Australian Government

Private Health Insurance Ombudsman

2007 ANNUAL REPORT

CONTACT DETAILS

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The objective of the Private Health Insurance Ombudsman is to

"protect the interests of people covered by private health insurance."

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

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TELEPHONE, FAX AND E-MAIL

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Free Call (higher cost from Mobiles)

1300 737 299 (website inquiries)

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

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

E-mail: info@phio.org.au

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9.00 am - 5.00 pm (Sydney time)

Monday - Friday

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

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

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CONTENTS

Australian Government

Private Health Insurance Ombudsman

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

Dear Minister

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

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2006 to 30 June 2007.

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

Yours sincerely

Samantha Gavel

Samantha Gavel
A/g Ombudsman
17 September 2007

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OMBUDSMAN'S OVERVIEW

In recent years, private health insurance has proved to be a dynamic area of operation. During 2006/07, the introduction of new legislation and a wider role and powers for the Ombudsman meant that this reporting period was even busier than usual for the Office.

Health Insurance Complaints

The Ombudsman received 2340 complaints in 2006-07, which was slightly less than the 2374 complaints received in 2005-06. This figure was a continuation of the trend over the last three years towards a gradual decrease in the number of complaints overall.

There are a number of reasons why complaint numbers have declined in recent years, including the introduction by some funds of better frontline complaints handling practices. A significant area of improvement has been the continuing decline in complaints about premium increases. During the January – March Quarter 2007, which is the period when annual rate increase notices were sent out by insurers, the Ombudsman received 29 complaints about premium increases, the lowest ever quarterly figure for complaints about this issue.

Figures released by the Private Health Insurance Administration Council (PHIAC)[1] confirmed that 2006/07 was a positive year financially for health insurers and this contributed to lower premium increases and lower complaint levels during this period.

The number of higher level (Level-3) complaints investigated by the Ombudsman during 2006/07 was slightly lower than in 2005/06. These are the more difficult, complex complaints that require additional investigation and work to resolve. It is pleasing to see the continuation of the trend towards insurers handling general complaints through their frontline complaints handling services, with only the more complex, difficult issues requiring intervention by the Ombudsman.

The more complex complaints received by the Office demonstrate the need for the higher level investigatory, mediation, negotiation skills and expertise the Ombudsman's office can bring to resolving these more difficult complaints. In addition, the Ombudsman is able to identify underlying, systemic issues from our complaints data and assist in resolving these with key stakeholders, to ensure the continued protection of consumers' entitlements under their private health insurance.

Wider role for PHIO

New legislation came into effect on 1 July 2006, which gave the Ombudsman wider jurisdiction to take complaints about ancillary providers and health insurance brokers, in addition to health funds, hospitals and medical providers. It also gave the Ombudsman power to compel a fund and a service provider to attend mediation, in order to resolve disputes about contractual arrangements, which have the ability to adversely affect consumers' entitlements under their health insurance policies.

During the reporting period, the Acting Ombudsman was involved in informally mediating a number of such disputes, but none met the requirements for formal mediation. The Office has organised with a commercial mediation organisation to provide suitable mediators if required and has also produced a set of guidelines, in consultation with industry, for use of the mediation power.

Private Health Insurance Act 2007

A significant development during the reporting period was the introduction and passage through Parliament of a new *Private Health Insurance Act 2007* and associated rules. This was a complete update of the *National Health Act,* which was originally passed in 1953.

The new Act contained a number of important consumer initiatives, including the introduction

[1] Source: PHIAC Media Release, 23/2/07

of broader health cover and the requirement to provide consumers with independent and reliable information about private health insurance in a standard format.

As with any new legislation, it is expected there will be areas that require clarification and possibly amendment. The Ombudsman will be working with the Department of Health & Ageing, consumers and industry to monitor the impact of the new legislation and provide advice and input into resolving any issues that arise.

Consumer Website & Standard Information Statements

In April 2006, the Government announced a number of significant reforms to private health insurance. The legislative framework for the reforms was incorporated into the new *Private Health Insurance Act 2007.*

An important reform initiative was the requirement for funds to produce Standard Information Statements (SISs) to show the main features of each of their health insurance policies. These would be loaded onto a new consumer website, developed and managed by the Ombudsman, that would enable people to see what their current policy, and other policies available for purchase, covered.

The website went live in early April 2007 and was promoted to consumers as part of the "Private Health Improvements" campaign conducted by the Department of Health & Ageing. The response from consumers to the website was very positive and the site received some 5000 visitors a day during the campaign period. The Ombudsman intends to further refine the site in 2007/08, in consultation with stakeholders.

Consumer Awareness

It is a legislative requirement for the Ombudsman to publicise the office, to ensure consumers are aware of the Ombudsman's complaint handling and consumer information services.

During 2006/07, there were a number of opportunities for the Ombudsman to provide information to consumers and other stakeholders about the Office and its services. The Acting Ombudsman presented at a number of industry and other fora and provided submissions to a number of organisations on issues affecting consumers with private health insurance. In addition, Ombudsman staff undertook extensive consultation and liaison with stakeholders as part of the introduction of the new consumer website.

The Ombudsman's annual Customer Satisfaction Survey showed even higher levels of satisfaction with the Office's services than in previous years. This was particularly pleasing, given the number of challenging issues and projects the Office was required to deal with during 2006/07.

The introduction of the new consumer website also enabled the Ombudsman to promote its services to consumers directly and through media interviews and other publicity associated with the website launch. The Ombudsman intends to build on these initiatives in the coming year, to ensure consumers are aware of their right to take their concerns to the Ombudsman and to access its consumer information services such as the www.privatehealth.gov.au website.

Corporate Governance Arrangements

In the past, the Ombudsman's Office operated under the *Commonwealth Authorities and Companies Act 1997.* Following the review of corporate governance of Commonwealth Government agencies by Mr John Uhrig AC, it was decided to prescribe the PHIO as an agency under the *Financial Management and Accountability Act 1997,* from 1 July 2007. In association with this change, PHIO staff became ongoing Australian Public Service

employees under the *Public Service Act 1999* from 1 July 2007.

Although these changes did not occur until after the close of the reporting period, most of the administrative work associated with the changes was completed prior to 1 July 2007 and required a significant allocation of staff and financial resources.

The Year Ahead

The Office has a number of priorities for 2007/08, including additional improvements to the functionality of the www.privatehealth.gov.au website; new measures to improve the way in which the office is publicised; and new initiatives to ensure continuation of a high quality complaints handling service that meets the needs and expectations of consumers.

Samantha Gavel
Acting Private Health Insurance Ombudsman

John Powlay –
Ombudsman
2002 - 2007

John Powlay

Staff of the Office would like to pay tribute to Private Health Insurance Ombudsman, John Powlay, who passed away on 16th January 2007. Mr Powlay had held the position of Private Health Insurance Ombudsman since November 2002.

Prior to his appointment as Private Health Insurance Ombudsman, Mr Powlay held a number of senior management roles in Commonwealth Government agencies, including the Commonwealth Ombudsman, in a career spanning over twenty years.

As Private Health Insurance Ombudsman, Mr Powlay introduced the annual State of the Health Funds report in 2004, to provide consumers with information about health fund performance, to assist them in understanding their own health insurance policy and in choosing a new policy. He was a passionate consumer advocate for people with private health insurance and a great believer in the importance of accessible and impartial information to help consumers understand the complexities surrounding private health insurance.

Mr Powlay is sadly missed by the staff of the Ombudsman's office and by his colleagues in government and the private health insurance industry.

Introduction

The Private Health Insurance Ombudsman is a statutory corporation under the *Private Health Insurance Act 2007.* [2]

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

Functions

The main role of the Ombudsman is to deal with complaints about private health insurance arrangements. A summary of the functions of the Ombudsman, as provided by section 238-5 of the *Private Health Insurance Act 2007,* are to:

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

Who can make a complaint?

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

Persons against whom a complaint may be made

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

What can the Ombudsman do with a complaint?

The Ombudsman is able to deal with complaints by:

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

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

[2] The Ombudsman was previously an authority under the *National Health 1953* which was superseded by the *PHI Act 2007* on 1 April 2007.

What happens at the end of a complaint or investigation?

The Ombudsman is able to recommend that:

- Health insurers, health care providers and health insurance brokers take a specific course of action in relation to a complaint; and
- A health insurer changes its rules or practices.

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

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

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

How the Ombudsman's staff resolve complaints

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

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

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

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

PHIO Staff (left to right), *Standing: Kaylie Blyton, David McGregor, Joanna Wong, Ramy Bakhos, Ursula Schappi, Tanya Snowden. Seated: Alison Leung, Samantha Gavel, Hilary Bassingthwaighte.*

Output performance measures

The 2006/07 Portfolio Budget Statement for the Health and Ageing Portfolio includes both quality and quantity measures for the Private Health Insurance Ombudsman's two output groups. The following is a summary of performance outcomes against these formal performance indicators during 2006/07.

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

Quality indicator: Quality, relevant, and timely advice, submissions and reports.

Measurement: Level of stakeholder satisfaction, as measured by stakeholder feedback.

Performance result: Overall high level of satisfaction achieved against the three measures – relevance, quality and timeliness.

Quantity indicator: Production of a range of advisory service products including submissions and public presentations.

Measurement: Production of at least 12 submissions and public presentations.

Performance result: 14 submissions and other items of written advice, 15 public presentations. (Further details are provided in the General Issues section of this report.)

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

Quality indicator: Efficient complaints handling service.

Measurement: Complaints received during the year finalised.

