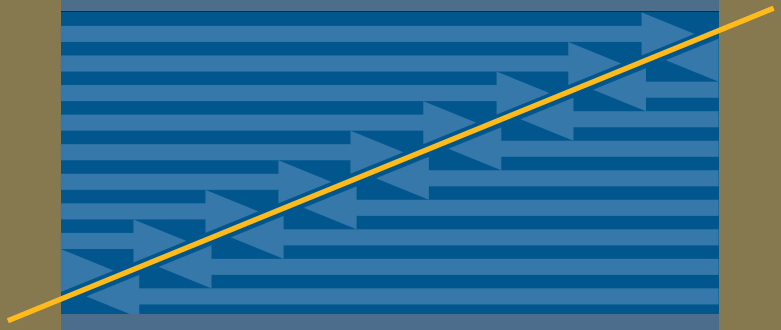
Private Health Insurance
OMBUDSMAN



Annual Report 2003

contact details

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

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Private Health Insurance Ombudsman
Suite 1201, Level 12
St Martins Tower
31 Market Street
Sydney NSW 2000

TELEPHONE, FAX AND E-MAIL

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

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

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

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Monday – Friday

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

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

ISSN 1327-5305

contents

Financials

Private Health Insurance
OMBUDSMAN

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

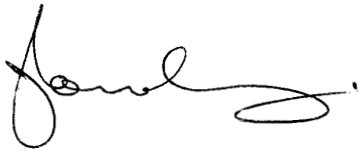
Dear Minister

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

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2002 to 30 June 2003.

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

Yours sincerely



John Powlay
OMBUDSMAN

10 October 2003

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ombudsman's overview

In November 2002, I was appointed to the position of Private Health Insurance Ombudsman for a three-year term, commencing on 18 November 2002. Norman Branson held the position of Private Health Insurance Ombudsman until 31 October 2002.

The role of the Private Health Insurance Ombudsman is concerned with the respective rights and interests of private health insurance contributors, private health providers and health funds and the promotion of fair, responsive and accountable administration of private health insurance arrangements.

John Powlay

PREMIUM RISES

Over the last year there has been a significant amount of public commentary and debate about private health insurance arrangements. The context for much of this debate is increasing costs and utilisation of health services within both the public and private health systems. It is not surprising therefore that a significant amount of comment has been directed at the price of private health insurance and that there is now considerable pressure on funds to take action to contain price increases.

Faced with rising costs for health services, funds have few options for containing prices. There is a risk that the value of health insurance products will be undermined through changes to benefits and other conditions in order to achieve this price containment.

Our experience on complaints about price rises this year (and in previous years) suggests that most consumers accepted that some increase in price was justified. Complaints were concentrated on certain products within two or three funds that had price increases over double the industry average. In most cases it appeared that those funds had significantly underpriced the particular products previously and found it necessary to drastically correct their premiums. I hope that such drastic corrections can be avoided through better management in future. If such changes are necessary the funds need to do better in explaining the reasons behind them.

BENEFIT CHANGES

During the year it was necessary for me to intervene with at least five funds that had introduced significant benefit reductions without adequate notice to consumers and without appropriate transitional arrangements for effected contributors.

I was able to get all the relevant funds to agree to transitional arrangements to protect people who had already booked hospital treatment or commenced a course of treatment (for example, dialysis or chemotherapy treatments).

Some of the funds also agreed to delay the introduction of the proposed changes, in recognition of my concerns about the lack of adequate notice. Unfortunately two funds would not agree to defer the effective date of the changes or provide extra time for affected contributors to upgrade their cover, despite my recommendations. However, both funds did indicate a willingness to look at individual complaints on a case-by-case basis.

Since taking up this matter with the funds involved and alerting all funds to my concerns about this issue I have seen an improvement in the management of fund rule changes (including providing more notice) and funds are more likely to consult with my office prior to implementing such changes. This issue takes on a greater significance because it is now proposed (as part of the reform of private health insurance arrangements) that funds will not have to seek prior approval of changes to their benefits. I have therefore consulted with health fund industry associations and suggested good practice guidelines on this issue. I expect that all funds would adhere to my guidelines as a matter of responsible self-regulation.

FUND HOSPITAL AGREEMENTS

One issue that has a very significant effect on the value of private hospital insurance products is whether or not a fund has an agreement with particular private hospitals. Where a hospital does have an agreement with the fund, this usually means that the fund member pays nothing (other than any agreed excess) for hospital accommodation and associated hospital fees. However, where the fund and hospital do not have an agreement, the fund's benefit will only cover part of the hospital's charge and the patient will be required to meet the remainder of the hospital charge (the "gap"), which can be significant in many cases.

There is a voluntary Code of Practice governing hospital/fund negotiations. The aim of the Code is to ensure that hospitals and funds adhere to fair and reasonable negotiation practices and minimise disputes. My experience is that too often funds and hospitals are acting outside the spirit of the Code and as a result members and patients are being disadvantaged or unduly concerned about the effect of any changes. This is particularly the case in relation to public statements made by both or either party during or following the conclusion of negotiations. Such apparent breaches of the Code are occurring too often. If the self-regulation approach, embodied in the Code is to continue, it needs to be strengthened and given a wider scope and all parties need to recommit to abiding by both the letter and spirit of the voluntary code.

COVERING THE GAP

My office continues to receive a significant number of complaints about patient "gaps" relating to doctors' charges for hospital treatment. The scope and effectiveness of such arrangements is also a factor that contributes to the value of hospital cover. Statistical reports indicate that the introduction of gap cover schemes by most funds has helped to reduce the incidence and size of gaps in relation to doctors' bills for hospital treatment. However we are receiving a growing number of complaints about the operation of these schemes. The complaints we have received suggest that funds need to do better in providing information to members on the availability of participating doctors and the operation of their gap cover schemes. Some funds also need to take on a greater advocacy role for their members in situations where doctors participating in their gap cover schemes are not complying with the conditions of the scheme in relation to fees and informed financial consent.

BENEFIT RESTRICTIONS

Previous reports by the Private Health Insurance Ombudsman have drawn attention to problems arising from health insurance products that include exclusions and restrictions on a range of treatments. We continue to receive complaints from people who have incurred substantial bills because they were unaware of, or did not fully understand, the implications of such restrictions. Many of these problems can be avoided if hospitals, doctors and funds have effective processes in place to ensure patients are given full information of the financial implications of treatment options. It is pleasing to see that the Department of Health and Ageing will be convening an industry working group this year to develop options for improving the provision of informed financial consent. My office will be participating in that process. I will also continue to assess the quality of information provided by funds to their contributors about restrictions or limitations on benefits for certain treatments.

"LIFESTYLE" BENEFITS

The effectiveness of using a few examples to illustrate a systemic issue was demonstrated by the impact of the final quarterly bulletin of the former Ombudsman. The bulletin was a light-hearted summary of some of the more extraordinary complaints the office received. This included some unusual requests for reimbursement of expenses under the "lifestyle" benefits offered by some funds. These few extreme examples, including classical music CDs, tents and golf clubs (where the office dealt with complaints of non-payment of benefits for these items) became an important element leading to pressure on the funds. This led to their eventual agreement that "lifestyle" benefits should be removed.

PRIVATE HEALTH INSURANCE REFORM

During the year the Government introduced the *Health Legislation Amendment (Private Health Insurance Reform Bill) 2003.* That bill includes measures to strengthen the powers of the Private Health Insurance Ombudsman, as well as an additional function: the preparation and publication of a "State of the Health Funds Report".

I was closely consulted in the development of the proposals to strengthen the Private Health Insurance Ombudsman's powers. I am comfortable that the proposed changes strike a reasonable balance between providing the Ombudsman with greater authority in key areas and maintaining an emphasis on cooperation and prompt informal resolution of complaints. The added authority given to my role through these changes is a necessary complement to less direct regulation of funds in areas such as fund rule changes.

The bill proposes that the Private Health Insurance Ombudsman publish the "State of the Health Funds Report" after the end of each financial year. The report will provide "comparative information on the performance and service delivery of all registered organisations during that financial year".

I have consulted with relevant stakeholders on the possible content and format of the report and expect to be able to publish an initial Report relating to the 2002/2003 financial year (subject to passage of the legislation). It is my aim that consumers will be able to use the report, in conjunction with other published information, to make more informed choices about which funds and health insurance products best meet their needs.

ombudsman's overview

CONSUMER INFORMATION

During the year I have conducted an informal assessment of the range of written information material available to consumers about private health insurance. This included information materials (brochures, leaflets etc) produced by my office, the Department of Health and Ageing and the Private Health Insurance Administration Council. As a result, I have been working cooperatively with those agencies to develop an approach that I believe will be more effective and efficient. During the coming year, my office will continue to assess the quality of information available to consumers from the funds. The achievement of improvements in this area will be one of my key priorities for the year.

Given my office's primary function of dealing with complaints, it is not possible to present a balanced picture of the operation of private health insurance arrangements in a report of our activities. Inevitably our focus is on what has gone wrong and the issues we report are often drawn from a relatively small number of complaints involving only a few of the forty two funds. Nonetheless, I am confident the issues raised in my report contain valuable lessons for all funds and others involved in the private health industry.

John Powlay

OMBUDSMAN

role and function

INTRODUCTION

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

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

FUNCTIONS

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

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

WHO CAN MAKE A COMPLAINT?

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

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

WHAT CAN THE OMBUDSMAN DO WITH A COMPLAINT?

The Ombudsman is able to deal with complaints by:

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

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

role and function

WHAT HAPPENS AT THE END OF A COMPLAINT OR INVESTIGATION?

The Ombudsman is able to recommend that:

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

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

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

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

HOW STAFF RESOLVE COMPLAINTS

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

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

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

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

Staff Names
Left to Right are:

Samantha Gavel,
Taran Sahdeva,
David McGregor (seated),
Ginette Bulmer,
Jacqueline Power,
John Powlay,
Ursula Schappi,
Hilary Bassingthwaighte
(seated).

INTRODUCTION

The Ombudsman received 3568 complaints in the reporting period 1 July 2002 to 30 June 2003, compared with 3182 for the corresponding period of the last report (a 12% increase).

Complaint numbers, which tend to average out at around 14 new cases per day, peaked at 36 new cases per day in March 2003 following the announcement of premium increases for most health funds.

During the first half of the year, there was an 18% increase in the level of complaints compared with the same period in the previous year. During the second half of the year, when a number of funds increased contribution rates, there was an overall 8.5% increase in the level of complaints compared to the same period the previous year.

Figure 1 shows the distribution of these complaints through the four quarters of the 2002/2003 financial year.

Figure 2 shows the total number of complaints received per year for the last 6 years. The jump in the number of complaints in the 2000/2001 year was associated with the large rise in health fund membership, following the introduction of the 30% rebate and lifetime health cover requirements. Despite a slight decline in fund membership since then, the number of complaints has risen to a new high.

RECORDING AND CATEGORISATION OF COMPLAINTS

An approach to the Ombudsman's office is recorded as a complaint when it meets the criteria contained in the *National Health Act 1953.* A complaint must be:

Figure 1
Total Complaints Received By Quarter

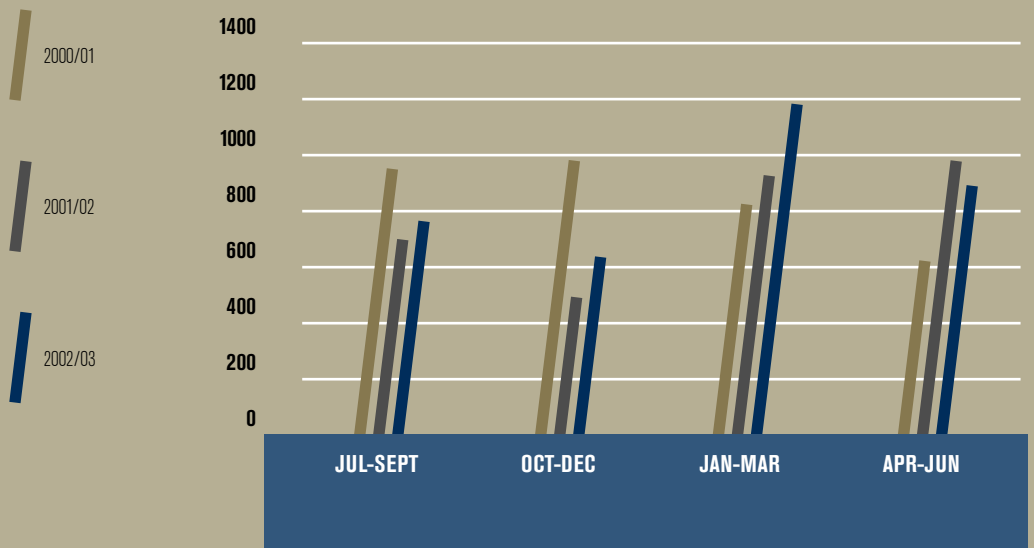
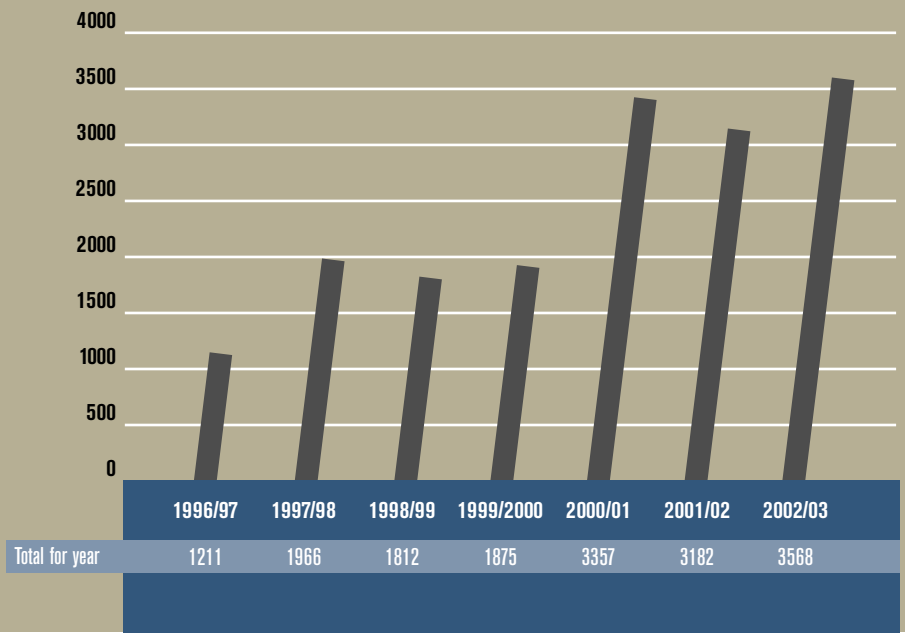


