting standards arising from AASB 8;
- AASB 101 Presentation of Financial Statements (reissued September 2007) and 2007-08 Amendments to Australian Accounting Standards arising from AASB 101;
- AASB 123 Borrowing costs and 2007-06 Amendments to Australian Accounting Standards arising from AASB 123;
- AASB 127 Consolidated and Separate Financial Statements and 2008-03 Amendments to Australian Accounting Standards from AASB 3 and AASB 127 [AASBs 1,2,4,5,7,101,107,112,114,116,121,128,131,132,133,134,136,137,138& 139 and Interpretations 9 & 107];
- AASB 1004 contributions;
- AASB 1050 Administered Items and 2007-9 Amendments to Australian Accounting standards arising from the Review of AASs 27, 29 and 31;
- AASB 1051 Land under Roads;
- AASB 1052 Disaggregated Disclosures;
- 2008-1 Amendments to Australian Accounting Standard – Share-based Payments: Vesting Conditions and Cancellations [AASB 2];
- 2008-2 Amendments to Australian Accounting Standards – Puttable financial Instruments and Obligations arising on Liquidation [AASB7, AASB 101, AASB 132, AASB 139 & Interpretations 2];
- AASB Interpretation 1 Changes in Existing Decommissioning, Restoring and Similar Liabilities;
- AASB Interpretation 4 Determining whether an Arrangement contains a Lease;
- AASB Interpretation 12 Service Concession Arrangements and 2007-2 Amendments to Australian Accounting Standards arising from Interpretation 12;
- AASB Interpretation 13 Customer Loyalty Programmes;
- AASB Interpretation 14 AASB 119 – The Limit on a Defined Benefit Asset, Minimum Funding Requirement and their Interaction;
- AASB Interpretation 129 Service Concession Arrangements; Disclosures;
- AASB Interpretation 1038 Contributions by Owners Made to Wholly-0wned Public Sector Entities.

Other

The following standards and interpretations have been issued but are not applicable to the operations of the Ombudsman.

- AASB 1049 Financial Reporting of General Government Sectors by Governments 2008-4 Amendments to Australian Accounting Standard – Key Management Personnel Disclosures by Disclosing Entities [AASB 124].

1.6 Revenue

Revenue from Government

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

Appropriations receivable are recognised at their nominal amounts.

Resources Received Free of Charge

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

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition, unless received from another Government Agency or Authority as a consequence of a restructuring of administrative arrangements (Refer to Note 1.7).

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

1.7 Transactions with the Government as Owner

Equity injections

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

Restructuring of Administrative Arrangements

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

1.8 Employee Benefits

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

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

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

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

Leave

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

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

Superannuation

Staff of the Ombudsman are members of the Public Sector Superannuation Scheme (PSS) or the PSS accumulation plan (PSSap). The PSS is a defined benefit scheme for the Australian Government. The PSSap is a

defined contribution scheme.

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

The Ombudsman makes employer contributions to the employee superannuation scheme at rates determined by an actuary to be sufficient to meet the current cost to the Government of the superannuation entitlements of the Ombudsman's employees. The Ombudsman accounts for the contributions as if they were contributions to defined contribution plans.

From 1 July 2005, new employees are eligible to join the PSSap scheme.

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

1.9 Leases

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

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

The Ombudsman has no finance leases.

1.10 Cash

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

1.11 Financial Liabilities

Supplier and other payables

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

1.12 Contingent Liabilities and Contingent Assets

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

1.13 Acquisition of Assets

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

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at

which they were recognised in the transferor Agency's accounts immediately prior to the restructuring.

1.14 Infrastructure, Plant and Equipment

Asset Recognition Threshold

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

Revaluations

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

ASSET CLASS	FAIR VALUE MEASURED AT
Leasehold Improvements	Depreciated replacement cost
Infrastructure Plant & Equipment	Market selling price

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

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

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

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

Depreciation

Depreciable infrastructure, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Ombudsman using, in all cases, the straight-line method of depreciation.

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

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

	2008
Leasehold Improvements	Lease Term
Plant & Equipment	4 to 10 years

Impairment

All assets were assessed for impairment at 30 June 2008. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs to sell and its value in use. Value in use is the present value of the future cash flows expected to be derived

from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the Ombudsman were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

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

1.15 Intangibles

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

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the Ombudsman's software is 5 years.