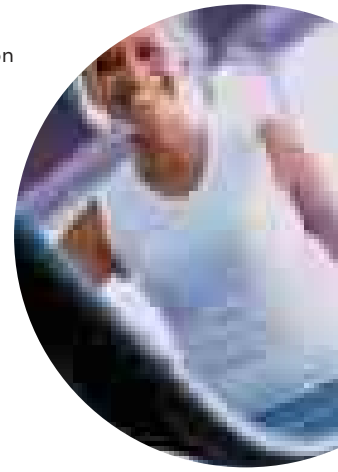
Performance result: 96% complaints received during the year finalised.

Quantity indicator: Accessible, effective and timely complaints handling service.

Measurement:. Consumer satisfaction survey.

Performance result: 88% respondents satisfied or very satisfied.

Quantity indicator: Improved fund or industry practices as a result of PHIO investigation recommendations.



Measurement: Proportion of recommendations that have resulted in changes to fund or industry practices.

Performance result: There were no formal recommendations to change fund or industry practices during the reporting period.

Quantity indicator: Information products produced are useful and informative for consumers.

Quantity indicator: Timeliness of complaint resolution.

Measurement: Percentage of complaints finalised within one month of receipt and a reduction in the average time taken to finalise Level-3 disputes.

Performance result: 84% complaints finalised in one month. Reduction in the average time taken finalising Level-3 disputes.

Quantity indicator: Quality, accurate information about private health insurance.

Measurement: Publication of the State of the Health Funds Report by 31 March 2007, Establishment of www.privatehealth.gov.au website by 1 April 2007.

Performance result: State of the Health Funds Report released on 28 March 2007, Website established by 1 April 2007.

Performance

The Ombudsman received 2340 complaints during 2006/07. This was 34 (1.4%) fewer complaints than the previous year. This is the lowest number of complaints the office has received in the last seven years.

There were 793 Level-3 complaints received during the year, 47 less (5.6%) than the year before. Level-3 complaints usually require more investigation by the Ombudsman's staff because a report is requested from the health fund (or other object), which is then assessed by the office and either closed as a satisfactory response (with an explanation provided to the complaint) or investigated further. Sometimes investigations involve several communications between the Ombudsman's office and health insurer, or other body.

The Ombudsman also received 843 phone, email and feedback form enquiries between 1 April and 30 June 2007 in relation to the new consumer website www.privatehealth.gov.au.

Figure 1 shows the distribution of complaints throughout the four quarters of the 2006/2007 financial year.

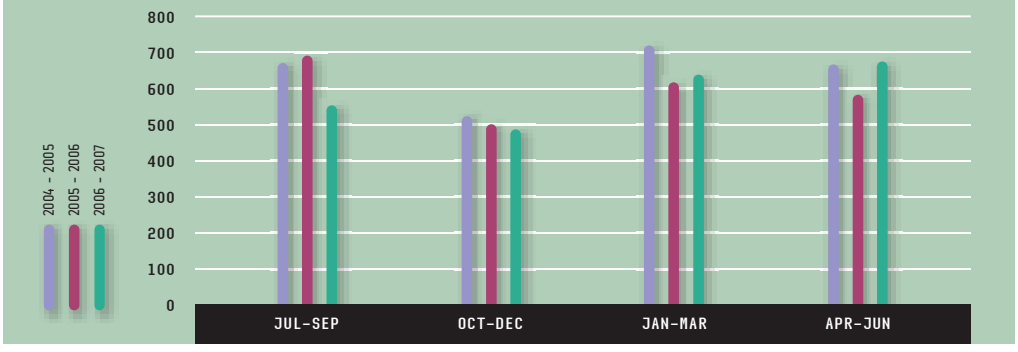
Figure 2 shows the total number of complaints received per year for the last 11 years (since the Ombudsman's office was established). The jump in the number of complaints in the 2000/2001 year was associated with a large increase in the numbers of Australians covered by private health insurance as a result of the Government's introduction of the 30% health insurance rebate, Lifetime Health Cover and other Private Health Insurance Initiatives.

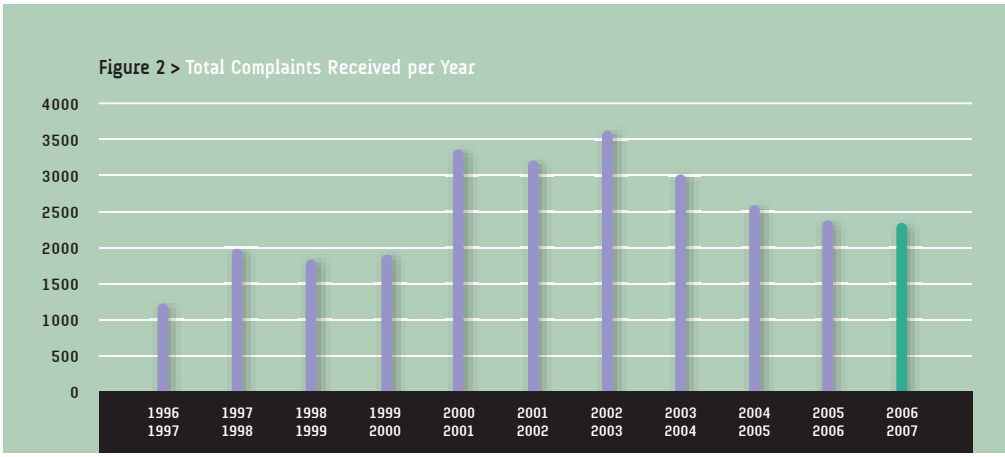
The reduction in complaints after 2002/03 is mostly attributable to a decline in complaints about premium increases.

Recording and categorisation of complaints

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

Figure 1 > Total Complaints Received per Quarter





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

Currently this categorisation is:

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

  Level-1 complaints are dealt with by referring the complainant back to the health insurer, health care provider or health insurance broker. This occurs where, in the view of the Ombudsman, the complainant has not made an adequate attempt to resolve the problem, or the Ombudsman is able to suggest to the complainant other ways to approach the problem. Issues within this category can be across the whole complaint range of product description, benefits paid, informed financial consent, pre-existing ailments and service quality. The Ombudsman's staff empowers the consumer to try and resolve the complaint directly and if they are not successful, they return and reactivate the complaint.

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

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

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

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

provided by the insurer or provider, price increases, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

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

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

The 2340 complaints recorded in 2006/07 consisted of 793 Level-3 complaints, 501 Level-2 complaints and 1046 Level-1 complaints. Figures 3 and 4 show these ratios and show a significant increase in Level-1 complaints and a reduction in Level-2 complaints. The increase in Level-1 complaints suggests that the office's procedures in referring complaints directly to insurers for a speedy response are successfully reducing the number of matters that escalate to Level-3 complaints.

Complaints handling procedures

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

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

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

- Hospitals (generally about inadequate information to enable informed financial consent);

Figure 3 >
Complaints Received per Year by Category

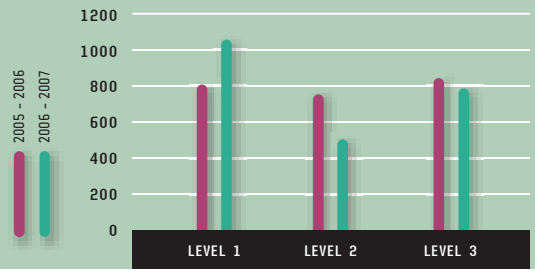


Figure 4 >
Complaints Category %

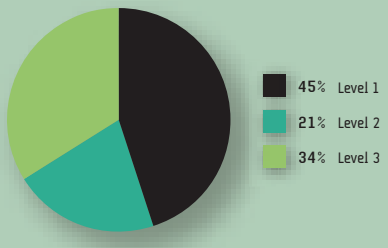


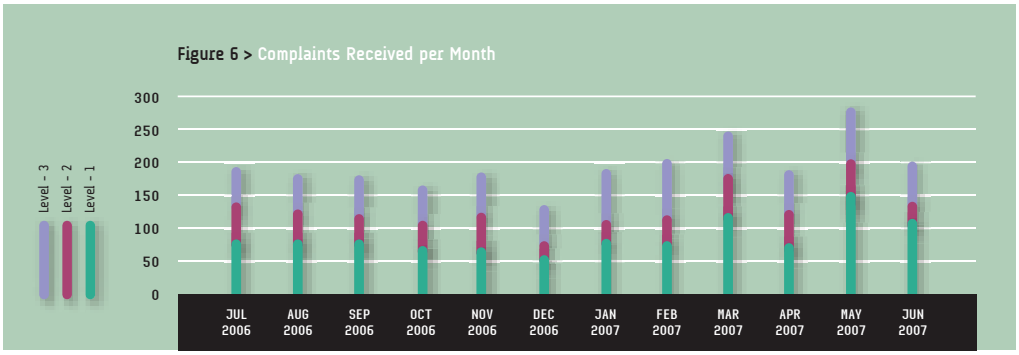
Figure 5 > Steps In Handling Approaches to the Ombudsman

LEVEL 3 (DISPUTE)	LEVEL 2 (GRIEVANCE)	LEVEL 1 (PROBLEM)
TIMEFRAME Depends on the nature and complexity of matter and responses from health fund and provider.	**TIMEFRAME** Usually within 24 hours.	**TIMEFRAME** Immediate.
ACTIONS PHIO contacts health fund or provider to obtain a report, then mediates the dispute between the parties or investigates the matter further.	**ACTIONS** Complainant provided with explanation or information to resolve matter, or if there is no avenue for the Ombudsman to take up the matter.	**ACTIONS** If complainant has made insufficient effort to resolve the matter with fund or provider, empower them with detail enabling them to take up the issue at an appropriate level.
OUTCOMES Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal recommendation by Ombudsman.	**OUTCOMES** Detailed information provided which appropriately resolves the issue.	**OUTCOMES** Referral to health fund or provider.