Figure 2
Complaints by Year



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

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

Currently this categorisation is:

Complaint level 1 - Problems: Moderate level of complaint

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

Complaint level 2 - Grievances: Moderate level of complaint where mediation is required

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

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

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

The 3568 complaints recorded in 2003/2004 consisted of 609 disputes, 1690 grievances and 1269 problems. Figures 3 and 4 show these ratios and indicate a significant increase in the grievance category of complaint.

Figure 3
Complaints Received per Year by Category

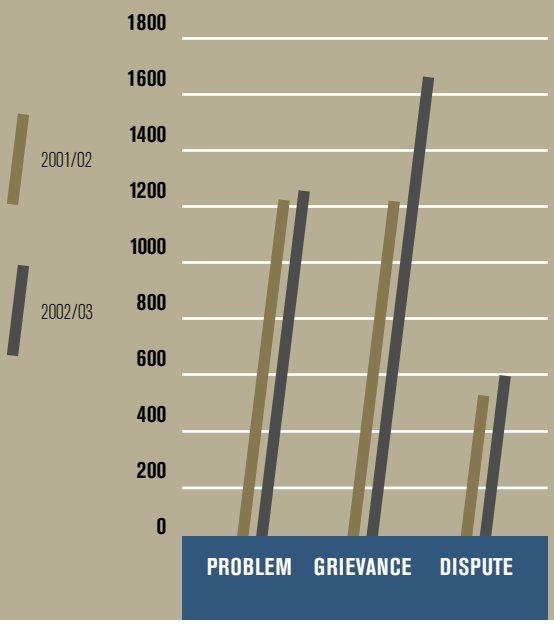
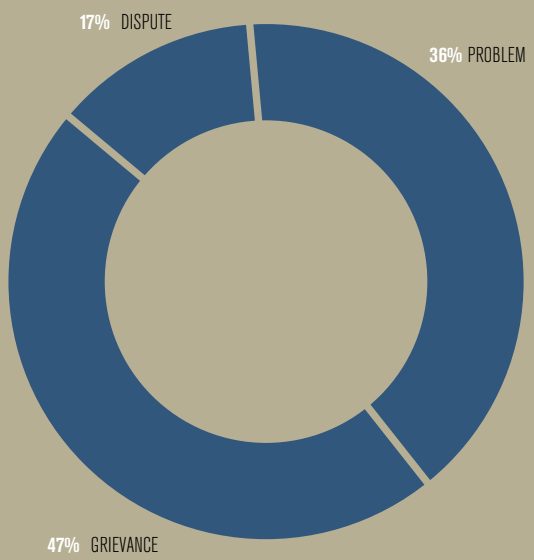


Figure 4
Complaints Category, Percentage



COMPLAINTS HANDLING PROCEDURES

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

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

Fund members also lodge complaints about their;

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

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

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

Figure 5
Steps in Handling Approaches to the Ombudsman

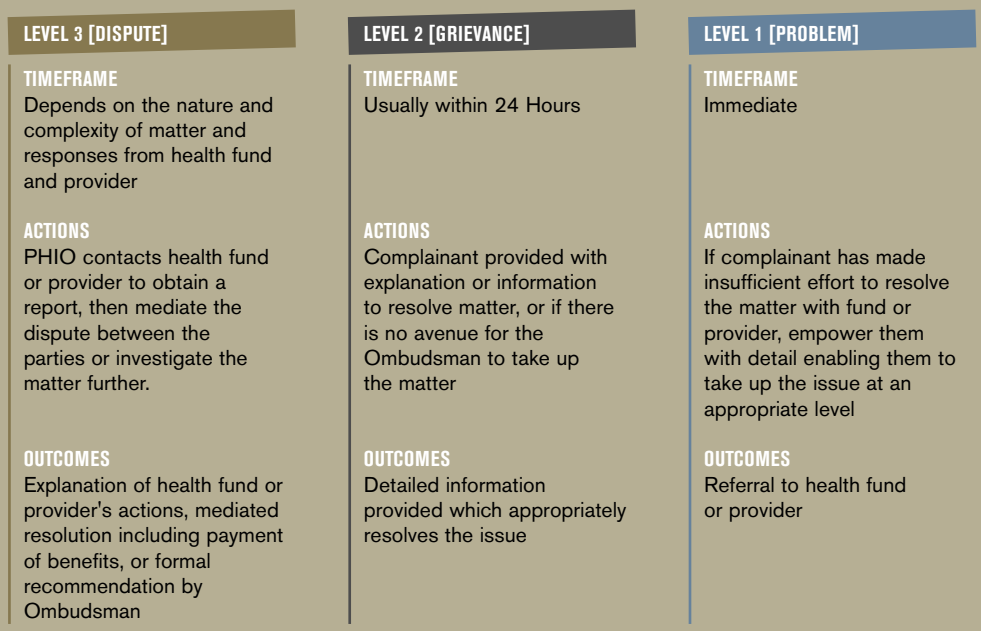
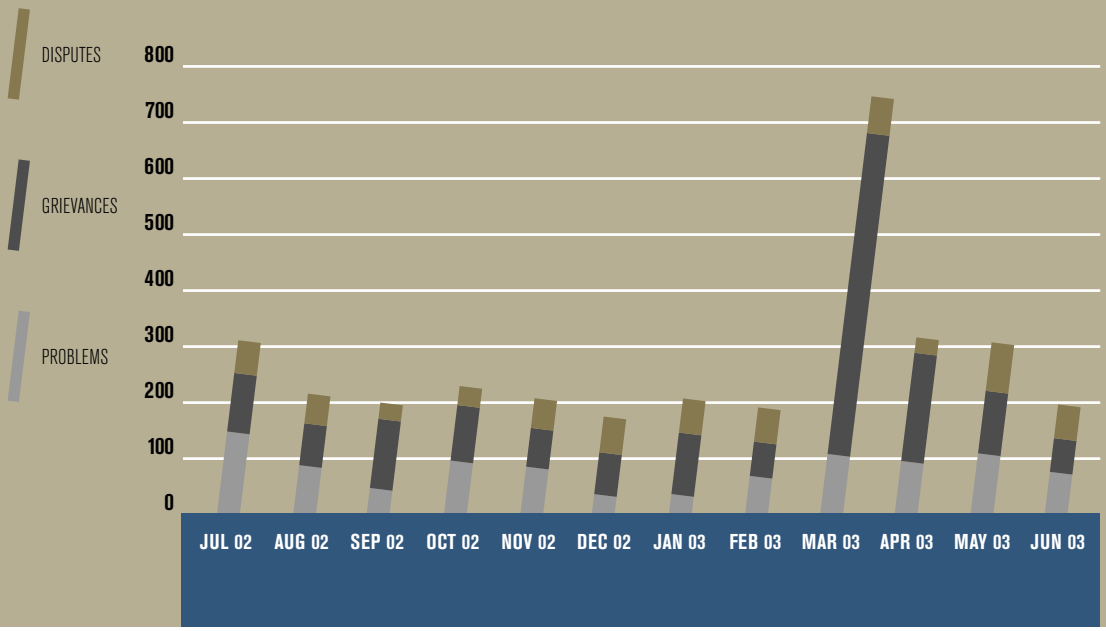


Figure 6
Total Complaints Received by Month



WORKLOAD

The office received 3568 complaints (problems, grievances and disputes) in 2002/2003, an average of 297 per month compared with 265 complaints per month in the previous year.

The office finalised 3572 complaints during the year; an average of 298 per month, compared with an average 265 complaints finalised per month in the previous year.

The workload for the office is also affected by the type and complexity of complaints. This year, there was an increase in complaints in the more work intensive complaint categories (grievances and disputes). The increasing complexity of health insurance arrangements has also contributed to increased workload pressures for the office.

Figure 6 shows the number of complaints received in each month of the year, indicating changes in workload over the year in the various complaint categories. The workload peak in March is associated with the announcement of health fund premium rises. Most complaints about that issue are recorded as grievances.

TIME TAKEN TO RESOLVE COMPLAINTS

Figures 7 and 8 provide information on the time taken to resolve complaints and show a similar resolution time as last year. The increase in cases taking a much longer period to finalise is a reflection of increased complexity, particularly in the dispute category.

Figure 7
Time Taken to Finalise Complaints

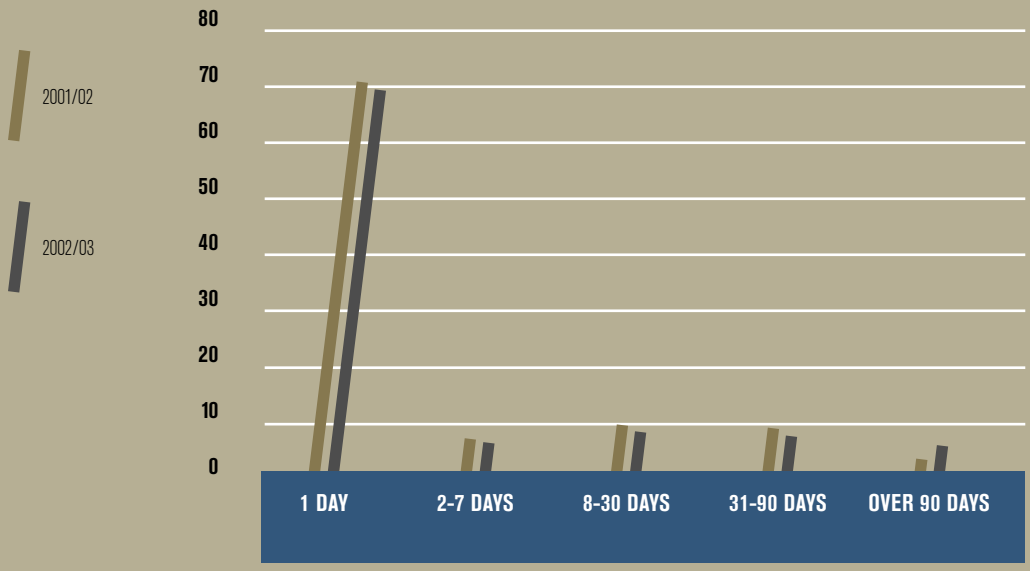
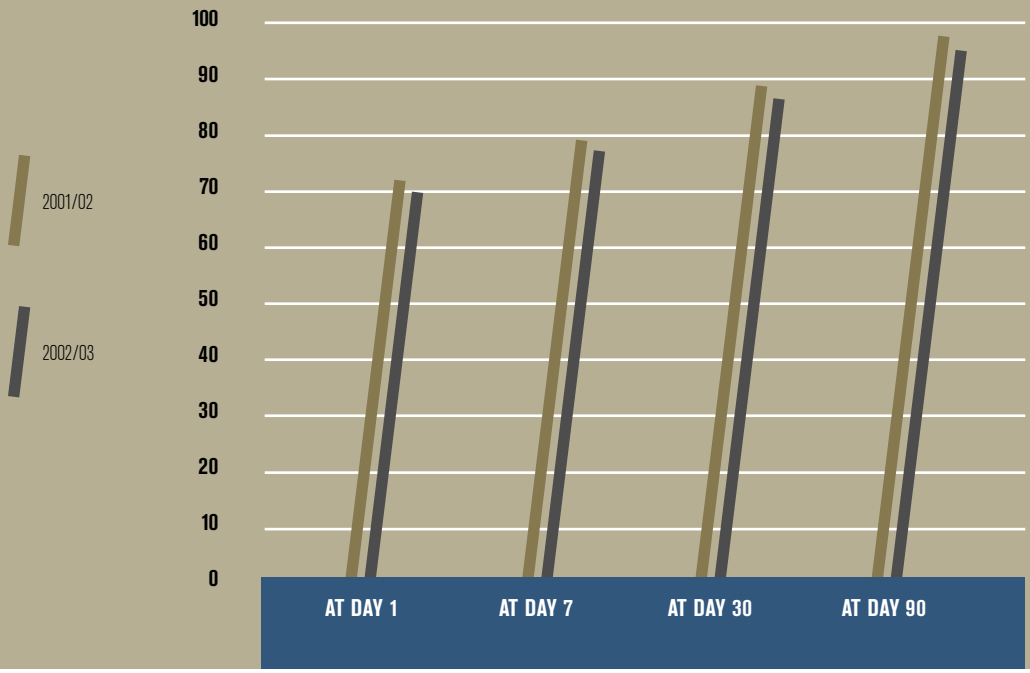


Figure 8
Complaints Completed Since Day of Lodgement



WHO WAS COMPLAINED ABOUT

Most complaints were made about health funds 3334, followed by practitioners (doctors and dentists), 254 and hospitals, 217. Some complaints concern a health fund as well as a hospital, doctor or dentist. Consequently, the total number of organisations or people being complained about 3805, adds up to more than the total number of complaints, 3568.