All software assets were assessed for indications of impairment as at 30 June 2008.

1.16 Taxation

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

Revenues, expenses and assets are recognised net of GST:

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

NOTE 2: INCOME

REVENUE	**2008 $**
NOTE 2A: REVENUE FROM GOVERNMENT	
Appropriations	
Departmental Outputs	1,957,000
Total revenue from Government	1,957,000

NOTE 2B: OTHER REVENUE	
Seminar Income	805
Resources received free of charge	11,000
Total other revenue	11,805

NOTE 3: EXPENSES

NOTE 3A: EMPLOYEE BENEFITS	2008 $
Wages and salaries	592,484
Superannuation:	
Defined contribution plans	79,849
Leave and other entitlements	52,091
Other employee expenses	7,925
Total employee benefits	732,349

NOTE 3B: SUPPLIERS	
Provision of goods – external parties	533,658
Operating lease rentals:	
Minimum lease payments	54,340
Workers compensation premiums	5,338
Total supplier expenses	593,337

NOTE 3C: DEPRECIATION AND AMORTISATION	
Depreciation:	
Infrastructure, plant and equipment	16,607
Leasehold improvements	507
Total depreciation	17,114
Amortisation:	
Intangibles:	
Computer Software	134,702
Total amortisation	134,702
Total depreciation and amortisation	151,816

NOTE 3D: LOSSES FROM ASSET DISPOSAL	
Carrying value of assets disposed	6,771
Total write-down of assets	6,771

NOTE 4: FINANCIAL ASSETS

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

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

All receivables are current.

NOTE 5: NON-FINANCIAL ASSETS

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

$2,992.00 of total leasehold improvements refers to enhancement to the fit-out of the current office accommodation.

No indicators of impairment were found for leasehold improvements.

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

All revaluations are conducted in accordance with the revaluation policy stated at Note 1. In 2007-08, no revaluations were conducted.

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

NOTE 5C: ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

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

	LEASEHOLD IMPROVEMENTS $	INFRASTRUCTURE, PLANT & EQUIPMENT $	TOTAL $
AS AT 1 JULY 2007			
Gross book value	-	-	-
Accumulated depreciation/amortisation and impairment	-	-	-
Net book value 1 July 2007	-	-	-
Additions:			
by purchase	-	26,350	26,350
From acquisition of entities or operations (including restructuring)	3,371	63,250	66,621
Depreciation/amortisation expense	(507)	(16,607)	(17,114)
Other movements	*128*	*(522)*	(394)
Disposals:			
Other disposals	-	(6,771)	(6,771)
Net book value 30 June 2008	2,992	65,700	68,692

NET BOOK VALUE AS OF 30 JUNE 2008 REPRESENTED BY:			
Gross book value	3,499	82,307	85,806
Accumulated depreciation/amortisation and impairment	(507)	(16,607)	(17,114)
	2,992	65,700	68,692

NOTE 5D: INTANGIBLES	2008 $
Computer software at cost:	
Consumer website	819,653
Total Computer Software	819,653
Accumulated amortisation	(157,803)
Total intangibles (non-current)	661,850

No indicators of impairment were found for intangible assets.

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

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

NOTE 6: PAYABLES

NOTE 6A: SUPPLIERS	2008 $
Trade creditors	41,669
Total supplier payables	41,669
Supplier payables are represented by:	
Current	41,669
Non-current	-
Total supplier payables	41,669

Settlement is usually made net 30 days.

NOTE 7: PROVISIONS

NOTE 7A: EMPLOYEE PROVISIONS	2008 $
Salaries and Wages	-
Annual leave	66,996
Long service leave	85,760
Total employee provisions	152,756
Employee provisions are represented by:	
Current	86,681
Non-current	66,076
Total employee provisions	152,756

The classification of current includes amounts for which there is not an unconditional right to defer settlement by one year, hence in the case of employee provisions the above classification does not represent the amount expected to be settled within one year of reporting date. Employee provisions expected to be settled in twelve months from the reporting date are $86,681 and in excess of one year $66,076.