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

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

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



Workload

The office received 2340 complaints (Levels 1, 2 & 3) in 2006/07, an average of 195 per month compared with 198 complaints per month in the previous year.

The office finalised 2362 complaints during the year; an average of 197 per month, compared with an average 198 complaints finalised per month in the previous year.

The office finalised 815 complaint investigations (Level-3 complaints) during the year, compared with 840 in the previous year.

The Ombudsman also received 843 phone, email and internet lodged enquiries between 1 April and 30 June 2007, relating to the new consumer website www.privatehealth.gov.au. Many of these calls were from consumers who wanted information about private health insurance but were unable to access the internet.

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.

Figure 7 > Time Taken to Finalise Complaints

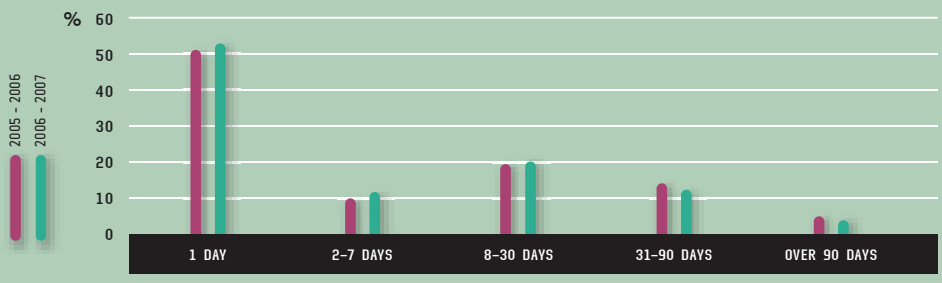
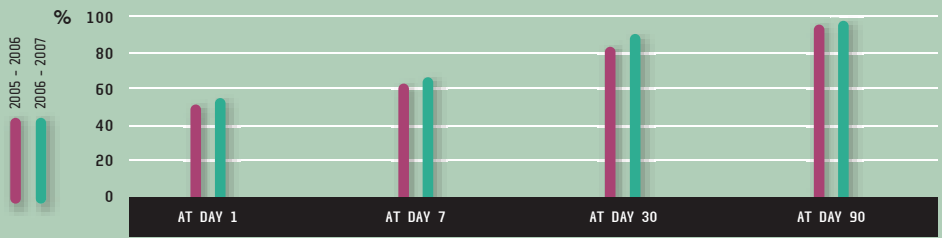


Figure 8 > Complaints Completed Since Day of Lodgement



Time taken to resolve complaints

Figures 7 and 8 provide information on the time taken to resolve complaints this year compared to last year. There has been a small improvement in the timeliness of handling complaints. 84% of complaints were handled within one month compared to 81% the previous year.

Who was complained about

Most complaints were made about registered health insurers (2209), followed by hospitals (141) and practitioners (94). The Ombudsman also received 54 complaints from people holding overseas health cover (these are not counted as registered health insurer complaints) and 36 complaints about health insurance brokers.

Some complaints concerned one or more health insurers, or a health insurer as well as a health care provider. Consequently, the total number of organisations or people that were complained about (2534) adds up to more than the total number of individual complainants contacting the Ombudsman (2340).

Figure 9 > Complaints by Health Insurer Market Share 01 July 2006 - 30 June 2007

Name of Fund	Complaints (1)	Percentage of Complaints	Level-3 Complaints (2)	Percentage of Level-3 Complaints	Market Share (3)
ACA Health Benefits	0	0.0	0	0.0	0.1
AHM	81	3.7	21	2.8	2.4
Australian Unity	182	8.2	69	9.2	3.6
BUPA (HBA)	167	7.6	59	7.8	9.9
CBHS	16	0.7	6	0.8	1.1
CDH (Cessnock District Health)	0	0.0	0	0.0	<0.1
Credicare	12	0.5	2	0.3	0.4
Defence Health	27	1.2	9	1.2	1.4
Doctors' Health Fund	0	0.0	0	0.0	0.1
Druids Victoria	7	0.3	2	0.3	0.1
GMHBA	26	1.2	4	0.5	1.5
Grand United Corporate Health	15	0.7	5	0.7	0.3
HBF Health	68	3.1	19	2.5	7.9
HCF (Hospitals Cont. Fund)	130	5.9	42	5.6	8.8
Health Care Insurance	0	0.0	0	0.0	0.1
Health Insurance Fund of W.A.	9	0.4	4	0.5	0.4
Healthguard	11	0.5	4	0.5	0.6
Health-Partners	11	0.5	3	0.4	0.7
Latrobe Health	5	0.2	0	0.0	0.6
Manchester Unity	66	3.0	16	2.1	1.4
MBF Alliances	55	2.5	15	2.0	2.2
MBF Australia Limited	591	26.8	219	29.1	16.7
Medibank Private	563	25.5	195	25.9	28.7
Mildura District Hospital Fund	2	0.1	0	0.0	0.3
N.I.B. Health	106	4.8	37	4.9	6.2
Navy Health	3	0.1	1	0.1	0.3
Peoplecare	1	0.0	0	0.0	0.3
Phoenix Health Fund	0	0.0	0	0.0	0.1
Police Health	3	0.1	2	0.3	0.2
Queensland Country Health	8	0.4	4	0.5	0.2
Railway & Transport Health	8	0.4	2	0.3	0.3
Reserve Bank Health	1	0.0	1	0.1	<0.1
St Lukes Health	1	0.0	1	0.1	0.4
Teacher Federation Health	10	0.5	1	0.1	1.6
Teachers Union Health	10	0.5	5	0.7	0.4
Transport Health	1	0.0	1	0.1	0.1
Westfund	13	0.6	4	0.5	0.7
TOTAL FOR REGISTERED FUNDS	**2209**	**100**	**753**	**100**	**100**

1. Number of Complaints (Levels 1, 2 & 3) from those holding registered health fund policies.
2. Level 3 Complaints required the intervention of the Ombudsman and the health fund.
3. Market share data provided by PHIAC as at 30 June 2006.

Complaints about registered health insurers

Figure 9 provides a summary of all complaints (Levels 1, 2 & 3) for individual health insurers compared with their market share. This data is also presented for the higher category "Level-3" complaints. Analysing the information at this further level of detail provides a more realistic picture of the way funds respond to their members' complaints. Higher Level-3 complaint to market share ratios are a pointer to a less than adequate internal disputes resolution process for complex issues within the fund.

Complaints about hospitals

During the year, there were 141 complaints about hospitals; this was 40 fewer complaints than the previous year. Most complaints about hospitals concerned inadequate *informed financial consent* (IFC) being sought from patients before a hospitalisation. Patients have contacted the Ombudsman after receiving unexpected hospital bills; either because the hospital did not perform a check of their likely benefits, or because a mistake had been made in advising them of out-of-pocket expenses.

In most cases, IFC is being appropriately sought by hospitals and it seems that the number of complaints about this issue is decreasing over time. 277 hospital complaints were received in 2003/4, 191 complaints in 2004/5, 183 in 2005/06 and 141 this year. It is pleasing to see that measures undertaken by hospitals and health insurers to ensure that IFC is being sought from patients seem to be reducing the number of complaints about this issue.

Complaints about practitioners

Most complaints about doctors and practitioners concerned medical gap issues and/or a lack of *informed financial consent* (IFC). During 2006/07 year the office received

115 complaints about medical gap issues, 10 fewer complaints than the previous year. The office registered 94 complaints against practitioners, which is 5 less than last year.

The reduction in complaints about medical gaps and against practitioners in the last few years indicates that practitioners have improved their advice to consumers and their efficiency in seeking *informed financial consent* from patients.

Resolving complaints

34% of complaints were resolved by the Ombudsman's office providing an independent and impartial explanation of the health insurer member's complaint.

41% of complaints were referred back to the health insurer or other agency. Many of these complainants were referred with the assistance of the Ombudsman's staff. Alternatively, the Ombudsman was generally able to suggest ways for the complainant to pursue the matter with the health insurer themselves.

12% of complaints (33% of the Level-3 complaint category) were resolved following payments by health funds or the writing-off of accounts by hospitals. These payments by health funds usually followed an investigation by the Ombudsman and then the health insurer agreeing that a member was entitled to a benefit payment or some other payment. In some cases, payment is made by health funds on an ex-gratia basis, for instance, where the fund accepts that the member relied on incorrect advice from the insurer. Accounts written off by hospitals are usually the result of hospitals accepting responsibility for their failure to adequately inform patients of their costs.

An additional 9% of complaints (24% of the Level-3 complaint category) were resolved by taking other remedial action, such as re-instating a membership or allowing the back payment of contributions where a membership had lapsed.

1% of complaints, which met the criteria for complaint contained in the *Private Health Insurance Act 2007,* were referred to another agency such as a hospital's patient liaison office, a state based health complaints handling body, the Privacy Commissioner, a state department of fair trading and a small number were referred to the ACCC. 2% of complaints were withdrawn or required no further action.

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

Who complained?

The *Private Health Insurance Act 2007* allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. Overwhelmingly, complaints were made by health insurance members (2301), followed by practitioners (25) and hospitals (10).

How complaints were made

78% of complaints were made initially by telephone, 16% were lodged by the internet or by email, 5% by letter and less than 1% by fax. The remainder were made by personal visit, or by parliamentary representation.