COMPLAINTS ABOUT HEALTH FUNDS

Figure 9 provides a summary of all complaints (problems, grievances and disputes) for individual health funds compared with their market share. This data is further dissected with respect to the higher category "disputes", again by market share. Analysing the information at this further level of detail provides a more realistic picture of the way funds respond to their members' complaints in general and to the higher level issues included in the dispute category. Higher dispute to market share ratios, are a pointer to a less than adequate internal disputes resolution process for complex issues within the fund.

COMPLAINTS ABOUT HOSPITALS

Complaints to the Ombudsman about hospitals are mostly related to the consequences of inadequate membership verification prior to a procedure being carried out.

During this year, the office also received a number of complaints that arose out of the actions of hospitals during or after the breakdown of negotiations between hospitals and funds about Hospital Purchaser-Provider Agreements (HPPA). These complaints generally arose out of media reporting of hospital comments or information provided by hospital staff, that led to concern or uncertainty for the health fund member. The office has also received complaints from health funds about the actions of hospitals during or after HPPA negotiations (and from hospitals about the actions of funds in these situations). Comment on this issue is included in the Ombudsman's Overview.

COMPLAINTS ABOUT DOCTORS

Most complaints about doctors concern the lack of informed financial consent. This year some complaints were lodged as a result of practitioners charging additional fees for patients who believed they were covered under health fund gap schemes. Similar to last year, there was a tendency for these complaints to be lodged after practitioners advised significant increases to original quotations or "booking fees" (apparently to cover higher medical indemnity costs).

RESOLVING COMPLAINTS

53% of complaints were resolved by the Ombudsman's office providing an independent and impartial explanation of the health fund member's grievance. This was consistent with the large level of grievance type complaints concerning contribution increases.

34% of complaints were referred directly back to the health fund through the complainant. The Ombudsman was generally able to suggest alternative ways for the complainant to pursue the matter with the health fund. Only in a relatively small number of instances was it subsequently necessary for the complaint to be re-opened as a dispute, and actioned by the office directly with the fund on behalf of the contributor.

However, a question on this issue was included in the Ombudsman's 2003 Client Satisfaction Survey. Only 25% of survey respondents were satisfied with the fund's response to their complaint after they were referred back to the health fund. 57% of respondents said that they were not satisfied with the fund's response, and 18% said they were unsure or had not pursued the matter

Figure 9
Complaints by Health Fund Market Share

NAME OF FUND	TOTAL NUMBER OF COMPLAINTS (1)	% OF TOTAL COMPLAINTS	TOTAL NUMBER OF DISPUTES (2)	% OF TOTAL DISPUTES	HEALTH FUND MARKET SHARE (3)
ACA Health Benefits	2	0.1	0	0.0	0.1
AMA Health Fund	0	0.0	0	0.0	0.1
Australian Health Management Group	438	13.2	26	4.5	2.5
Australian Unity	86	2.6	21	3.6	3.1
CBHS	32	1.0	7	1.2	1.0
CDH (Cessnock District Health)	0	0.0	0	0.0	<0.5
Credicare	25	0.8	8	1.4	0.4
Defence Health	18	0.5	5	0.9	1.2
Druids NSW	0	0.0	0	0.0	<0.5
Druids Victoria	5	0.2	0	0.0	0.1
Federation Health	7	0.2	2	0.3	0.2
GMF Health (4)	33	1.0	8	1.4	0.6 (5)
GMHBA	35	1.1	7	1.2	1.3
Grand United Corporate Health	7	0.2	1	0.2	0.2
Grand United Health	14	0.4	2	0.3	0.4
HBA Health Insurance	311	9.3	53	9.1	9.9
HBF Health	120	3.6	28	4.8	8.6
HCF(Hospitals Contribution Fund)	103	3.1	16	2.7	7.6
Health Care Insurance	2	0.1	0	0.0	0.1
Health Insurance Fund of W.A.	15	0.5	4	0.7	0.4
Healthguard	3	0.1	2	0.3	0.6
Health-Partners	14	0.4	3	0.5	0.6
I.O.R. Australia	116	3.5	23	3.9	0.9
IOOF Health	6	0.2	1	0.2	0.2
Latrobe Health	5	0.2	2	0.3	0.4
Lysaght Peoplecare	2	0.1	0	0.0	0.3
Manchester Unity	70	2.1	15	2.6	1.3
MBF (Medical Benefits Fund)	597	17.9	58	9.9	16.7
Medibank Private	895	26.9	216	37.0	29.7
Mildura District Hospital Fund	2	0.1	0	0.0	0.3
N.I.B. Health	180	5.4	41	7.0	5.5
Navy Health	4	0.1	1	0.2	0.3
NRMA Health	107	3.2	17	2.9	2.1
Phoenix Health Fund	2	0.1	1	0.2	0.1
Police Health (SA)	3	0.1	1	0.2	0.1
Queensland Country Health	9	0.3	3	0.5	0.2
Railway & Transport Health	0	0.0	0	0.0	0.3
Reserve Bank Health	1	0.0	1	0.2	<0.5
St Lukes Health	12	0.4	1	0.2	0.4
Teacher Federation Health (NSW)	12	0.4	2	0.3	1.5
Teachers Union Health (QLD)	14	0.4	3	0.5	0.4
Transport Health	2	0.1	1	0.2	0.1
Westfund	19	0.6	3	0.5	0.8
TOTAL FOR REGISTERED FUNDS	**3328**	**100.0**	**583**	**100**	

Note 1. Complaints = problems, grievances and disputes
Note 2. Disputes required intervention by the Ombudsman with Fund
Note 3. Source: PHIAC: Market Share as at 30/06/2003
Note 4. Since December 2002 Healthguard has been conducting the health insurance business of GMF Health. GMF Health complaints will not be reported separately in future.
Note 5. GMF Market Share as at 30/09/2002

with the health fund. As a result of this finding, the office now intends to undertake more follow up with complainants who have been referred back to their health fund.

Four percent of complaints (54% of the dispute category) were resolved following payments by health funds or the writing off of accounts by hospitals.

Payments by health funds generally result from a health fund agreeing with the Ombudsman that the fund member was entitled to the payment of a benefit under the terms of the member's level of private health insurance cover, or the payment was made on an ex gratia basis to a loyal member. Accounts written off by hospitals would have been a direct result of hospitals needing to accept their responsibility after failing initially to adequately inform patients of their costs.

An additional 6% of complaints were resolved by taking other remedial action, such as re-instating a membership or allowing the back payment of contributions where a membership had lapsed.

The relatively small proportion of complaints recorded as being resolved by an additional payment or other remedial action reflects the small proportion of disputes compared to the total number of problems and grievances. Many of the matters referred back to funds (problems) may have been resolved in this way but that outcome is not known or recorded by this office.
The outcomes for disputes alone, where the Ombudsman intervenes, show that 23% resulted in the fund offering an additional payment and 31% were resolved by taking other remedial action.

1% of complaints were withdrawn or required no further action.

It was necessary this year to refer 2% of complaints, which met the criteria for complaint contained in the *National Health Act 1953,* to another agency such as the ACCC.

Information about the resolution of complaints and disputes is provided in Figures 10 and 11.

TYPE OF COMPLAINANT

The *National Health Act 1953* allows health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf to lodge complaints. Overwhelmingly, complaints were made by health fund members (98%), followed by hospitals/day hospitals, practitioners, and health funds.

HOW COMPLAINTS WERE MADE

89% of all problems, grievances and disputes were made initially by telephone. 6% were received by letter. Almost 5% were lodged by email. While the proportion of complaints received electronically is still relatively low, the number of complaints received via email this year represented a 365% increase on the previous year. The remaining were made by fax, personal visit, or by Parliamentary Representation.

INVESTIGATIONS INTO HEALTH FUND PRACTICES AND PROCEDURES

The Ombudsman concluded an investigation under Section 82ZT of the *National Health Act 1953* to determine the capability of health funds to provide information to hospitals to determine membership eligibility for procedures. A report of this investigation was distributed to health funds and private hospital groups and was published on the Ombudsman's Internet site.

The Ombudsman does not necessarily prepare a public report of all investigations conducted under Section 82ZT.

During the year, the Ombudsman also initiated an investigation under Section 82ZT into the practices of certain funds in relation to the implementation of