NOTE 8: CASH FLOW RECONCILLIATION	2008 $
RECONCILIATION OF CASH AND CASH EQUIVALENTS AS PER BALANCE SHEET TO CASH FLOW STATEMENT	
REPORT CASH AND CASH EQUIVALENTS AS PER:	
Cash Flow Statement	54,960
Balance Sheet	54,960
DIfference	-
RECONCILIATION OF OPERATING RESULT TO NET CASH FROM OPERATING ACTIVITIES:	
Operating result	484,532
Depreciation /amortisation	151,816
Net write down of non-financial assets	6,771
(Increase) / decrease in net receivables	(423,575)
Increase / (decrease) in employee provisions	49,952
Increase / (decrease) in supplier payables	42,064
Net cash from operating activities	311,560

NOTE 9: SENIOR EXECUTIVE REMUNERATION	2008
The number of senior executives who received or were due to receive total remuneration of $130,000 or more:	
$160 000 to $174 999	1
The aggregate amount of total remuneration of senior executives shown above.	$167,544
The aggregate amount of separation and redundancy/termination benefit payments during the year to executives shown above.	-

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

No other services were provided by the Auditor-General.

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

NOTE 11B: FAIR VALUES OF FINANCIAL ASSETS AND LIABILITIES

The fair value of each class of the Ombudsman's financial assets and financial liabilities equals its carrying amount.

NOTE 11C: CREDIT RISK

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

The Ombudsman has no significant concentration of credit risk.

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

NOTE 11D: LIQUIDITY RISK

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

NOTE 11E: MARKET RISK

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

The Ombudsman is not exposed to Currency Risk or Other Price Risk.

NOTE 12: APPROPRIATIONS

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

PARTICULARS	DEPARTMENTAL OUTPUTS 2008 $
Balance brought forward from previous period	-
Appropriation Act:	
Appropriation Act (No.1) 2007-08	1,923,000
Appropriation Act (No.3) 2007-08	34,000
FMA Act:	
Refunds credited (FMA section 30)	1,514,722
Appropriations to take account of recoverable GST (FMA section 30A)	36,864
Annotations to 'net appropriations' (FMA section 31)	805
Total appropriation available for payments	3,509,391
Cash payments made during the year (GST inclusive)	1,487,709
Balance of Authority to Draw Cash from the Consolidated Revenue Fund for Ordinary Annual Services Appropriations	2,021,682
Represented by	
Cash at bank and on hand	54,960
Departmental appropriations receivable	1,966,722
TOTAL	2,021,682

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

NOTE 13: SPECIAL ACCOUNTS

The Ombudsman has a Special Account established with the name *Services for Other Entities and Trust Moneys - Private Health Insurance Ombudsman Special Account.* This account was established under section 20 of the Financial Management and Accountability Act 1997 (FMA Act). For the years ended 30 June 2007-2008 the account had nil balances and there were no transactions debited or credited to it.

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

(a) disburse amounts temporarily held on trust or otherwise for the benefit of a person other than the commonwealth;

(b) disbursing amounts in connection with services performed on behalf of other Governments and bodies that are not FMA Act agencies; and

(c) repay amounts where an Act or other law requires or permits the repayment of an amount received.

NOTE 14: REPORTING OF OUTCOMES

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

The output groups support the outcome:

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

NOTE 14A: NET COST OF OUTCOME DELIVERY	OUTCOME 1 2008 $
EXPENSES	
Departmental	1,484,273
Total expenses	1,484,273
OTHER EXTERNAL REVENUES	
Departmental	11,805
Total other external revenues	11,805
NET COST OF OUTCOME	1,472,468

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

OUTCOME 1	OUTPUT 1 2008 $	OUTPUT 2 2008 $	TOTAL 2008 $
DEPARTMENTAL EXPENSES			
Employees benefits	187,110	545,239	732,349
Suppliers	151,594	441,743	593,337
Depreciation and amortisation	38,788	113,028	151,816
Write-down of assets	1,730	5,041	6,771
Total departmental expenses	379,222	1,105,051	1,484,273
FUNDED BY:			
Revenue from Government	500,000	1,457,000	1,957,000
Other revenue	3,016	8,789	11,805
Total departmental revenues	503,016	1,465,789	1,968,805

Net costs shown include intra-government costs that are eliminated in calculating the actual Budget outcome.

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