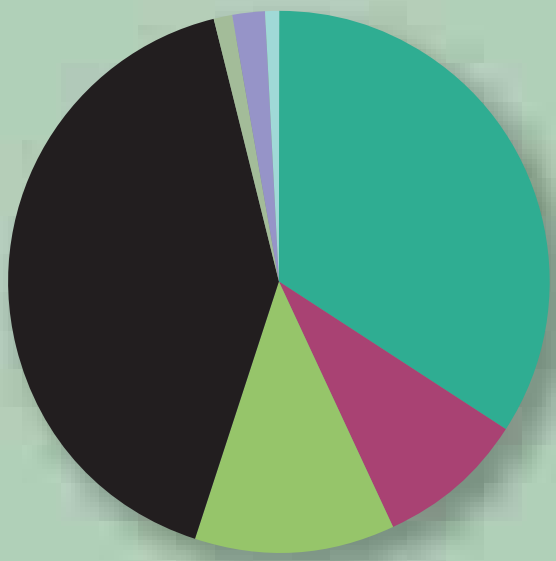


Figure 10 >
Outcomes of Finalised Complaints

34%	Further Explanation
9%	Other Satisfactory Outcome
12%	Additional Payment
41%	Referral to Insurer
1%	Referral to Other Agency
2%	Withdrawn
1%	Other

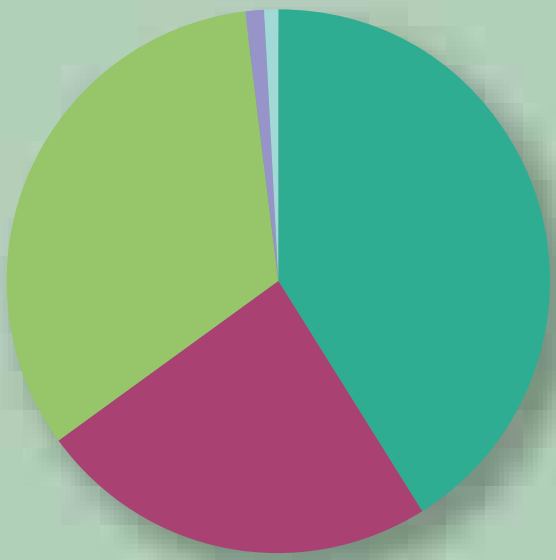


Figure 11 >
Outcomes of Finalised
Level 3 Complaints

41%	Further Explanation
24%	Other Satisfactory Outcome
33%	Additional Payment
1%	Withdrawn
1%	Other

Complaints by State/Territory

Figure 12 identifies, on a state-by-state basis, where complaints originate. This data is shown by state and territory, against the percentage of people who have private health insurance coverage. Generally, a greater proportion of complaints came from members in Victoria, South Australia, Queensland and Tasmania. The proportion of complaints coming from each state in 2006/2007 was similar to the previous year.

Investigations

From 1 July 2006 to 30 June 2007 there were no investigations under section 244 of the *Private Health Insurance Act 2007* (or under the preceding Act).

Introduction

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

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

Benefit Issues

The Ombudsman received 993 complaints concerning a wide range of benefit issues. The most significant concerns for consumers were benefits amounts, levels of cover, delays in payments, medical and hospital gaps and providers not being recognised.

Figure 13 > Complaint Issues %

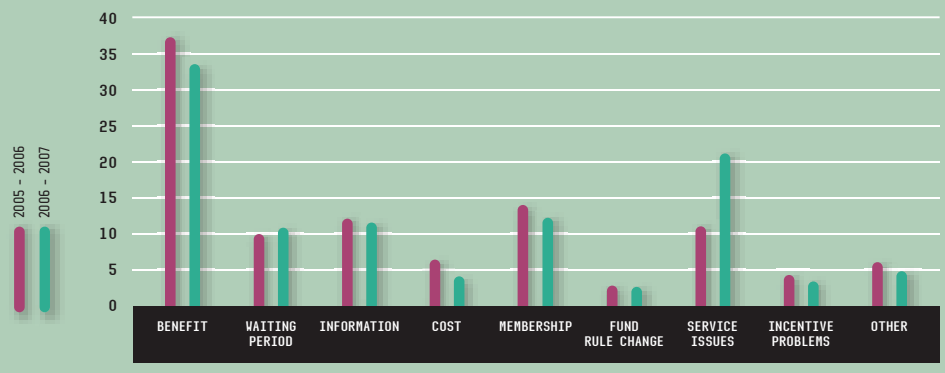
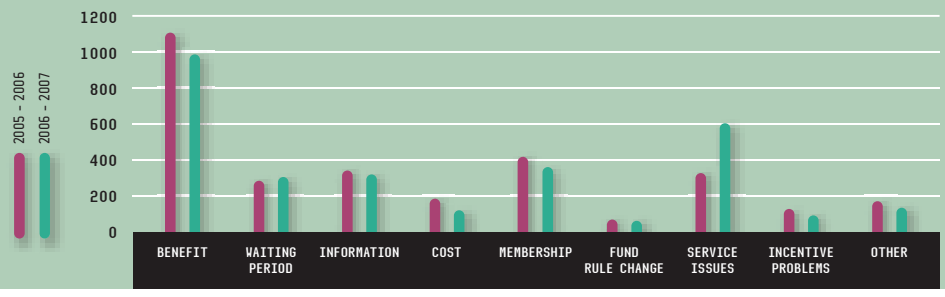


Figure 14 > Complaint Issues (numbers)



Service & Payment Related Issues

Service and membership payment related complaints increased compared to the previous year. The Ombudsman received 266 (34% more) membership payment complaints and 343 (300% more) service related complaints during 2006/07. The increase is mostly attributable to a computer administration problem at one particular insurer, where errors were made deducting and refunding membership and benefit payments.

Membership Issues

The Ombudsman received 358 matters about membership issues. These usually concerned problems with membership cancellation and suspension, transfer and continuity and arrears.

Information Issues

Of the 326 matters relating to membership issues, the majority were about oral advice provided by health insurers, with a small number of complaints about printed materials and notifications.

Health Insurer Premium Increases

During 2006/07 the Ombudsman received only 59 complaints concerning premium increases, the lowest number ever received by the office. The decrease in complaints about this issue is attributable to both a decline in the scale of premium increases in recent years and significant improvements in the way in which increases are communicated to members.

Overseas Visitors Health Cover

The Ombudsman assisted 54 consumers with complaints concerning *overseas visitors cover* (for visitors to Australia). This type of insurance is required to be taken out to comply with visa requirements in some circumstances. Overseas visitor cover is not a registered health insurance product and is consequently not counted in the list of complaints against health insurers.

The most common types of complaints investigated by the office in relation to overseas visitor cover were those concerning the *pre-existing ailment* waiting period. These cases tended to be complicated because medical information about a person's history before joining a health fund is held overseas. The office also received a small number of complaints about other types of issues such as difficulties obtaining membership refunds.

Case Studies

→ 1. Pre-existing Ailment Assessments & Advice

The Ombudsman's office received 217 complaints about the application of the pre-existing ailment waiting period during the year. Under section 75 of the *Private Health Insurance Act 2007* [3], a health insurer can apply a 12 month waiting period for pre-existing ailments to new or upgrading members. An insurer's medical practitioner can determine that a condition is a pre-existing ailment if the signs or symptoms of the ailment, illness or condition existed at any time during the 6 months prior to the person becoming insured or upgrading their level of cover.

Under community rating, which underpins private health insurance, an insurer must not discriminate against a member on grounds of health status, age or other criteria set out in legislation. The pre-existing ailment waiting period provides protection for existing members against people joining or upgrading their cover only when they require treatment. If there were no waiting periods, the costs of such claims would have to be paid by the long term members, which would in turn lead to higher premiums.

Of the complaints that the Ombudsman received, 26% were referred back to the insurer or other agency because the matter hadn't been sufficiently addressed by the insurer. When the Ombudsman refers a complaint, the staff member provides advice on how to negotiate the complaint with the insurer. Staff members advise complainants to contact them again if they are dissatisfied with the insurer's or other agency's response. If a complainant asks the office to investigate a matter again the complaint is re-classified as a Level-3 complaint.

In 47% of complaints, an explanation of the reasons for the insurer's determination was provided to the member without any further benefit being paid. In such cases, the Ombudsman investigates the reasons for the health insurer's decision and as an independent umpire, reviews whether the rule has been appropriately applied. The consumer is provided with an explanation of the rule and specifically how it has been applied to their situation, based on the medical information provided.

26% of complaints were investigated by the Ombudsman to ascertain whether the rule had been appropriately applied and resulted in a further payment to the complainant. In some cases, the Ombudsman referred matters to an independent medical adviser, who determined that the rule was incorrectly applied and that therefore a benefit should be paid.

The following case study is an example of an Ombudsman investigation resulting in a payment because the appropriate pre-existing ailment procedures were not followed by the insurer.

Mr Bluegum joined a health insurer as a new member in September 2006. Five months later, he visited his GP for an unrelated reason and was advised that he might have sleep apnoea. In order to investigate this further, the doctor organised for Mr Bluegum to undergo a sleep study test in a private hospital.

Two weeks before the proposed hospital admission date, Mr Bluegum arranged for a medical certificate to be completed by his GP, to enable his insurer to determine whether the pre-existing ailment rule would apply to his hospitalisation. He himself believed his condition was not a pre-existing ailment and continued with the hospitalisation.

Several days after his visit to the hospital, Mr Bluegum received a large bill in the

[3] The Pre-existing ailment rule also existed under the *National Health Act 1953* which was superseded by the *Private Health Insurance Act 2007* on 1 April 2007.

post and a letter from his insurer advising him that he was not covered for the hospitalisation, due to the pre-existing ailment rule. He did not believe this was a fair decision and asked the Ombudsman to investigate.