Figure 10
Outcomes of Finalised Complaints

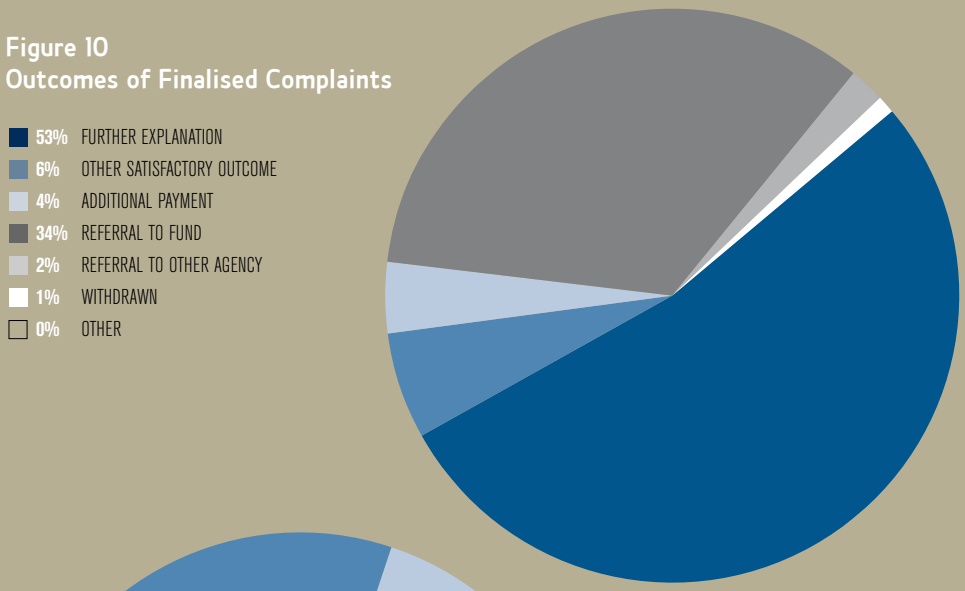


Figure 11
Outcomes of Finalised Disputes

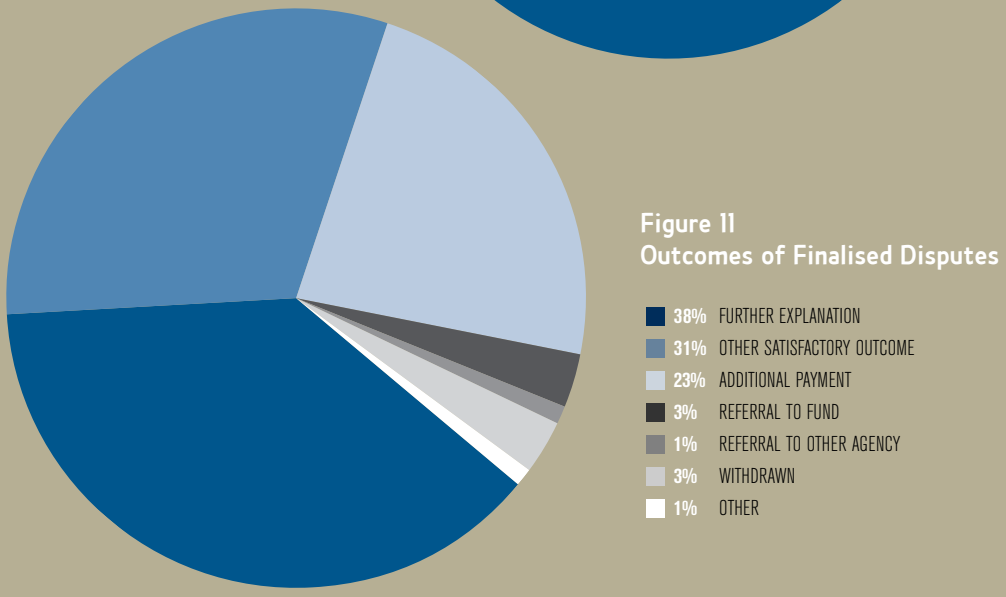
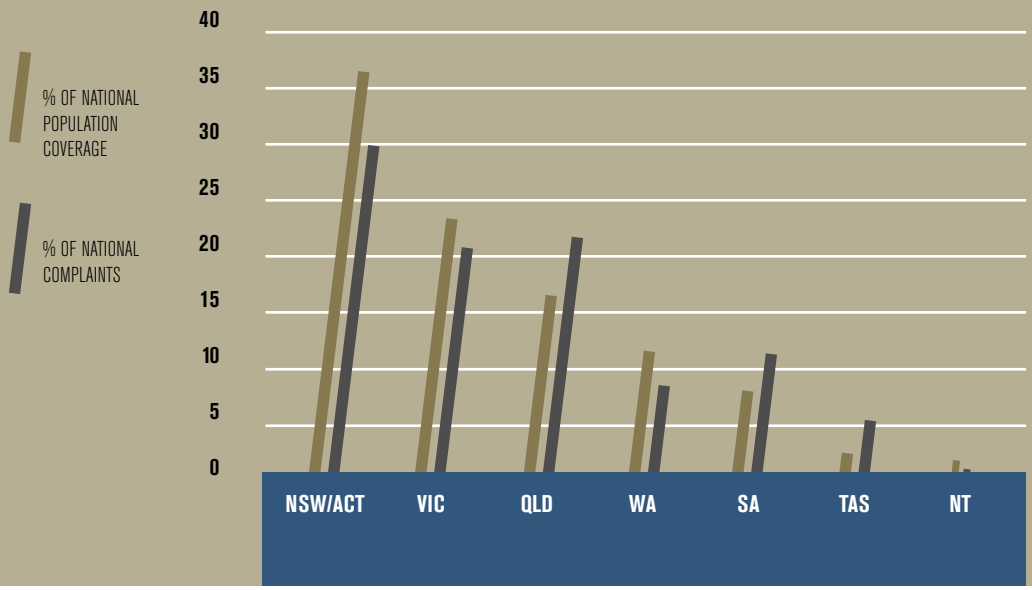






Figure 12
Complaints Covered by State & Territory



detrimental changes to fund rules. The Ombudsman achieved some changes to the funds' implementation arrangements through informal mediation. The Ombudsman also made formal recommendations to two funds (HBA Health Insurance and NRMA Health) as a result of the investigation. As reported in the Ombudsman's Overview, there has been an improvement in administration in this area, following the Ombudsman's investigation and subsequent action.

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

COMPLAINTS BY STATE/TERRITORY

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

Staff Names Left to Right are: Ursula Schappi, Ginette Bulmer, Hilary Bassingthwaighte, Jacqueline Power, Samantha Gavel, Taran Sahdeva, David McGregor

complaints issues

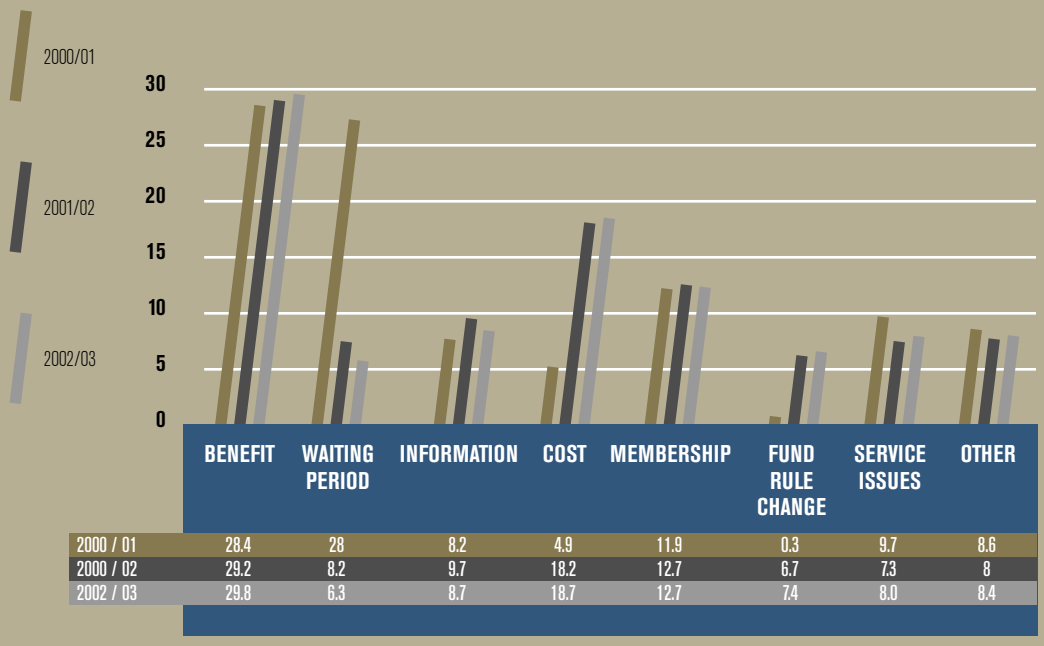
INTRODUCTION

Complaints to the Ombudsman must first meet the requirements of the Section 82Z of the *National Health Act 1953.* Embodied in that section is the requirement that a complaint be about a health insurance arrangement.

CONTRIBUTION INCREASES

The 2003 round of premium increases again produced a significant level of complaint to PHIO, with the number of complaints registered in the month of March 2003 the highest on record since the inception of the office. However we

Figure 13
Complaint Issues



	BENEFIT	WAITING PERIOD	INFORMATION	COST	MEMBERSHIP	FUND RULE CHANGE	SERVICE ISSUES	OTHER
2000 / 01	28.4	28	8.2	4.9	11.9	0.3	9.7	8.6
2000 / 02	29.2	8.2	9.7	18.2	12.7	6.7	7.3	8
2002 / 03	29.8	6.3	8.7	18.7	12.7	7.4	8.0	8.4

This year issues about benefits and premium increases again dominated our complaints. There was also a small, but significant, increase in complaints about fund rule changes.

Figure 13 compares the relative complaint issues over the past three years.

recorded very few complaints for the majority of funds. Most complaints were received in relation to a small number of funds that announced significant increases to one or more of their products.

The members of those funds who contacted my office, were not complaining about the increase itself. They were complaining about the fact that the increase on their particular

Figure 14
Cost Complaints by Health Fund Market Share

NAME OF FUND	AVERAGE % PREMIUM INCREASE ACROSS FUND (1)	PREMIUM INCREASE COMPLAINTS (2)	% TOTAL PREMIUM COMPLAINTS	HEALTH FUND MARKET SHARE (3)
ACA Health Benefits	8.8	1	0.1	0.1
AMA Health Fund	5.5	0	0.0	0.1
Australian Health Management Group	19.6	298	43.5	2.5
Australian Unity	5.9	2	0.3	3.1
CBHS	15.4	2	0.3	1.0
CDH (Cessnock District Health)	5.8	0	0.0	<0.5
Credicare	11.1	6	0.9	0.4
Defence Health	4.8	0	0.0	1.2
Druids NSW	2.8	0	.0	<0.5
Druids Victoria	3.0	0	0.0	0.1
Federation Health	6.9	0	0.0	0.2
GMF Health (4)	n/a	8	.2	0.6 (5)
GMHBA	3.2	1	0.1	1.3
Grand United Corporate Health	9.1	1	0.1	0.2
Grand United Health	8.7	1	0.1	0.4
HBA Health Insurance	6.3	31	4.5	9.9
HBF Health	9.9	7	1.0	8.6
HCF(Hospitals Contribution Fund)	10.9	12	1.8	7.6
Health Care Insurance	13.2	1	0.1	0.1
Health Insurance Fund of W.A.	12.7	2	0.3	0.4
Healthguard	11.7	1	0.1	0.6
Health-Partners	10.1	0	0.0	0.6
I.O.R. Australia	n/a (6)	37	5.4	0.9
IOOF Health	9.8	0	0.0	0.2
Latrobe Health	3.2	0	0.0	0.4
Lysaght Peoplecare	11.4	0	0.0	0.3
Manchester Unity	12.0	1	0.1	1.3
MBF (Medical Benefits Fund)	7.4	136	19.9	16.7
Medibank Private	4.9	82	12.0	29.7
Mildura District Hospital Fund	3.1	0	0.0	0.3
N.I.B. Health	3.2	3	0.4	5.5
Navy Health	18.8	0	0.0	0.3
NRMA Health	15.4	47	6.9	2.1
Phoenix Health Fund	14.0	1	0.1	0.1
Police Health (SA)	6.3	0	0.0	0.1
Queensland Country Health	10.0	1	0.1	0.2
Railway & Transport Health	6.7	0	0.0	0.3
Reserve Bank Health	3.0	0	0.0	<0.5
St Lukes Health	7.0	0	0.0	0.4
Teacher Federation Health (NSW)	9.5	1	0.1	1.5
Teachers Union Health (QLD)	7.4	0	0.0	0.4
Transport Health	10.7	0	0.0	0.1
Westfund	7.1	2	0.3	0.8
TOTAL FOR REGISTERED FUNDS		**685**		

Note 1. Source: Report on Premium Increases for the Quarter Ending 31 March 2003 (Department of Health & Ageing).
Note 2. Cost: Premium increase matters registered.
Note 3. Source: PHIAC: Market Share as at 30/06/2003
Note 4. Since December 2002 Healthguard has been conducting the health insurance business of GMF Health. GMF Health complaints will not be reported separately in future.
Note 5. GMF Market Share as at 30/09/2002
Note 6. IOR did not increase premiums in 2003 (but in October 2002)

product was above the industry average, or was coupled with changes to benefit entitlements or the application of higher excesses and/or co-payments.

The manner in which the increase was introduced and communicated to members also appeared to have an impact on whether people were sufficiently aggrieved by the changes to complain to my office. There were a number of funds that introduced premium increases well above the average, but because they gave their members good information on why the increase was necessary and good advance notification, we received very few complaints from members of those funds.

Mr and Mrs Acacia are a retired pensioner couple who had been long-term members of a health fund. In October 2002, they responded to an intensive television advertising campaign by another fund promoting a special private health insurance cover for seniors. This cover was advertised to be priced at an affordable level for seniors and had benefits structured to meet their needs. On contacting the fund, Mr A confirmed that their seniors health cover would be available at a lower price than their current cover. It also offered immediate access to a range of benefits that appeared attractive to Mr and Mrs A, including increased benefits for some ancillary services of interest to them. Mr A therefore arranged to transfer their membership to the seniors cover.

Late in December 2002 Mr A was dismayed to receive a letter from their new fund advising of significant reductions in the ancillary benefits provided under his seniors cover. The letter advised that the changes would take effect from 1 January 2003 (within two weeks). This was the first time he had been advised of the proposed changes.

In mid March 2003 Mr A received another letter from the fund advising that:

- the name of his product would be changed (It was no longer to be called a seniors cover.);
- the premium for his cover would be increased by over 70%;
- he would now be required to pay a higher excess for any hospital admissions; and
- these changes would take effect from 1 April 2003.

The changes to Mr A's health insurance product had been scrutinised by the Department of Health and Ageing and the Private Health Insurance Administration Council and had not been disallowed. The extent of change did appear necessary in this case to maintain the financial viability of the product. In these circumstances the Ombudsman can only explain the approval process and outline the options available if Mr A could not afford the new premium. However, both Mr A and the Ombudsman question why this product was actively marketed only a few months previously, when the fund should have been aware of the performance of the product and why the fund could not have given contributors more notice of such drastic changes. Mr A was also astounded to read, in the fund's letter, that a major factor leading to the need for these changes in his seniors cover was "the ageing of the population"!

RATE PROTECTION (REFERRAL TO ACCC)

In 2002, the Private Health Insurance Administration Council (PHIAC) appointed an administrator to Goldfields Medical Fund (GMF). The Administrator determined that a number of actions were necessary to safeguard the rights of the membership of the fund. These included significant premium increases of between 40% and 70% and the withdrawal of rate protection for members who had paid their premiums in advance, even though the fund literature stated that rate protection was a right.

This office received a significant number of complaints from members in relation to the withdrawal of rate protection. A joint meeting between PHIO, PHIAC, the Commonwealth Department of Health & Ageing, the ACCC and the Administrator failed to resolve the matter. Following this, PHIO formally referred the matter to the ACCC in accordance with the provisions of Section 82ZSBA of the *National Health Act 1953.*

The ACCC investigated the matter to determine whether GMF or its directors may have engaged in misleading conduct or made false representation (in breach of the *Australian Securities and Investment Commission Act 2001*), by offering rate protection in circumstances where GMF did not intend to honour that guarantee or had no reasonable grounds for making such representations.