At first, his complaint appeared to be a simple case of an insurer correctly applying the pre-existing ailment rule and the complainant misunderstanding the rule. The fund medical adviser had assessed the claim as pre-existing three days before the hospitalisation and noted that the form completed by Mr Bluegum's doctor stated the condition was "chronic" and of some duration at the time Mr Bluegum visited him in November 2006 (only one month after joining the fund).

In such cases, PHIO can investigate the matter and explain the reasoning behind the decision. The medical certificates and assessment of Mr Bluegum's condition appeared to be correct and consistent with the medical view that a patient does not develop chronic sleep apnoea that requires treatment in a period of less than four weeks. In this case, however, although the decision appeared to be correct, the Ombudsman queried why no one advised Mr Bluegum that benefits would not be payable before his hospital admission, particularly given that he lodged the forms well ahead of the admission date.

It was Mr Bluegum's view that he was advised he would be covered for his procedure. He cited a phone call that he made three days before the hospitalisation. As this phone call was recorded by the insurer, the Ombudsman reviewed the recording and confirmed he was told that he would not be covered if it was a pre-existing ailment. It was also confirmed that this advice was given to Mr Bluegum on the same day that the pre-existing ailment assessment had been made by the insurer. The Ombudsman asked the insurer why it did not advise Mr Bluegum on that day that the assessment had been completed and he would definitely not be covered, to which the response was that all pre-existing ailment assessments are advised in writing.

The Ombudsman made the insurer aware of the "Best Practice Guidelines" for funds interpreting the pre-existing ailment rule, which states that fund staff should telephone the member if it is unlikely that the written confirmation of the assessment will reach the member prior to the planned admission. The Ombudsman's view was that whilst the insurer had correctly assessed the claim as a pre-existing ailment, the assessor should have noted the hospitalisation was only three days away (it was stated clearly on the forms) and telephoned Mr Bluegum to alert him to the financial implications of proceeding with his hospitalisation.

The insurer agreed with the Ombudsman's view and offered to pay Mr Bluegum's claim in recognition that it should have advised him of the pre-existing ailment assessment by telephone. The insurer also undertook to review its procedures for advising members in similar situations.

2. Informed Financial Consent

Informed Financial consent is the process by which a consumer is able to give informed consent to incurring out of pocket costs not covered by their insurer. There has been a continuing decline in complaints to the Ombudsman about lack of *informed financial consent* (IFC) in relation to hospital charges in recent years. This has occurred because private hospitals and health insurers have reviewed their processes to ensure correct information about the cost of treatment and level of benefits is provided wherever possible. The following is a case of proper consent not being provided in a public hospital.

Mrs Waratah was expecting a baby and made arrangements to be admitted to a local public hospital, some months before her due date. She chose to be a private patient in the public hospital so that she could choose her own obstetrician. When a patient elects to be treated privately, the public hospital bills them or their insurer on a daily basis.

The hospital confirmed Mrs Waratah's booking and sent her a letter asking for her private health insurance details. The letter also stated that the hospital would contact her health fund one month prior to the admission date to confirm whether she would be covered as a private patient.

On admission to the hospital, hospital staff advised that she had the option of staying in either a shared room or a single room. Mrs Waratah opted for the single room, believing the cost would be the same because no one told her otherwise.

After being discharged from hospital, Mrs Waratah received a bill for $1400 - the difference between the cost of a shared and single room. It turned out that her private health insurance would only cover the cost of a shared room in a public hospital, not the cost of a single room in a public hospital.

Although Mrs Waratah signed the hospital admission forms which stated that she accepted liability for any additional charges not covered by her health insurer, at no stage prior to or during her admission was she advised whether additional charges would in fact apply, nor how much these charges were likely to be.

PHIO took the view that the hospital should have done more to advise Mrs Waratah about the restrictions on her cover, so she could make an informed choice between a shared and single room. A "cover all" form in which a patient agrees to pay an unspecified amount for a hospital stay does not constitute informed financial consent.

As the hospital was unable to establish that they had obtained Mrs Waratah's informed financial consent to incurring the extra charges, it agreed to waive these charges and review its admission processes.

3. Transferring between Health Insurers (Brokers)

From 1 July 2006, the Ombudsman was given jurisdiction to take complaints about health insurance brokers. The office received 36 complaints specifically about brokers during 2006/07. While this is not a large number of complaints, the following case study has been included to demonstrate the way in which the Ombudsman deals with complaints about brokers.

When PHIO receives a complaint from a consumer concerning a broker, it is expected that the broker and health insurer will ensure that one or both parties take ownership of the complaint. This includes ensuring that if it has

been established that a consumer has been misadvised about a benefit, an agreement is reached between the broker and the health insurer so that the consumer is adequately paid any benefits that were promised.

The following case study is an example of a broker and health insurer coming to such an agreement.

Mr Heath held top hospital cover with a $200 excess. He contacted a health insurance broker to see if he could purchase a similar level of cover with no excess at another insurer. He was hoping to find an equivalent or better level of cover at a lower price.

The broker offered him a new policy with another health insurer which was cheaper than his current policy. Mr Heath asked if the new policy had a nil excess and the broker confirmed that this was the case. Based on this information, Mr Heath transferred to the new policy.

Shortly afterwards, Mr Heath was arranging to go to hospital. The admissions staff at the hospital asked him to pay a $500 excess for his stay. He thought this was a mistake and checked his policy, only to find that he did in fact have a $500 excess. This was the first time he became aware that he was on a policy with an excess, because it took some time for paperwork from his new insurer to reach him.

When he contacted the broker to find out why he had been misinformed about the level of his excess, the broker was initially unable or unwilling to assist him. Although the broker's error had resulted in Mr Heath's purchase of the cover, the onus for correcting the mistake fell to the insurer.

As the insurer was satisfied that the broker had given Mr Heath incorrect information about the excess on the policy, it agreed to change Mr Heath's policy to one with no excess. The insurer also made an ex-gratia payment of $500 to Mr Heath to compensate him for the excess he had to pay to the hospital.

Mr Heath was happy with the response from the insurer, but as the new policy with no excess was actually more expensive than his original policy, he left the insurer and rejoined his old insurer on the same policy as before.

→ 4. Claims Service Complaints

The Ombudsman received 199 complaints about delays in the payment of claims during the year. This makes it a significant complaint issue for the office, although it is not a high level of complaint when compared to the millions of individual claims that are paid by insurers each year.

Most complaints about delays are a result of complications in the claims process, such as missed paperwork or requests for additional paperwork before a claim can be assessed.

The following case study is an example of a consumer aggrieved at the difficulties experienced in making a general treatment claim.

Ms Orchid was a long term member of a health insurer and had been claiming orthotics regularly for several years. Under the terms of her policy, orthotics were payable if there was a medical need for them and they were provided by a registered provider.

Usually, she was only required to send the claim into the fund on a claim form, because details about her medical need to use orthotics were held on the insurer's computer system and she always used the same supplier.

Earlier this year, Ms Orchid required a replacement orthotic. She sent her claim to her insurer as usual and waited for a benefit to be paid. Since the last time she had claimed, her insurer had been taken over by another health insurance company in a different state. The new insurer recognised all her previous entitlements, but changed the requirements for claiming benefits.

The new insurer held her claim and sent her a letter requesting that she obtain a letter from her doctor recommending the orthotic as a medically necessary item. She was unhappy that the details of her previous claims were now insufficient, but agreed to obtain the details the insurer was asking for.

Ms Orchid visited her doctor and obtained the letter and sent it back to the insurer. Some time later, she was advised that the insurer did not have the provider details from the orthotic supplier and these would need to be obtained before a benefit could be paid.

Over the next few weeks, Ms Orchid phoned the insurer several times to query her claim. She was advised that the forms for the orthotic supplier had been faxed a number of times and they were still waiting on a response. After a few weeks and growing tired of waiting, Ms Orchid phoned PHIO to seek assistance.

PHIO's investigation revealed that the doctor's letter, which Ms Orchid took the trouble to have completed on a specific visit to her Medical Practitioner, was not required and the request that she obtain it had been made in error. The real issue for the insurer was that the orthotic supplier was not registered.

The insurer also advised that the incorrect form had initially been sent to the orthotic supplier but a new form was on its way. After some time, the insurer phoned the orthotic supplier and concluded that "they do not have qualification details to supply orthotics" and therefore no benefit would be paid.

PHIO conveyed the insurer's response to Ms Orchid who expressed her dissatisfaction with the time taken in processing her claim and her disbelief that the orthotic provider would not be qualified to issue orthotics. At this stage, Ms Orchid indicated that the claim was only $200 and that was she considering dropping the case and changing insurers.

Unfortunately, although the case had not been handled well by the insurer and Ms Orchid had experienced considerable inconvenience, the insurer declined to change its stance and pay a benefit for her orthotics. As the insurer was acting within its rules, the PHIO did not have grounds to require the payment of the benefit. Ms Orchid expressed her intention of leaving the insurer and that in her experience "not all health insurers are the same".

→ 5. Day Only Hospital Covers

Budget hospital covers usually restrict or exclude benefits for a range of procedures. Generally, health insurers recommend these covers only for younger, healthier people; because the benefits payable for more expensive treatments that older people are more likely to need are very limited.

PHIO recommends that consumers reassess their health insurance needs every year, particularly if they are on a policy with a restriction or exclusion. Otherwise, as they age, they may find they are not privately insured for procedures they are more likely to need, such as cardiac procedures, psychiatric treatment, joint replacements, eye surgery, obstetrics, rehabilitation, dialysis, and other services.

In some cases, insurers offer entry level policies that only pay benefits for a limited number of services such as wisdom teeth extraction, appendectomies, accidents or day only procedures. The following case study illustrates some of the difficulties consumers can experience with these types of policies.