The ACCC concluded that it was unlikely that a court would find GMF or its directors breached the *Australian Securities and Investment Commission Act 2001* by making false or misleading representations about rate protection. The Commission considered that there appeared to be insufficient evidence to satisfy a court that GMF or its directors made representations about rate protection in circumstances where they did not have the intention to honour the rate protection guarantee or where they had no reasonable grounds for making such representations. The ACCC therefore decided not to take any further action in relation to the matter.

During the ACCC's investigation, GMF was taken over by Healthguard. The fund administrator requested members affected by the withdrawal of rate protection to submit a statement of claim documenting the amount of money that they believed was owed to them by the fund. These members were subsequently reimbursed and most complainants were satisfied with this resolution of their complaint.

INFORMED FINANCIAL CONSENT (IFC)

PHIO has been concerned for some time with the need to ensure that health fund members are able to give informed financial consent to incurring any out-of-pocket expenses which may result from their hospitalisation. There are many reasons why a hospital admission may not be fully covered by the member's health fund, including the application of an excess or co-payment, arrears on the membership, waiting periods or restricted benefits for some procedures.

The provision of advice to the member about out-of-pocket expenses prior to admission enables them to proceed with the hospitalisation with full knowledge of the cost to themselves, or to postpone the admission and discuss their treatment options with their doctor.

While the number of complaints to PHIO about out-of-pocket hospital expenses in 2003 was not large, the financial cost of an admission to a private hospital which is not fully covered by the fund can be very high. This office receives complaints from members with unexpected accounts for several thousand dollars on a regular basis and instances of accounts for $10,000 or more are not uncommon.

Under Sections 73BD(2)(d) and 73BDAA(1)(c) of the *National Health Act 1953*, there is a requirement that Hospital Purchaser Provider Agreements contain a clause that members be informed prior to admission of any probable out-of-pocket expenses which they may incur. This can only happen if there are good systems in place to allow hospital staff to access accurate and up to date membership information from health funds.

During 2002, the Ombudsman conducted a project to determine whether the systems which hospitals and funds have in place are able to respond in an accurate and timely manner to requests for membership verification.

The overall results of the project were very encouraging but it did reveal some deficiencies in the existing systems. In October 2002, the Ombudsman released a report that contained a number of general recommendations for the whole private health industry, and detailed shortcomings in the administrative systems currently in use.

The project found that most problems resulted from insufficient or inaccurate information passing between the hospital and health fund. These types of administrative problems can and should be easily fixed, to ensure that patients do not receive accounts for out-of-pocket expenses which they have not consented to prior to admission.

PHIO recognises that there may be instances in emergency situations, or when the procedure is altered during surgery for medical reasons, where it is not possible to give an accurate estimate of the financial impact on the patient. PHIO considers that contractual agreements between health funds and hospitals should explicitly provide for such circumstances.

Following the completion of the project, the then Ombudsman advised funds and hospitals that PHIO would now expect them to fix any problems resulting from administrative problems with their membership verification systems, without the member being involved.

It is hoped that the IFC project will result in a reduced level of complaint to PHIO about unexpected out-of-pocket hospital costs, as funds and hospitals modify their systems to eliminate the problems identified during the project.

Mr Grevillea had been a member of his health fund for some 5 years. He was on a cover that paid lower benefits for cardiac procedures in a private hospital, when he was admitted to a private hospital as a day stay patient for a coronary angiogram. Mr G knew he was not covered for major coronary surgery, but was under the misapprehension that an angiogram would be covered by his health fund. He did not consider a day stay angiogram as a cardiac procedure (or major surgery).

Prior to admission, the hospital did not perform a fund check and did not inform Mr G that his fund would only pay limited benefits toward his angiogram. Mr G was discharged without incident. Nearly a year later, he was very surprised to receive an account from the hospital advising him that he owed some $2,100 because his fund had only paid a portion of the account. The hospital requested payment within 7 days.

Ombudsman staff investigated Mr G's complaint and concluded that the hospital had not complied with its obligations to enable Mr G to consent to incurring the $2,100 out-of-pocket cost if he proceeded with the hospitalisation. As it was not an emergency admission, there was no reason why this information could not have been provided to Mr G. Accordingly, the Ombudsman recommended that the hospital write off the outstanding amount, as its own administrative processes had been deficient.

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

BENEFIT LIMITATIONS AND RESTRICTIONS

Consumers continue to experience difficulty with products which have limitations on the benefits they receive. The number of complaints to PHIO about this issue in 2003 was not large. Unfortunately, however, the procedures which are usually limited involve large out-of-pocket costs for members when they are performed in a private hospital.

Mr Waratah had joined his health fund when he left high school. At that time, he took out a cover designed for young, healthy singles, which only paid very limited benefits for certain procedures, including cardiac surgery if performed in a private hospital. As time went by, Mr W added his wife and their children to the cover, but as he believed himself to be in good health, he did not consider it necessary to upgrade his cover, even though he was no longer in the same demographic group for which the cover he held was intended. Mr W also believed that in the (as he considered unlikely) event that he suffered a cardiac emergency, he would be taken to the Accident & Emergency department of a public hospital. Accordingly, he preferred to continue with a lower level of cover in return for a lower premium.

Now in his fifties, Mr W's doctor booked him into a private clinic on the campus of a private hospital for a cardiac test. At the conclusion of the test, the treating doctor became very concerned at the findings and immediately transferred Mr W to the cardiac unit of the nearby private hospital. As soon as a theatre became available, an angiogram was commenced, followed by an angioplasty and insertion of a stent. Mr W remained in the hospital for five nights.

On the morning of his discharge, Mr W was informed that due to the restriction for cardiac surgery on his health insurance table, he would be responsible for a substantial out-of-pocket account from the hospital of over $10,000.

Mr W was very distressed to receive such a large and unexpected account. He believed that hospital staff had not complied with their responsibilities to inform him upfront of his out-of-pocket costs. In response to these concerns, the hospital reduced the account by several thousand dollars. As they had provided the services to Mr W and believed their staff had been instrumental in saving his life, the hospital did not believe any further reduction of the account was warranted.

Mr W approached to Ombudsman office, as he was still very upset at the failure by the hospital to advise either him or his wife of the costs involved upfront. Following its investigation of the matter, PHIO advised Mr W that the hospital had done a membership eligibility check with his health fund at the first available opportunity on the evening of his admission to the hospital. The fund check revealed that there was a restriction on the cover and that there would be large out-of-pocket expenses.

Hospital staff explained that this was their first opportunity to do the fund check, as Mr W had been admitted in an emergency suffering a suspected heart attack. Staff explained that transfering to another facility was not an option for

medical reasons, and that they had not wanted to discuss financial issues with Mrs W that evening when she was still in shock at her husband's emergency surgery. Staff also explained that due to the emergency nature of the procedure, by the time they were able to contact the fund, Mr W had already incurred the most expensive part of the account: the theatre fee. They had agreed to write off the accommodation fee for all but one night of Mr W's stay. This was in recognition that at that stage they had the information that Mr W was not fully covered, but did not pass it on.

In the circumstances, as the hospital had already written down the account, the Ombudsman did not believe there were grounds for seeking any further reduction from the hospital.

The Ombudsman took the matter of the restricted cover up with the fund and requested the fund to contribute towards the outstanding account. This was done on the basis of Mr W's long-term membership and the unusual circumstances surrounding his admission to a private hospital. The fund agreed to do so and the account was finally settled with a three way split between the member, the fund and the hospital.

This case is illustrative of the problems that can arise, particularly in emergencies, with restricted covers. PHIO recommends that members review their health insurance every year, to ensure that as their circumstances change, they consider whether their health insurance is still adequate for their changing needs. Members must recognise that when they choose a lower level of cover in return for a lower premium, they are exposing themselves to a higher risk. At the conclusion of this case, the Ombudsman wrote to the fund concerned and requested that it undertake a campaign to inform its members on restricted products of the need to review their cover regularly and to be aware of the restrictions applying to them at all times.

NOTIFICATION OF CHANGES TO COVER

Another issue that created considerable concern for consumers related to the decision by some funds to downgrade the benefits available to existing products. In one instance, members were advised in mid-December of significant changes to the application of their excess due to take effect on 1 January 2003. Because of the intervening Christmas holiday period, the effective period of notice which some members received about these significant changes to their cover, was only a week.

This caused great difficulty for members who were booked into hospital or who wanted to change their level of cover before the changes came into effect. Many members were unable to get through to the fund during the few days available because of the volume of callers attempting to contact the fund.

The Ombudsman considers that it is particularly unfair to introduce significant detrimental changes to hospital benefits (increases in excesses or co-payments or additional restrictions) without a reasonable notice period. This is because the effected contributor is given insufficient time to upgrade to another product within their existing fund or to transfer to another fund's product should they wish to preserve their previous, or equivalent, benefit structure. If they fail to do so, before the change takes effect, they can be locked in to the reduced benefits for the standard waiting periods (i.e.12-months in respect to pre-existing conditions and obstetrics).

Where such changes are introduced , there is also a need to provide concessions for contributors who had already booked for hospital treatment or commenced a course of treatment before being advised of the changes.

Mrs Eucalypt contacted the Ombudsman's office on 24 March 2003 after receiving a letter from her health fund advising of an increase in her premium as well as changes to the hospital excess arrangements for her policy. She had previously purchased a policy with a $500 excess for hospital treatment. The excess applied only once in each year.

The fund's letter advised her that, effective from 1 April 2003, the $500 excess would now apply to each hospital admission up to a maximum of $1000 in each year. In addition to the higher excess, the fund now also required a co-payment of $50 for each day of hospitalisation. The fund had offered in its letter to waive any waiting period should Mrs E wish to upgrade her policy, before 1 April 2003, to one without any excess but, this would mean paying a much higher premium (approximately $60 per month more.)

Mrs E's daughter had been admitted to hospital for treatment in February 2003 and, at that time, Mrs E had paid the first $500 of the hospitalisation costs (the $500 excess). Her daughter had also already been booked into hospital for further treatment on 2 April 2003, expected to involve a three-day stay in hospital. On receiving the letter from her fund about the excess changes, Mrs E contacted the fund and was advised that for her daughter's next admission she would now have to pay another $500 excess plus $50 for each day her daughter was in hospital. Mrs E could therefore expect to pay an additional $650 for her daughter's next hospital admission.

The Ombudsman contacted the fund and suggested that, as Mrs E's daughter had been booked into hospital before receiving any notice of the changes, the fund should not apply the additional excess and new co-payments in her case (or similar cases). In response the fund advised that:

- since Mrs E's daughter had been booked into hospital prior to the changes being notified, the fund would not apply the new $50 per day co payments;
- Mrs E would have to pay the extra $500 excess as a result of the change notified to her in the letter; and
- Mrs E would have to upgrade her policy and pay an additional monthly premium of $60 in advance, before 30 March (within 4 days) if she wanted to upgrade to the higher cover and avoid the extra excess.

After discussing these options with the Ombudsman's office, Mrs E told the office that she would take up the option to upgrade to the nil excess cover, pay the additional $60 for one month's premium and therefore avoid the $500 excess for her daughter's admission. Mrs E said that in view of the fund's treatment of her she would transfer to another fund, immediately after her daughter's hospital treatment.

She contacted a senior manager within the fund to arrange the upgrade to her cover. However after reconsidering her situation the fund decided to waive the additional $500 excess. As a result Mrs E decided not to upgrade to the higher cover and decided to stay with the fund.

At present, the legislation does not specify any required period of advance notice for members of fund rule changes. It simply requires that funds endeavour to advise affected contributors prior to the change taking effect. The Ombudsman does not believe it would be desirable to formally regulate the period of notice required, because it will vary, depending on the nature of the change. However, as indicated in the Ombudsman's Overview, the Ombudsman has developed good practice guidelines on this issue and distributed these to the funds.

It is pleasing to note that in 2003 a number of funds sought input from PHIO before effecting changes to their products.

MEDICAL GAPS AND GAPCOVER SCHEMES

The Ombudsman continues to receive complaints about medical gaps and lack of informed financial consent to medical practitioners. The office received 280 complaints about medical gaps during the reporting period, out of some 4154 complaints overall. In most of these cases, informed financial consent had been provided, but the member was not happy with the imposition of a gap.

Consumers also expressed concerns over difficulties in accessing information about doctors participating in their fund's gap scheme, and participating doctors choosing not to provide them with a gap service. Complaints received by the Ombudsman indicate that the arrangements surrounding gap schemes make them very confusing for consumers. Consumers tend to assume that if a doctor is listed as a gap doctor with their fund, then they will automatically receive a gapcover service. In reality, the legislation surrounding gapcover schemes provides for the doctor to choose whether or not to bill the patient under the fund's gapcover scheme.

Mrs Banksia required back surgery, and her GP referred her to a surgeon who advised her that she would have a $5,000 out of pocket gap if he performed the procedure. Mrs B did not believe she could afford such a large gap and approached her fund for a list of surgeons participating in its no-gap scheme. The fund provided her with the names of several surgeons and Mrs B organised a consultation with one of these doctors.