Mr Banksia held a budget hospital cover that paid private hospital benefits only for day procedures. He needed to have a laparoscopy procedure and as it was a day procedure, he requested it be performed at a private hospital where he understood he would be covered. His cover also charged a $200 excess, which he was happy to pay.

On admission, the hospital staff member made it clear to Mr Banksia that he would not be covered for staying overnight. Mr Banksia did not take much notice of this advice because he was being admitted for a simple day procedure. He was also confident that a benefit would be paid because he had taken the extra step of contacting the insurer himself, who confirmed that a benefit for his day procedure would be paid. He paid his $200 excess and went ahead with the procedure.

He was booked to have the procedure at 1.00 pm but unfortunately, the theatre list was running late that day and Mr Banksia was not sent to theatre until 5.00 pm.

Upon waking from anaesthetic at 9.00 pm, he was told he would need to stay overnight. Mr Banksia asked how much this overnight stay would cost, but was advised that they could not tell him, because there were no clerical staff at the hospital at that time of night.

Mr Banksia went home the next morning and a few weeks later a bill for $3000 arrived in the post. This caused Mr Banksia some distress, because he could not understand how the extra few hours in hospital could possibly cost an extra $3000. He queried the cost with the insurer and was advised that under his policy, no benefit is paid for the theatre fee (the main cost of a hospitalisation) for an overnight stay; the cost of the theatre fee is only paid for a day procedure. This means there is a significant financial cost if a member stays overnight for any reason.

Dissatisfied that no one warned him about the significant additional cost of staying overnight.

The hospital and health insurer both advised that they did not tell Mr Banksia of the extent of his costs if he stayed overnight. Given the hospital's response, PHIO requested the hospital to reduce the outstanding account, because although it had advised that he would not be covered for an overnight stay, advice about the likely costs had not been given and informed financial consent had not been appropriately sought from Mr Banksia.

The insurer was also requested to provide a higher level of benefit, because it did not give Mr Banksia sufficient warning of the costs associated with staying overnight when he contacted the fund to check his level of cover.

Following negotiations, it was decided that each party would pay approximately a third of the costs associated with Mr Banksia's hospitalisation. Mr Banksia was required to pay a third of the cost because he was clearly aware that he was on a budget cover that only paid for day procedures. The hospital agreed to write off $1000 because it had failed to advise Mr Banksia of the cost of staying overnight. The insurer paid $1000 extra because it did not provide sufficient warning of likely costs of staying overnight in a private hospital.

It was pleasing to see that following Mr Banksia's complaint, the insurer decided to change its policy in relation to paying benefits in cases like Mr Banksia's. Where a patient is booked for a day only procedure and is required to stay overnight because of circumstances beyond their control, the insurer will cover the theatre fee. This leaves the consumer responsible for the difference between the day accommodation and the overnight stay, which is usually several hundred, rather than several thousand dollars.

Access and Public Awareness

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

To raise awareness of the services provided by the Ombudsman, the following strategies were employed during 2006/07:

- Details of the Ombudsman's services are referenced in various Government publications and in publications produced by other agencies and consumer bodies.
- Health insurers provide information about the availability of the Ombudsman's services and contact details in brochures, publications and in some correspondence to their members. These details are also included on health insurers' internet sites.
- The Ombudsman produces and distributes a range of brochures on health insurance issues.
- The Acting Ombudsman participated in a number of media interviews during the year. This year there was additional media coverage of the Ombudsman's role associated with the new consumer website, http://www.privatehealth.gov.au.
- The Ombudsman also contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites.
- The Ombudsman publishes a regular quarterly report and state of the Health Funds Report which are distributed in both printed format and on the PHIO website.
- The Ombudsman hosts an internet site where consumers can access a range of brochures, recent Ombudsman Quarterly Bulletins and Annual Reports. The site enables consumers to make inquiries, lodge complaints and request printed copies of brochures. It also provides consumers with links to other useful sites. The Ombudsman's web site is located at: http://www.phio.org.au.
- The Ombudsman and staff spoke at a number of health industry conferences during the year.

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

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

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

Relations with Stakeholders

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

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

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

Client Survey > About the Survey

In May 2007, the office carried out a postal survey of 225 randomly selected complainants who had lodged complaints during the period December 2006 to May 2007. 74 clients responded to the survey (34%).

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

Improvements in Client Satisfaction

This year's survey has again shown an improvement in client satisfaction.

The greatest improvements in satisfaction occurred with Level-1 Complaints. These occur where the client is referred back to the insurer or other agency with the assistance of the office. 87% of Level-1 complainants reported that they were very satisfied with the overall handling of their complaint in 2007.

This compares to 69% reporting that they were very satisfied two years ago. This reflects the recent change in PHIO's complaint handling policy to assist consumers by directly referring complaints to the insurer, instead of asking the consumer to contact them independently.

In summary, of the respondents to the survey:

- 95% said that staff listened to their concerns, an increase from 94% the year before.
- 91% said that staff explained what sort of assistance we could provide, an increase from 85% last year.

- 92% said that staff were easy to understand, an increase from 87% the previous year.
- 88% said that they were satisfied or mostly satisfied with the manner in which staff handled their complaint, this was an increase from 86% the year before.
- 86% said that we had resolved their complaint or provided an adequate explanation, an increase from 74% last year.
- 88% reported that PHIO was independent in dealing with their complaint, an increase from 87% the previous year.
- 90% said that they would recommend PHIO to others, compared to 82% the year before.
- 92% of those whose cases lasted more than a week said that they were happy with the time taken resolving their complaint. This was an increase from 76% last year.

Health Policy > Liaison with Other Bodies

The Ombudsman's office has a role in assisting with the broader issues associated with health policy. During the year, the Office provided information and assistance to various bodies involved in the formulation of health policy and the compliance with established rules and laws. Some significant activities included:

- Continued participation in the development of policies and procedures for providing for informed financial consent by medical providers.
- Submission to the ACCC's 8th Report to the Senate on *anti-competitive and other practices by health funds and providers in relation to private health insurance.*
- Participation in the consultation in relation to the Review of National Safety and Quality Accreditation Standards.
- Submission to the Parliamentary Inquiry into the Medibank Private Sale Bill.
- Drafting of guidelines for the use of the Ombudsman's mediation power, to assist in resolving contractual disputes that may affect consumers' entitlements under their private health insurance.

Corporate Governance

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

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

Management of Human Resources

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

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

Staff Details

As at 30 June 2007, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman (acting)	1	–
Director, Policy & Compliance (acting)	1	–
Senior Project Officer	–	1
Financial Officer	1	–
Dispute Resolution Officers*	4	1
Administrative Assistant	–	1
Customer Service Officer – Website	1	–
Total	8	3

* 1 Dispute Resolution Officer is on Maternity Leave.

Statutory Positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry Date
Mr J Powlay	Ombudsman	3 years	Nov 2008

Mr Powlay passed away in January 2007. Ms Samantha Gavel was appointed acting Ombudsman on an ad hoc basis from August – December 2006 and on a full time basis from mid December until the end of the reporting period.

Staff Development and Training

During the 2006/07 financial year, $38 012 was spent directly on PHIO staff attending training courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff. In addition, the decision to prescribe the PHIO under the Financial Management Act 1997 and appoint staff under the Public Service Act 1999 from 1 July 2007 required the office to allocate more resources to staff training and development than in previous years.

Staff Employment Status

The Private Health Insurance Ombudsman is committed to providing a safe working environment that supports the rights, responsibilities and legitimate needs of all staff.

The Ombudsman is committed to best practice in selection, recruitment and promotion of staff in line with the merit principle.

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

The following table shows the numbers and status of staff who were employed on 30 June 2007.

Occupational Group	Women	Men	Total Staff	NESB1
SES	1	0	1	–
Other	8	3	11	4
Total	9	3	12*	4

Note:

SES	Senior Executive Service, Acting Ombudsman
Other	All other staff - temporary and permanent
NESB1	Non-English speaking background, 1st Generation
*	Includes part time employees and those on maternity leave.
	Actual EFT = 10.2

Performance Appraisal

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

Industrial Democracy

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

Accounting

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

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

Outcomes and Outputs

The 2006/07 Portfolio Budget Statement indicates that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 9, *Private Health.*

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

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

Consultants Engaged

The Ombudsman continued to engage Complete GST Solutions as a consultant during the financial year to assume responsibility for regular in-house accounting functions. The office also engaged P T & A Health and Dr Geoff Dreher on an ad hoc basis as medical referees on cases requiring a medical opinion.

Two significant projects during the year required additional consultancy services. These were the development of the www.privatehealth.gov.au website and the decision to transfer the office's financial administration from the *Commonwealth Authorities and Companies Act 1997* to the *Financial Management & Accountability Act 1997* and the associated transfer of staff to the *Australian Public Service Act 1999* from 1 July 2007.

Website Consultants

The following consultants were engaged to assist with the development of the www.privatehealth.gov.au website:

- Acumen Alliance was engaged by competitive tender to provide procurement and project management services during the development of the website;
- Human Solutions of Tasmania was awarded the tender for the development and maintenance of the website, at a total cost of $1.1 million.
- IPSOS Australia was engaged to conduct a small focus test of the website, following its completion.

Transfer to Financial Management and Public Service Acts

- Resolution Consulting Services was engaged to provide financial and other advice in relation to the transfer of the PHIO's finances to the *Financial Management Accountability Act 1997;*
- The Interaction Consulting Group was engaged to provide assistance and advice in relation to staffing issues, including work level standards and accountabilities under the *Public Service Act 1999*; and

- Marana Consulting Group was engaged to set up a more formal performance management system to enable the PHIO to meet the requirements of the *Public Service Act 1999.*

Information Systems

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

Payroll Services

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

Fraud Control

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

Service Charter

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

The Service Charter sets out what we do, the service standards our clients can expect and the steps they can take if these standards are not met. The Charter was developed in consultation with staff and clients. It was updated in early 2006 and issued under the office's "About Our Service" brochure.