This doctor advised Mrs B that he could perform the surgery she required and provided her with a full quote for the cost of the operation. The quote indicated that his charge for the operation was $3,500 and that Mrs B would have a gap of $2,400 after her health fund and Medicare had paid their portions of the account. It was clear in the quote that the surgeon was not providing Mrs B with a "no-gap" service and that he was providing her with informed financial consent in respect of the gap which she would be required to pay on his fee. The surgeon reinforced this with her by requiring her to pay the amount of his gap prior to surgery taking place.

However, because Mrs B had been told by her fund that the surgeon was a participant in its no-gap scheme, she assumed that the fund would pay the $2,400 listed on her quote as the gap. The matter became more complicated when she rang the fund and asked how much she would get back on a gap fee of $2,400. The fund staff member correctly advised her that for the medical item number she quoted, she would receive a combined benefit of some $1100 from the fund and Medicare. The problem was that the surgeon had already taken this amount into account when advising Mrs B of the gap which she would have to pay on his $3,500 account.

Mrs B was very aggrieved when she submitted her medical account to the fund and found that she did not receive any reimbursement for the $2,400 gap which she had paid. The $1100 amount quoted to her by fund staff was paid directly to the surgeon as part of his $3,500 fee. At this point, Mrs B believed fund staff had misled her by advising her that she would receive $1100 back on the $2,400 gap payment which she had paid the surgeon.

PHIO staff investigated whether fund staff had given Mrs B incorrect advice regarding her ability to access a "no-gap" doctor and the amount of money which she would get back from the fund for the doctor's account. In this case, fund staff had made notes about the information given to Mrs B. After viewing these notes and the quote given to Mrs B by her surgeon, Ombudsman staff were unable to conclude that either the fund staff or the doctor had given Mrs B incorrect information. The difficulties experienced by Mrs B in understanding her entitlements appeared in this instance to relate to the complexities of the gap scheme and her expectation that she would be fully covered (even in the face of a quote and up front payment to the surgeon which both indicated that this was not the case).

The Ombudsman has reminded funds of the need to ensure that all of the information available to its members about its gap scheme emphasises the onus on the member to check with treating doctors about whether they are providing a gap service or not. This includes the information in its brochures, on its internet site and given to consumers over the telephone by fund staff.

During the reporting period, the Ombudsman also received a small number of complaints that specifically identified the practice of charging a "booking" or "administration" fee in addition to billing the patient under the fund's "no gap" scheme. Investigation of these complaints has revealed that only three funds operate pure no-gap schemes. All other funds operate schemes that generally allow the doctor to decide to treat the patient on a no-gap or known-gap basis. (Most funds' schemes prescribe a maximum allowable known-gap.)

Some doctors (including those participating in the pure no-gap arrangements) are getting around the no-gap rules by classifying the extra charge as a "booking fee" or "administration charge" (and, therefore not part of the cost associated with the hospital admission) or adding the extra charge to a consultation (out-patient) service that is not part of the service provided at hospital. In general, funds do not appear to be taking any action to discourage these practices.

It appears that some funds are not prepared to take any action in relation to doctors who do not comply with the "informed financial consent" requirements of the gap cover schemes.

In view of the range of issues being raised through these complaints the Ombudsman intends to undertake an investigation of the administration and operation of gap-cover schemes during this financial year.

THIRD PARTY COMPENSATION

The Ombudsman received 39 complaints related to third-party compensation matters during the 2002/03 year. This is an increase from 15 complaints in the previous year. While this not a significantly large number of complaints, the impact on some individuals can sometimes be considerable and complaints seem to come from a small number of funds.

Health Insurance funds, like Medicare, are regarded as insurers of last resort. Generally, if a health fund establishes that an individual has the right to claim compensation damages from another source (eg. Third Party Automobile or Workers Compensation) it may refuse to pay benefits. The intention of this approach is to ensure that health fund members are not paying expenses that are the responsibility of a compensation insurer and for which that insurer has accepted premiums.

Difficulties for individuals can arise if their health fund believes that their treatment was related to an accident but it later turns out that they did not have a case against any other party. Health fund staff need to be careful that members do not misunderstand their advice; believing that they must seek legal redress for accidents where they have no apparent case.

Miss Melaleuca had been playing poker machines at her local club at around midday. She got up to go to the bathroom. She has no memory of events, but has been told that while passing through the club she collapsed or fainted. There were no observable problems with the floor or other obstacles in the club and it was confirmed that she had only been drinking diet cola. She was transported to a public hospital.

She later required treatment for neck problems. On the understanding she was covered by her health fund, she chose to be treated at a private hospital. The cost of treatment was approximately $4000.

Miss M says that a few weeks after her treatment, health fund staff told her that the fund would not pay her claim and that she must pursue her case with the club by engaging the services of a lawyer. She had no previous experience of legal matters, so she says that she relied on the fund's advice.

Miss M's lawyer sent her for some medical tests and assessed her case. Clearly, she had no compensation case against anyone. After presenting this information to the health fund together with a completed accident form, the fund paid for her private hospital treatment. However, Miss M had spent some $3000 in legal fees and $600 in fees to the medical officers who assessed her case. Understandably, she was not happy to have spent $3600 for a claim, which the fund later advised her, was payable all along. She complained to the Ombudsman.

The Ombudsman's staff investigated her allegation but could not discover exactly what she was advised because there were no records kept. Most of the initial advice provided by fund staff seems to have been provided verbally, with no contemporaneous records kept.

Although it had no written record, the health fund said that it had received some advice that Miss M's claim was related to an accident for which she should seek compensation. This is why the fund felt justified in initially refusing benefits until an accident form was assessed. Later, the fund could not tell the Ombudsman's office exactly where this advice had come from.

The health fund says that it had advised Miss M that if she had no right to claim compensation, benefits would be paid. However, Miss M did not know what she was required to do to prove that she had no right to claim compensation. She felt she had no option but to seek (and pay for) the assistance of a lawyer.

The Ombudsman's investigation of Miss M's case is continuing.

ACCESS AND PUBLIC AWARENESS

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

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

- Details of the Ombudsman's services are referenced in various Government publications and in publications produced by other agencies and consumer bodies.
- Health funds provide information about the availability of the Ombudsman's services and contact details in brochures, publications and on some correspondence to fund members. These details are also included on health fund internet sites.
- The Ombudsman produces and distributes a range of brochures on health insurance issues.
- The Ombudsman participated in a number of radio and television interviews during the year.
- The Ombudsman publishes a regular quarterly report which is distributed in both written format and available on the PHIO website.
- The Ombudsman hosts an internet site where consumers can access a range of brochures, recent Ombudsman Quarterly Bulletins and Annual Reports. The site enables consumers to make inquiries, lodge complaints and request printed copies of brochures. It also provides consumers with links to other useful sites. The Ombudsman's web site is located at: http://www.phio.org.au.
- The Ombudsman and staff spoke at a number of conferences during the year and again sponsored a successful national seminar open to the whole private health industry.

The Ombudsman provides a speedy and informal complaints and inquiry service which is free of charge. Complaints and inquires can be made from anywhere in Australia on the free-call Hotline 1800 640 695. Complaints may be lodged by telephone, fax and e-mail.

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

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

A primary goal is to raise community awareness about the Ombudsman through the media and through the wide distribution of pamphlets, bulletins and our annual report to community groups, private hospitals, doctors' surgeries, health funds, Ombudsmans' offices, consumer affairs organisations and Members of Parliament.

RELATIONS WITH STAKEHOLDERS

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

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

In February 2003, the Office conducted its fourth annual seminar in Sydney, inviting participation from the private health industry. Feedback from participants was again excellent and it is intended to conduct further seminars to assist in maintaining an awareness by appropriate personnel of the issues which come before the office and the means adopted to resolve complaints.

CLIENT SURVEY

In June 2003, the office carried out a mail survey of a randomly selected 300 complainants who had lodged completed complaints during October 2002 through to February 2003. 121 complainants responded to the survey.

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

The survey found that, in general, there was a high level of satisfaction among consumers with the Ombudsman's services. Overall satisfaction levels were similar to previous years. Complainants were most likely to be satisfied and most likely to see the Ombudsman's office as impartial and independent, if their complaint was escalated to the dispute category.

Complainants were least likely to consider the Ombudsman's staff as independent if their complaint was dealt with as a "grievance". (Many of the complaints in this category related to premium increases.)

Among the findings, the study showed that:

- 89% reported that staff listened to their concerns.
- 75% of respondents said they were satisfied or mostly satisfied with the way staff handled the complaint.
- 89% were satisfied with the time it took to finalise the complaint.
- 79% considered that the Ombudsman's staff were independent in dealing with their complaint.
- 75% reported they were satisfied with the Ombudsman's service overall.

A series of illustrations summarising the results of the survey is included as an appendix on page 42 to this report.

HEALTH POLICY - LIAISON WITH OTHER BODIES

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

- During 2002, the Ombudsman conducted a project to determine whether the systems which hospitals and funds have in place are able to respond in an accurate and timely manner to requests for membership verification. A report of the findings was released In October 2002, containing a number of general recommendations for the whole private health industry and detailed information about shortcomings in the administrative systems currently in use.
- The Ombudsman made a submission to the Senate Community Affairs Committee in relation to its inquiry into the Health Legislation Amendment (Private Health Insurance Reform) Bill 2003. As noted in the Ombudsman's overview, this Bill includes provisions to strengthen the Ombudsman's powers and provides for the Ombudsman to undertake some additional functions. The Ombudsman also gave evidence at the Committee's hearing on that matter.
- The Ombudsman has also participated in industry consultations on the reform of private health insurance and has prepared an industry discussion paper on proposals to improve the provision of information for consumers.

CORPORATE GOVERNANCE

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

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

MANAGEMENT OF HUMAN RESOURCES

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

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

STAFF DETAILS

As at 30 June 2003, the staff employed by the Private Health Insurance Ombudsman comprised:

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

STATUTORY POSITIONS

The Private Health Insurance Ombudsman comprises one statutory office holder:

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

Mr Powlay was appointed as Private Health Insurance Ombudsman in November 2002, following Norman Branson, whose three-year term expired in October that year. The Ombudsman's remuneration is determined by the Remuneration Tribunal.

STAFF DEVELOPMENT AND TRAINING

During the 2002-2003 financial year $3,363 was spent directly on PHIO staff attending training courses, conferences and seminars. During the financial year the Ombudsman continued its internal staff development and training program for dispute resolution staff.

In February 2003 the Ombudsman's Office conducted its fourth annual seminar, which is a significant training event attended by customer service and dispute staff associated with the private health insurance funds, together with staff from hospitals and other key industry stakeholders. This seminar is self-funding.

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

STAFF EMPLOYMENT STATUS

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

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

The following table shows the numbers and status of staff who are employed on 30 June 2003.

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

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

*Includes part time employees. Actual EFT = 7.4

PERFORMANCE APPRAISAL

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

INDUSTRIAL DEMOCRACY

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

ACCOUNTING

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

The Ombudsman's Audit Committee, which comprises PHIO staff, Hall Chadwick Accountants and the National Audit Office, held appropriate discussions during the financial year.

OUTCOMES AND OUTPUTS

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

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

statutory reporting information

CONSULTANTS ENGAGED

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

INFORMATION SYSTEMS

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

PAYROLL SERVICES

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

FRAUD CONTROL

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

SERVICE CHARTER

The Ombudsman's Service Charter has been in operation since June 1998 and provides a framework against which the effectiveness of our service delivery can be monitored.

The Service Charter sets out what we do, the service standards our clients can expect and the steps they can take if these standards are not met. The Charter was developed in consultation with staff and clients.

OCCUPATIONAL HEALTH AND SAFETY

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

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

No reportable incidents occurred during the year.

EQUAL EMPLOYMENT OPPORTUNITY

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

freedom of information statement

This statement is published to meet the requirements of Section 8 of the *Freedom of Information Act 1982 (FOI Act).* It is correct as at 30 June 2003.

ESTABLISHMENT

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

PUBLIC INFORMATION

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

REQUESTS

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

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

DOCUMENTS HELD BY THE OMBUDSMAN

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

- A series of consumer brochures produced by the Office
- A booklet and brochure "Private Patients' Hospital Charter"
- Complaints Register and Complaints files
- Correspondence and working papers relating to the administration of the Ombudsman, including personnel and financial papers
- Other guidelines for staff of an administrative nature to assist in the efficient and effective operation of the office

DOCUMENTS AVAILABLE FREE OF CHARGE

The following brochures are available free of charge upon request:

- A brochure "Who We Are"
- A brochure "Making a Complaint"
- A brochure "The Ten Golden Rules of Private Health Insurance"
- A brochure "Service Charter"
- A brochure "When the Doctor's Bill Makes You Ill"
- A brochure "The Right to Change - Portability in Health Insurance"
- A booklet and brochure "Private Patients' Hospital Charter"

freedom of information statement

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

ACCESS TO DOCUMENTS

People may obtain documents:

- from the office of the Ombudsman located at Suite 1201, Level 12, St Martins Tower, 31 Market Street, Sydney, NSW, 2000
- by telephoning (02) 9261 5855 or 1800 640 695 (Free-call)
- by fax on (02) 9261 5937
- by e-mail to info@phio.org.au
- from the web site http://www.phio.org.au

INFORMATION AND PROCEDURES FOR *FREEDOM OF INFORMATION ACT* REQUESTS

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

Director, Policy and Compliance
Private Health Insurance Ombudsman

Suite 1201, Level 12
St Martins Tower
31 Market Street
SYDNEY NSW 2000.