Occupational Health And Safety

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

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

No reportable incidents occurred during the year.

Equal Employment Opportunity

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

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 2007.

Establishment

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

Public Information

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

Requests

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

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

Documents held by the Ombudsman

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

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

Documents available free of charge

The following brochures are available free of charge upon request:

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

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

Access to documents

People may obtain documents:

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

Information and procedures for Freedom of Information Act requests

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

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

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

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

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

Courts

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

Commonwealth Ombudsman

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

Other

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

Service Charter

In line with requirements for all Australian Government agencies, the Ombudsman introduced a Service Charter in June 1998, which was reviewed in 2006.

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

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

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

FINANCIAL INFORMATION

Australian National
Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Ageing

Scope

We have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2007. The financial statements comprise: a statement by the Ombudsman; income statement; balance sheet; statement of changes in equity; cash flow statement; schedules of commitments and contingencies; a summary of significant accounting policies; and other explanatory notes.

The Responsibility of the Ombudsman for the Financial Statements

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

Auditor's Responsibility

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

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

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

Australian National
Audit Office

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

Independence

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

Auditor's Opinion

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

(a) have been prepared in accordance with Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997* and Australian Accounting Standards (including Australian Accounting Interpretations); and

(b) give a true and fair view of the matters required by the Finance Minister's Orders including the Private Health Insurance Ombudsman's financial position as at 30 June 2007 and of its financial performance and its cash flows for the year then ended.

Australian National Audit Office

P Hinchey
Senior Director
Delegate of the Auditor-General

Sydney
17 August 2007

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

PRIVATE HEALTH INSURANCE OMBUDSMAN
STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2007 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*.

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

Signed... Samantha Gavel
Samantha Gavel
A/g Ombudsman

17 August 2007

Private Health Insurance Ombudsman
Income Statement
for the year ended 30 June 2007

	Note	2007 $	2006 $
INCOME			
Revenue			
Revenues from government	**2A**	**2,794,000**	1,160,000
Interest	**2B**	**110,212**	41,448
Other	**2C**	**57**	1,000
Total Revenue		**2,904,269**	1,202,448
Gains			
Sale of assets	**2D**	**1,545**	0
Total Gains		**1,545**	0
TOTAL INCOME		**2,905,814**	1,202,448
EXPENSES			
Suppliers	**3A**	**588,786**	313,560
Employee Benefits	**3B**	**770,391**	781,056
Depreciation and amortisation	**3C**	**38,774**	14,270
Write down and Impairment of assets		**2,548**	0
TOTAL EXPENSES		**1,400,499**	1,108,886
SURPLUS		**1,505,315**	93,562

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

Private Health Insurance Ombudsman
Balance Sheet
as at 30 June 2007

	Note	2007 $	2006 $
ASSETS			
Financial assets			
Cash and cash equivalents	4A	**1,447,968**	267,608
Investments under s18 of the CAC Act	4B	**0**	500,000
Trade & Other Recievables	4C	**65,199**	0
Total financial assets		**1,513,167**	767,608
Non-financial assets			
Infrastructure, plant and equipment	5A,B	**66,621**	64,732
Intangibles	5C	**626,109**	0
Total non-financial assets		**692,730**	64,732
TOTAL ASSETS		**2,205,897**	832,340
LIABILITIES			
Payables			
Suppliers	6A	**0**	33,342
Total payables		**0**	33,342
Provisions			
Employee Provisions	7A	**102,803**	201,219
Total provisions		**102,803**	201,219
TOTAL LIABILITIES		**102,803**	234,561
EQUITY			
Retained surplus		**2,103,094**	597,779
Total equity		**2,103,094**	597,779
Current Assets		**1,513,167**	767,608
Non-current assets		**692,730**	64,732
Current liabilities		**76,159**	100,497
Non-current liabilities		**26,644**	134,064

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

Private Health Insurance Ombudsman
Statement of Cash Flows
for the year ended 30 June 2007

	Note	2007 $	2006 $
OPERATING ACTIVITIES			
Cash Received			
Appropriations		**2,794,000**	1,160,000
Interest		**110,212**	41,448
Other		**1,601**	1,000
Total cash received		**2,905,813**	1,202,448
Cash Used			
Suppliers		**(687,318)**	(300,730)
Employees		**(868,816)**	(755,187)
Total cash used		**(1,556,134)**	(1,055,917)
Net cash from operating activities	8	**1,349,679**	146,531
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**(20,109)**	(19,366)
Purchase of internally developed software		**(649,210)**	0
Proceeds from investments		**500,000**	0
Total cash used		**(169,319)**	(19,366)
Net cash used by investing activities		**(169,319)**	(19,366)
Net increase in cash held		**1,180,360**	127,165
Cash at the beginning of the reporting period		**267,608**	140,443
Cash at the end of the reporting period	4A	**1,447,968**	267,608

Private Health Insurance Ombudsman
Statement of Changes in Equity
for the year ended 30 June 2007

Item	Accumulated Results		Total	
	2007 $	2006 $	2007 $	2006 $
Opening balance	**597,779**	504,217	**597,779**	504,217
Net Operating Result	**1,505,315**	93,562	**1,505,315**	93,562
Total income and expenses	**1,505,315**	93,562	**1,505,315**	93,562
Closing balance at 30 June	**2,103,094**	597,779	**2,103,094**	597,779

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

Private Health Insurance Ombudsman
Schedule of Commitments
as at 30 June 2007

	2007 $	2006 $
BY TYPE		
Other commitments		
Operating Leases	**0**	40,424
Total other commitments	**0**	40,424
Commitments receivable	**0**	3,675
Net commitments by type	**0**	36,749
BY MATURITY		
Operating lease commitments		
One year or less	**0**	40,424
From one to five years	**0**	0
	0	40,424
Commitments receivable	**0**	3,675
Net commitments by maturity	**0**	36,749

NB: Commitments are GST inclusive where relevant.

1. Operating leases included are effectively non-cancellable and comprise:

Nature of Lease	General description of leasing arrangement
Leases for office accommodation	The lease expired on 28 February 2007 and tenure is by month.

Private Health Insurance Ombudsman
Schedule of Contingencies
as at 30 June 2007

There were no contingent losses or gains as at 30 June 2007.

The above statements 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 2007

Note 1: Summary of Significant Accounting Policies

1.1 Basis of Preparation of the Financial Statements

The Financial Statements and notes 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 continued existence of the Private Health Insurance Ombudsman in its present form and with its present programs is dependent on Government policy and on continuing appropriations by Parliament for the Private Health Insurance Ombudsman's administration and programs.

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

• Finance Minister's Orders (FMO's) for the reporting periods ending on or after 1 July 2006; and

• Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The Financial Statements have been prepared on an accrual basis and are in accordance with historical cost convention, except for certain assets at fair value.

Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

The Financial Report is presented in Australian dollars.

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

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

1.2 Significant Accounting Judgements and Estimates

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

1.3 Statement of Compliance

The financial report complies with Australian Accounting Standards, which include Australian Equivalents to International Financial Reporting Standards (AEIFRS).

1.4 Revenue

Revenues from Government

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

Other types of Revenues

Interest revenue is recognised using the effective interest method as set out in the AASB 139 Financial Instruments: Recognition and Measurement

1.5 Gains - Sale of Assets

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

Private Health Insurance Ombudsman
Notes To and Forming Part of Financial Statements
for the year ended 30 June 2007

1.6 Employee Benefits

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

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

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

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

Leave

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

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

Superannuation

Employees of the Ombudsman are members of the Commonwealth Superannuation Scheme (CSS) and the Public Sector Superannuation Scheme (PSS + PSSap).

The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap is a "profit for members" fund for the Australian Government.

The liability for defined benefits recognised in the financial statements of the Australian Government are settled by the Australian Government in due course.

Private Health Insurance Ombudsman makes employer contributions to the PSS and CSS at rates determined by an actuary to be sufficient to meet the cost to the Government of the superannuation entitlements for the Ombudsman's employees.

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

1.7 Leases

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

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

The Ombudsman has no finance leases.

1.8 Cash

Cash means notes and coins held and any deposits held at call with a bank or financial institution. Cash is recognised at its nominal amount.

1.9 Financial Risk Management

The Ombudsman's activities expose it to normal commercial financial risk. As a result of the nature of the ombudsman's business and internal and Australian Government policies, dealing with the management of financial risk, the Ombudsman's exposure to market, credit, liquidity and cash flow and fair value interest rate risk is considered to be low.

1.10 Derecognition of Financial Assets and Liabilities

Financial assets are derecognised when the contractual rights to the cash flows from the financial assets expire or the asset is transferred to another Entity. In the case of a transfer to another

Entity, it is necessary that the risks and rewards of ownership are also transferred.

Financial liabilities are derecognised when the obligation under the contract is discharged, cancelled or expires.

1.11 Impairment of Financial Assets

Financial assets are assessed for impairment at each balance date.

Financial Assets held at Amortised Cost

If there is objective evidence that an impairment loss has been incurred for loans and receivables or held to maturity investments held at amortised cost, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the Income Statement.

Financial Assets held at Cost

If there is objective evidence that an impairment loss has been incurred on an unquoted equity instrument that is not carried at fair value because it cannot be reliably measured, or a derivative asset that is linked to and must be settled by delivery of such an unquoted equity instrument, the amount of the impairment loss is the difference between the carrying amount of the asset and the present value of the estimated future cash flows discounted at the current market rate for similar assets.