Initial enquires about access to documents may be made in person or by telephone. The office is open for business between 9.00am and 4.30pm on weekdays.

external review and scrutiny

The office subjects itself to regular review of its performance by conducting a survey of complainants.

Detail of the review for this year is provided in the body of this report.

COURTS

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

COMMONWEALTH OMBUDSMAN

During the year, no complaints about the Private Health Insurance Ombudsman were made to the Commonwealth Ombudsman or investigations notified.

OTHER

There were no other reviews conducted of the Private Health Insurance Ombudsman's office.

SERVICE CHARTER

In line with requirements for all Commonwealth Government agencies, the Ombudsman introduced a Service Charter in June 1998 which was reviewed in 2001.

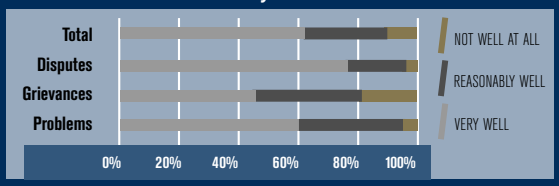
The Service Charter covers all of PHIO's clients and sets out the service delivery standards which they can expect from the office. The Charter was developed in consultation with staff and clients; copies of the charter are routinely sent out to people who contact the office.

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

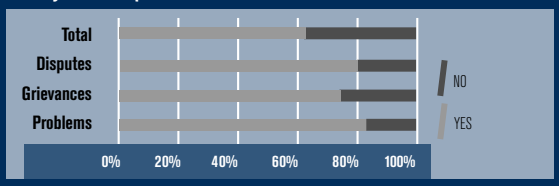
The key performance standards listed in the Service Charter are: Accessibility, Timeliness, Courtesy and Sensitivity and High Quality Advice.

client satisfaction results

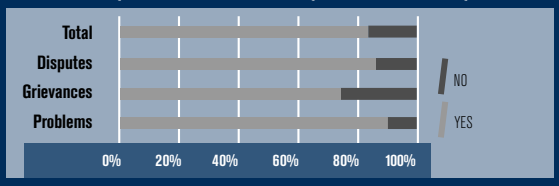
How well did staff listen to your Concerns?



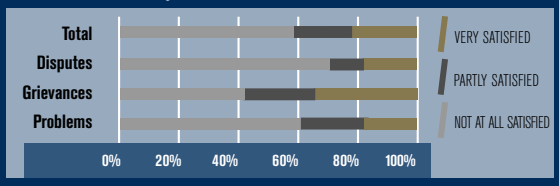
In your view, was the Ombudsman independent in dealing with your complaint?



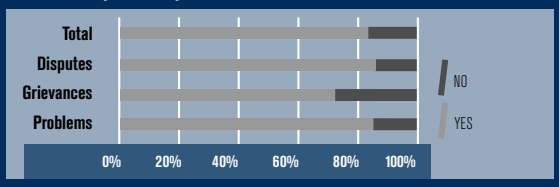
Did Staff Explain what sort of help this office can provide?



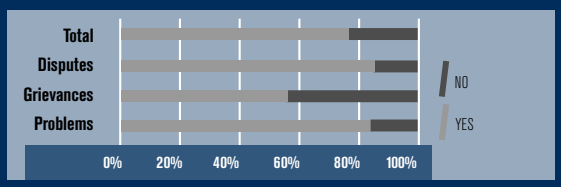
How satisfied are you with the Ombudsman's service overall?



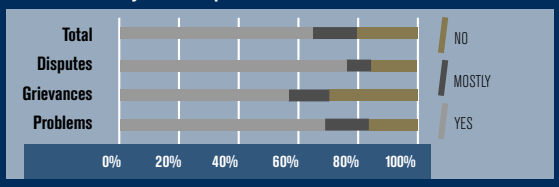
Did you find the explanation of what we could, or could not do for you, easy to understand?



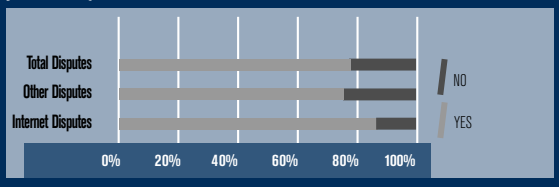
Would you use the Ombudsman's services again or recommend them to others?



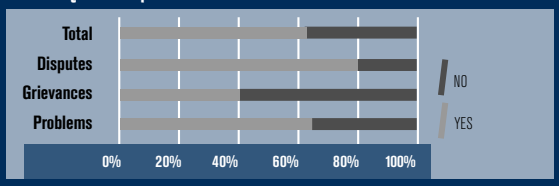
Are you satisfied with the manner in which staff handled your complaint?



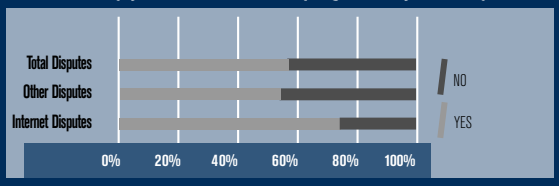
Were you satisfied with the time it took to finalise your complaint?



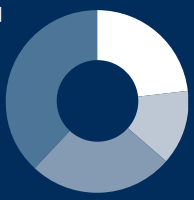
Were staff able to resolve your complaint or provide an adequate explanation?



Did staff keep you informed of the progress of your complaint?

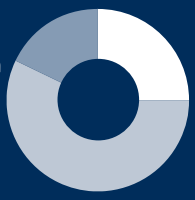


How did you find out about PHIO?



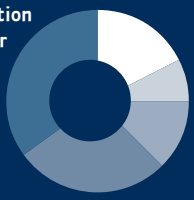
- 23% HEALTH FUND BROCHURE
- 13% FRIENDS/RELS
- 26% MEDIA
- 38% OTHER

If you were referred back to your fund - were you happy with fund's response?



- 23% YES
- 13% NO
- 26% N/A

Did you take any action after we closed your grievance?



- 18% CHANGED COVER, SAME FUND
- 8% CHANGED FUND
- 13% DROPPED PHI
- 27% OTHER
- 34% N/A

financial information

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Ageing

Scope

I have audited the financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2003. The financial statements comprise:

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

The Ombudsman is responsible for the preparation and presentation of the financial statements and the information they contain. I have conducted an independent audit of the financial statements in order to express an opinion on them to you.

The audit has been conducted in accordance with Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards, to provide reasonable assurance as to whether the financial statements are free of material misstatement. Audit procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Accounting Standards and other mandatory professional reporting requirements in Australia and statutory requirements so as to present a view which is consistent with my understanding of the Private Health Insurance Ombudsman's financial position, its financial performance and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

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

Audit Opinion

In my opinion the financial statements:

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

(ii) give a true and fair view, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Finance Minister's Orders, of the financial position of the Private Health Insurance Ombudsman as at 30 June 2003, and its financial performance and cash flows for the year then ended.

Australian National Audit Office

P Hinchey
Senior Director

Delegate of the Auditor-General

Sydney
24 September 2003

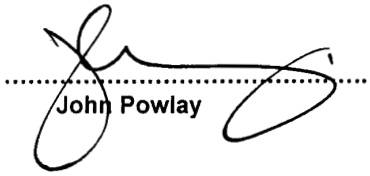
Private Health Insurance
OMBUDSMAN

Private Health Insurance Ombudsman

Statement by the Ombudsman

In my opinion, the attached financial statements for the year ended 30 June 2003 give a true and fair view of the matters required by the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*.

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



John Powlay

24/9/03
Dated

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PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 2003

	Note	2003 $	2002 $
Revenues from ordinary activities			
Revenue from Government	**2A**	**950,000**	950,000
Interest	**3A**	**17,839**	14,564
Other	**3B**	**85,508**	60
Revenues from ordinary activities		**1,053,347**	964,624
Expenses from ordinary activities			
Suppliers	**4A**	**332,603**	322,719
Employees	**4B**	**679,296**	560,292
Depreciation and Amortisation	**4C**	**23,768**	60,274
Expenses from ordinary activities		**1,035,667**	943,285
Net operating surplus from ordinary activities		**17,680**	21,339
Net credit to asset revaluation reserve recognised directly in equity		**4,299**	-
Increase in accumulated results on application of transitional provisions in *AASB 1041 Revaluation of Non-Current Assets*		**3,252**	-
Total revenues, expenses and valuation adjustments recognised directly in equity		**7,551**	-
Total changes in equity other than those resulting from transactions with owners as owners		**25,231**	21,339

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

The accompanying notes form part of these financial statements

PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF FINANCIAL POSITION

As at 30 June 2003

	Note	2003 $	2002 $
ASSETS			
Financial assets			
Cash	**5A**	**117,697**	285,348
Other Investments	**5B**	**300,000**	-
Total financial assets		**417,697**	285,348
Non-financial assets			
Infrastructure, plant and equipment	**6**	**30,301**	32,759
Intangibles	**6**	**4,991**	11,579
Prepayments		-	644
Total non-financial assets		**35,292**	44,982
Total assets		**452,989**	330,330
LIABILITIES			
Payables			
Suppliers	**7A**	**26,410**	33,863
Total payables		**26,410**	33,863
Provisions			
Employees	**7B**	**156,295**	51,413
Total provisions		**156,295**	51,413
Total liabilities		**182,705**	85,276
EQUITY			
Reserves	**8**	**4,299**	-
Accumulated surplus	**8**	**265,986**	245,054
Total equity		**270,285**	245,054
Current liabilities		**81,814**	85,276
Non-current liabilities		**100,891**	-
Current Assets		**417,697**	285,992
Non-current assets		**35,292**	44,982

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

PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF CASH FLOWS

For the year ended 30 June 2003

	Note	2003 $	2002 $
OPERATING ACTIVITIES			
Cash Received			
Appropriations		**950,000**	950,000
Interest		**17,839**	14,564
Other		**85,508**	60
Total cash received		**1,053,347**	964,624
Cash Used			
Suppliers		**(339,411)**	(318,297)
Employees		**(574,414)**	(558,724)
Total cash used		**(913,825)**	(877,021)
Net cash from operating activities	**14**	**139,522**	87,603
INVESTING ACTIVITIES			
Cash used			
Purchase of investment		**(300,000)**	-
Purchase of property, plant and equipment		**(7,172)**	(21,275)
Total cash used		**(307,172)**	(21,275)
Net cash used by investing activities		**(307,172)**	(21,275)
Net increase (decrease) in cash held		**(167,651)**	66,328
Cash at the beginning of the reporting period		**285,348**	219,020
Cash at the end of the reporting period	**5A**	**117,697**	285,348

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

PRIVATE HEALTH INSURANCE OMBUDSMAN SCHEDULE OF COMMITMENTS

As at 30 June 2003

	2003 $	2002 $
BY TYPE		
OTHER COMMITMENTS		
Operating Leases	**97,650**	195,300
Total other commitments	**97,650**	195,300
BY MATURITY		
Operating lease commitments		
One Year or Less	**97,650**	97,650
From one to two years	**-**	97,650
From two to five years	**-**	
	97,650	195,300

PRIVATE HEALTH INSURANCE OMBUDSMAN SCHEDULE OF CONTINGENCIES

As at 30 June 2003

	2003 $	2002 $
CONTINGENT LOSSES	-	-
CONTINGENT GAINS	-	-
Net Contingencies	-	-

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

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

For the year ended 30 June 2003

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Basis of Accounting

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

The statements have been prepared in accordance with:

- Finance Minister's Orders (being the *Commonwealth Authorities and Companies (Financial Statements for reporting periods ending on or after 30 June 2003) Orders);*
- Australian Accounting Standards and Accounting Interpretations issued by the Australian Accounting Standards Board; and
- Consensus Views of the Urgent Issues Group.

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

Assets and liabilities are recognised in the Statement of Financial Position when and only when it is probable that future economic benefits will flow and the amounts of the assets or liabilities can be reliably measured. Assets and liabilities arising under agreements equally proportionately unperformed are however not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the Schedule of Commitments and the Schedule of Contingencies (other than unquantifiable or remote contingencies)

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

1.2 Changes in Accounting Policy

The accounting policies used in the preparation of these financial statements are consistent with those used in 2001-02, except in respect of:

- Measurement of certain employee benefits at nominal amounts (Note 1.4);
- The initial revaluation of property plant and equipment on a fair value basis (Note 1.8); and
- The imposition of an impairment test for non-current assets carried at cost (Note 1.9).

1.3 Revenue

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

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

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

Revenue from Government - Output Appropriations

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

1.4 Employee Benefits

Benefits

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

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

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability. This is a change in accounting policy from last year required by initial application of a new Accounting Standard AASB 1028 from 1 July 2002.

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

Leave

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

The leave liabilities are calculated on the basis of employees' remuneration, including the 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

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

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

1.5 Leases

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

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

The Ombudsman has no finance leases.

1.6 Cash

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

1.7 Financial Instruments

Accounting policies for financial instruments are stated at Note 15.

NOTES CONTINUED **For the year ended 30 June 2003**

1.8 Property, Plant and Equipment

Asset Recognition Threshold

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

Revaluations

Land, buildings, infrastructure, plant and equipment are carried at valuation. Revaluations undertaken up to 30 June 2002 were done on a deprival basis; revaluations since that date are at fair value. This change in accounting policy is required by Australian Accounting Standard AASB 1041 *Revaluation of Non-Current Assets.*

Fair and deprival values for each class of assets are determined as shown below.

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

Under both deprival and fair value, assets which are surplus to requirements are measured at their net realisable value. At 30 June 2003 the Ombudsman held no surplus assets. (30 June 2002: $0)

The financial effect for 2002-03 of this change in policy relates to those assets to be recognised at fair value at 30 June 2003. The financial effect of the change is given by the difference between the carrying amount at 30 June 2002 of these assets and their fair values as at 1 July 2002. The financial effect by class is as follows:

ASSET CLASS	ADJUSTMENT	CONTRA ACCOUNT
Leasehold Improvements	4,299	Asset Revaluation Reserve
Plant & Equipment	3,252	Accumulated Results

Total financial effect was a credit to the asset revaluation reserve of $4,299 and a credit to accumulated results of $3,252.

Accounting Standard AAS 6 *Accounting Policies* requires, where practicable, presentation of the information that would have been disclosed in the 2001-02 Statements had the new accounting policy always been applied. It is impracticable to present this information.

Frequency

Property, plant and equipment assets are revalued every three years.

Recoverable Amount Test

From 1 July 2002, Schedule 1 no longer requires the application of the recoverable amount test in *AAS 10 Recoverable Amount of Non-Current Assets* to the assets of authorities when the primary purpose of the asset is not the generation of net cash inflows.

No property plant and equipment assets have been written to recoverable amount per AAS10. Accordingly the change in policy has had no financial effect.

Depreciation and Amortisation

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

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

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

	2003	2002
Leasehold improvements	**Lease term**	Lease term
Plant and equipment	**4 to 9 years**	3 to 7 years

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 4C.

1.9 Intangibles

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

From 1 July 2002, Schedule 1 no longer requires the application of the recoverable amount test in Australian Accounting Standard *AAS 10 Recoverable Amount of Non-Current Assets* to the assets of authorities when the primary purpose of the asset is not the generation of net cash inflows.

However Schedule 1 now requires such assets, if carried on the cost basis, assessed for indications of impairment. The carrying amount of impaired assets must be written down to the higher of its net market selling price or depreciated replacement cost.

All software assets were assessed for impairment as at 1 July 2002. None found to be impaired.

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

	2003	**2002**
Useful lives are: Internally developed software	**7 years**	n/a

1.10 Taxation

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

1.11 Capital Usage Charge

A Capital Use Charge is imposed by the Government on the net assets of the Authority. The Charge is accounted for as a dividend to Government.

In accordance with the recommendations of a review of the Budget Estimates and Framework, the Government has decided that the Charge will not operate after 30 June 2003. Therefore, the amount of the charge payable in respect of 2003 is the amount appropriated (2002: 11% of adjusted net assets).

1.12 Insurance

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

1.13 Comparative Figures

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

1.14 Economic Dependency

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

NOTES CONTINUED **For the year ended 30 June 2003**

	2003 $	2002 $
2 REVENUES FROM GOVERNMENT		
2A Parliamentary appropriations		
Appropriation for outputs	**950,000**	950,000
	950,000	950,000
3 REVENUES FROM INDEPENDENT SOURCES		
3A Interest		
Deposits	**17,839**	14,564
	17,839	14,564
3B Other Income		
Transfer of employee entitlements from other agency.	**85,508**	60
	85,508	60
4 GOODS AND SERVICES EXPENSES		
4A Suppliers expenses		
Supply of Goods and Services - all external	**207,957**	217,628
Operating Lease Rentals	**124,646**	105,090
	332,603	322,719
4B Employee expenses		
Wages and Salaries	**500,005**	480,540
Superannuation	**68,529**	70,859
Leave and other benefits	**107,798**	687
Other employee expenses	**2,964**	8,207
	679,296	560,292

Leave and other benefitss expense includes the increase in the benefits provision as a result of employees transferred from other Government Authorities.

4C Depreciation and Amortisation		
Depreciation	**17,180**	50,930
Amortisation - Lease Fitout	**6,588**	9,344
	23,768	60,274

NOTES CONTINUED For the year ended 30 June 2003

5 FINANCIAL ASSETS

5A Cash		
Cash on Hand	**149**	129
Cash at Bank	**117,548**	285,219
	117,697	285,348
5B Other Investments		
Term Deposit - current	**300,000**	-
	300,000	-

6 NON FINANCIAL ASSETS

6A Buildings		
Leasehold Fitout - at valuation 30 June 2000	-	80,620
Less: Accumulated Amortisation	-	(78,689)
	-	1,931
Leasehold Fitout - at valuation 1 July 2002	**6,230**	-
Less: Accumulated Amortisation	**(2,546)**	-
	3,684	-
6B Plant and Equipment		
Plant and Equipment - at valuation 1 July 2000	-	265,019
Less: Accumulated Amortisation	-	262,505)
	-	2,514
Plant and Equipment - at valuation 1 July 2002	**34,079**	-
Less: Accumulated Depreciation	**(13,262)**	-
	20,817	-
Plant and Equipment - at cost	**7,172**	38,766
Less: Accumulated Depreciation	**(1,372)**	(10,452)
	5,800	28,314
Intangibles - at cost	**17,412**	17,412
Less: Accumulated Depreciation	**(12,421)**	(5,833)
	4,991	11,579
Total Buildings, Plant and Equipment	**35,292**	44,338

6C Reconciliation of the opening and closing balances of buildings, plant and equipment and intangibles

Item	Leasehold	Plant & Fitout $	Equipment $	Intangibles $	Total $
As at 1 July 2002					
Gross Book Value		80,620	303,785	17,412	401,817
Accumlated Depreciation/ammortisation		(78,689)	(272,957)	(5,833)	(357,479)
Net Book Value		1,931	30,828	11,579	44,338
Addition by purchase		-	7,172	-	7,172
Net revaluation increment/decrement		4,299	3,252	-	7,551
Depreciation / amortisation expense		(2,546)	(14,634)	(6,588)	(23,768)
Disposalsat	cost	-	(49,072)	-	(49,072)
	accumulated depreciation	-	49,072	-	49,072
As at 30 June 2003					
Gross Book Value		**6,230**	**41,251**	**17,412**	**64,893**
Accumulated Depreciation/amortisation		**(2,546)**	**(14,634)**	**(12,421)**	**(29,601)**
Net book value		**3,684**	**26,617**	**4,991**	**35,292**

6D Assets At Valuation

	Plant & Equipment $
As at 30 June 2003	
Gross Value	40,309
Accumulated depreciation/amortisation	(15,808)
Net Book Value	24,501
As at 30 June 2002	
Gross Value	345,639
Accumulated depreciation/amortisation	(341,194)
Net Book Value	4,445

NOTES CONTINUED **For the year ended 30 June 2003**

7 PROVISIONS AND PAYABLES

	2003 $	2002 $
7A Suppliers		
Trade creditors - current	**18,155**	18,378
Accruals - current	**8,255**	15,485
	26,410	33,863
7B Employees		
Salaries and Wages	**16,026**	18,942
Annual Leave	**39,378**	26,308
Long Service Leave	**100,891**	6,163
Aggregate Employee Entitlements	**156,295**	51,413
Current	**55,404**	51,413
Non-current	**100,891**	-

NOTE 8: EQUITY

8A Analysis of Equity

Item	Accumulated Results		Asset Revaluation Reserve		Total	
	2003 $	2002 $	2003 $	2002 $	2003 $	2002 $
Opening balance at 1 July	245,054	223,715	-	-	245,054	223,715
Net surplus	17,680	21,339	-	-	17,680	21,339
Net revaluation increment/(decrement)	-	-	4,299	-	4,299	-
Increase in accumulated results on application of transitional provisions in AASB 1041 Revaluation of Non-Current Assets	3,252	-	-	-	3,252	-
Closing balance at 30 June 2003	**265,986**	**245,054**	**4,299**	**-**	**270,285**	**245,054**

NOTES CONTINUED **For the year ended 30 June 2003**

	2003 $	2002 $

9 REMUNERATION OF OFFICERS

The position of Ombudsman was filled by 2 people during the reporting period. The remuneration, when at least $100,000 fell within the following bands:

$190,000 - $199,999	**-**	1
The aggregate amount of total remuneration of officers shown above.	**182,734**	193,451

10 REMUNERATION OF AUDITORS

Remuneration to the Auditor-General for auditing the Financial Statements	**4,000**	3,500

The auditors received no other benefits

11 SUPERANNUATION

The Ombudsman's office contributes to the Commonwealth Superannuation (CSS) and the Public Sector (PSS) superannuation schemes which provide retirement, death and disability benefits to employees. Contributions to the scheme are at rates calculated to cover existing and emerging obligations. Current contribution rates are 23.8% of salary (CSS) and 9.9% of salary (PSS). An additional amount of up to 3% is contributed for employer productivity benefits. Casual staff can choose to be a member of any approved superannuation fund and receive employer benefits at the Superannuation Guarantee Charge rate, currently 9%.

12 ECONOMIC DEPENDENCY

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

13 SEGMENT REPORTING

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

NOTES CONTINUED For the year ended 30 June 2003

	2003 $	2002 $
14 CASH FLOW RECONCILIATION		
Operating Surplus	**17,680**	21,339
Amortisation - Lease fitout	**6,588**	9,344
Non Cash Adjustments -		
Internet Costs	**-**	(13,570)
Computer Consumables	**-**	(314)
Leave Provisions	**107,798**	(2,310)
Depreciation	**17,180**	50,930
Salaries & Wages	**(2,916)**	3,878
Decrease/(Increase) in GST Credits	**-**	1,609
Decrease/(Increase) in Other Debtors	**-**	-
(Decrease)/Increase in Trade Creditors	**(222)**	9,344
(Decrease)/Increase in Accruals	**(7,231)**	8,000
Decrease/(Increase) in Other Prepayments	**646**	(646)
Net Cash provided by operating activities	**139,523**	87,603

15 FINANCIAL INSTRUMENTS

a) Terms, Conditions and accounting policies

Financial Instruments	Accounting Policies and methods (including recognition criteria and measurement basis)	Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows)
Financial Assets	Financial assets are recognised when control over future economic benefits is established and the amount of the benefits can be reliably measured.	
Other Debtors	These receivables are recognised at the nominal amounts due less any provision for bad and doubtful debts. Provisions are made when collection of the debt is judged to be less rather than more likely.	Credit terms are net 14 days (2001-02: 14 days)
Financial Liabilities	Financial Liabilities are recognised when a present obligation to another party is entered into and the amount of the liability can be reliably measured.	
Trade Creditors	Creditors and accruals are recognised at their nominal amounts, being the amounts at which the liabilities will be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of being invoiced).	Settlement is usually made net 30 days.

b) Interest rate risk

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

	Weighted average effective interest rate		Carrying amount	
	2003 %	**2002** %	**2003** **$**	2002 $
Financial Assets				
Cash (at call) Investments	**4.15**	4.15	**117,697**	285,348
(less than one year)	**4.75**	N/A	**300,000**	-
Total Financial Assets			**417,697**	285,348
Total Assets			**452,989**	330,330
Financial Liabilities				
Trade Creditors Current)	N/A	N/A	**18,155**	18,378
Total Financial Liabilities			**18,155**	18,378
Total Liabilities			**182,705**	85,276

c) Credit Risk

The maximum exposure to credit risk at balance date is the carrying amount as disclosed in the Statement of Financial Position and notes to the financial statements.
The Ombudsman has no significant concentration of credit risk.

d) Net Fair Values

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

NOTES CONTINUED **For the year ended 30 June 2003**

16 STAFFING LEVELS

	2003	2002
The average staffing levels for the Ombudsman during the year were:	**8**	8

17 REPORTING OF OUTCOMES

17a Outcomes

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

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

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

17B Net Cost of Outcome Delivery

	2003	2003
	$	$
Departmental expenses	**1,035,667**	943,285
Other external revenues		
Interest	**17,839**	14,564
Other	**85,508**	60
Total external revenues	**103,347**	14,624
Net cost of outcome	**932,320**	**928,661**

18 APPROPRIATIONS

Year ended 30 June 2003		
Balance carried forward from previous year	**-**	**-**
Appropriation Act 1	**950,000**	**950,000**
Available for payment from CRF	**950,000**	**950,000**
Payment made out of CRF	**950,000**	**950,000**
Balance carried forward to next year	**-**	**-**

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Private Health Insurance
OMBUDSMAN