1.12 Supplier and other payables

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

1.13 Contingent Liabilities and Contingent Assets

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

1.14 Acquisition of Assets

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

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

1.15 Property, Plant and Equipment

Asset Recognition Threshold

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

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in property leases taken up by Private Health Insurance Ombudsman where there exists an obligation to restore the property to its original condition. These costs are included in the value of the Ombudsman's leasehold improvements with a corresponding provision for the 'make good' taken up.

Revaluations

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

Asset Class	Fair value measured at:
Leasehold Improvements	Depreciated replacement cost
Plant and Equipment	Market selling price

Private Health Insurance Ombudsman
Notes To and Forming Part of Financial Statements
for the year ended 30 June 2007

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

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of asset revaluation reserve except to the extent that it reverses a previous revaluation decrement of the same asset class that was previously recognised through the income statement. Revaluation decrements for a class of assets are recognised directly through the income statement except to the extent that they reverse a previous revaluation increment for that class.

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

Depreciation and Amortisation

Depreciable property, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Ombudsman using, in all cases, the straight-line method of depreciation. Leasehold improvements are depreciated 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), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

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

	2007	2006
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 3C.

Impairment

All assets were assessed for impairment at 30 June 2007. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

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

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

1.16 Intangibles

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

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the Ombudsman's software is 5 to 10 years (2005-06: 7 to 10 years).

All software assets were assessed for indications of impairment as at 30 June 2007.

1.17 Taxation

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

Revenues, expenses and assets are recognised net of GST:

• except where the amount of GST incurred is not recoverable from the Australian Taxation Office; and

• except for receivables and payables.

NOTE 2: INCOME

Revenues

Note 2A:	Revenues from Government		
	Appropriation for outputs	**2,794,000**	1,160,000
	Total revenue from government	**2,794,000**	1,160,000
Note 2B:	Interest		
	Interest on Deposits	**110,212**	41,448
	Total Interest revenue	**110,212**	41,448
Note 2C:	Other Revenues		
	Seminar Income	**0**	1,000
	Other	**57**	0
	Total Other Revenues	**57**	1,000

Gains

Note 2D:	Sale of assets		
	Property Plant and Equipment:		
	Proceeds from sale	**1,545**	0
	Carrying value of assets sold	**0**	0
	Selling Expense	**0**	0
	Net gain from sale of assets	**1,545**	0

NOTE 3: OPERATING EXPENSES

Note 3A:	Suppliers expenses		
	Supply of Goods and Services - all external	**539,588**	261,083
	Operating Lease Rentals	**49,198**	52,477
	Total suppliers expenses	**588,786**	313,560
Note 3B:	Employee benefits		
	Wages and Salaries	**591,550**	582,078
	Superannuation	**93,068**	104,610
	Leave and other entitlements	**32,252**	25,932
	Other employee expenses	**53,521**	68,436
	Total employee benefits	**770,391**	781,056

NOTE 3: OPERATING EXPENSES (Continued)

Note 3C:	Depreciation and Amortisation		
	Depreciation		
	Leashold Improvements	**492**	492
	Plant and equipment	**15,181**	13,778
	Total Depreciation	**15,673**	14,270
	Amortisation		
	Intangibles		
	Computer Software	**23,101**	0
	Total amortisation	**23,101**	0
	Total depreciation and amortisation expense	**38,774**	14,270

Private Health Insurance Ombudsman
Notes To and Forming Part of the Financial Statements
for the year ended 30 June 2007

		2007 $	2006 $
NOTE 4: FINANCIAL ASSETS			
Note 4A:	Cash and cash equivalents		
	Cash at Bank	**1,447,689**	267,348
	Cash on Hand	**279**	260
	Total cash and cash equivalents	**1,447,968**	267,608
Note 4B:	Investments under s18 of the CAC Act		
	Term Deposits	**0**	500,000
	Total investments	**0**	500,000
	Term deposits are with the Ombudsman's bank and earn an effective interest rate of 5.95% (2006: 5.70%). Interest is payable quarterly. Terms are between 3 and 6 months.		
Note 4C:	Trade & Other Receivables		
	ATO Sundry Debtors	**65,199**	0
	Total trade and other receivables (net)	**65,199**	0
NOTE 5: NON-FINANCIAL ASSETS			
Note 5A:	Leasehold Improvements		
	Lease Fitout at valuation	**4,354**	4,915
	Accumulated depreciation	**(983)**	(1,053)
	Total Buildings (non-current)	**3,371**	3,862
Note 5B:	Infrastructure, Plant and Equipment		
	- at cost	**36,329**	19,366
	- at 2005 valuation (fair value)	**52,215**	55,282
	- accumulated depreciation	**(25,294)**	(13,778)
		63,250	60,870
Note 5C:	Intangibles - at cost		
	Intangibles	**649,210**	17,412
	Accumulated depreciation	**(23,101)**	(17,412)
	Total intangibles	**626,109**	0

Note 5D: Reconciliation of the opening and closing balances of property, plant and equipment

Item	Leasehold Improvements $	Plant & Equipment $	Intangibles $	Total $
As at 1 July 2006				
Gross Book Value	4,915	74,648	17,412	96,975
Accumulated Depreciation/amortisation	(1,053)	(13,778)	(17,412)	(32,243)
Opening Net Book Value	**3,862**	**60,870**	**0**	**64,732**
Additions:				
By Purchase	0	20,109	649,210	669,319
Depreciation/amortisation expense	(492)	(15,181)	(23,101)	(38,774)
Disposals:				
Other Disposals	0	(2,548)	0	(2,548)
As at 30 June 2007				
Gross Book Value	4,354	88,545	649,210	742,109
Accumulated Depreciation/amortisation	(983)	(25,295)	(23,101)	(49,379)
Closing Net Book Value	**3,371**	**63,250**	**626,109**	**692,730**

Private Health Insurance Ombudsman
Notes To and Forming Part of the Financial Statements
for the year ended 30 June 2007

		2007 $	2006 $
NOTE 6: PAYABLES			
Note 6A:	Suppliers		
	Trade creditors - current	**0**	25,062
	Accruals - current	**0**	8,280
	Total supplier payables	**0**	33,342
	Supplier payables are represented by:		
	Current	**0**	33,342
	Non-current	**0**	0
	Total supplier payables	**0**	33,342
NOTE 7: PROVISIONS			
Note 7A:	Employee Provisions		
	Salaries and Wages	**2,137**	2,069
	Annual Leave	**55,268**	65,085
	Long Service Leave	**45,398**	134,065
	Total Employee Provisions	**102,803**	201,219
	Employee provisions are represented by:		
	Current	**76,159**	67,154
	Non-Current	**26,644**	134,065
	Total Employee Provisions	**102,803**	201,219

	2007 $	2006 $
NOTE 8: CASH FLOW RECONCILIATION		
Reconciliation of cash per Income Statement to Statement of Cash Flows		
Cash at year end per Statement of Cash Flows	**1,447,968**	267,608
Balance Sheet comprising 'Financial Asset - Cash'	**1,447,968**	267,608
Reconciliation of operating result to net cash from operating activities		
Operating result	**1,505,315**	93,562
Depreciation/amortisation	**38,774**	14,270
Gain on disposal of assets	**2,548**	0
(Increase)/decrease in net receivables	**(65,199)**	0
Increase/(decrease) in employee provisions	**(98,417)**	25,869
Increase/(decrease) in supplier payables	**(33,342)**	12,830
Net cash from/(used by) operating activities	**1,349,679**	146,531

NOTE 9: EXECUTIVE REMUNERATION

		Number	Number
The number of senior executives who received or were due to receive total remuneration $130,000 or more:			
$205,000 - $219,999		**0**	1
	Total	**0**	1

There were no executives with a remuneration of $130,000 or more during the 2006/07 year.

	$	$
The aggregate amount of total remuneration of executives shown above	**0**	208,724

NOTE 10: REMUNERATION OF AUDITORS	**$**	$
The cost of the financial statement audit services provided to the Ombudsman were:	**6,500**	6,500

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

NOTE 11: AVERAGE STAFFING LEVELS	**2007 Number**	2006 Number
The average staffing levels for the Ombudsman during the year were:	**10**	9

Private Health Insurance Ombudsman
Notes To and Forming Part of the Financial Statements
for the year ended 30 June 2007

12 FINANCIAL INSTRUMENTS

Note 12A: 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 for 2006-2007 are net 14 days (2005-06: 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.

Note 12B: Interest Rate Risk

Financial Instruments	Floating Interest Rate		Non-Interest Bearing		Total		Weighted Effective	Average Interest Rate
	2007 $	2006 $	**2007** $	2006 $	**2007** $	2006 $	**2007** %	2006 %
Financial Assets								
Cash at bank	**1,447,968**	267,348	**0**	0	**1,447,968**	267,348	**5.50**	5.25
Investments - term deposits	**0**	500,000	**0**	0	**0**	500,000	**5.95**	5.70
Receivables for goods and services (gross)	**0**	0	**0**	0	**0**	0	**n/a**	n/a
Total	**1,447,968**	767,348	**0**	0	**1,447,968**	767,348		
Total Assets					**2,205,897**	832,174		
Financial Liabilities								
Trade and other Creditors	**0**	0	**0**	33,342	**0**	33,342	**n/a**	n/a
Total	**0**	0	**0**	33,342	**0**	33,342	**n/a**	n/a
Total Liabilities					**102,803**	234,561		

Note 12C: Fair Values of Financial Assets and Liabilities

The fair value of each class of the Ombudsman's financial assets and financial liabilities equals its carrying amount in both the current and immediately preceding reporting period.

Note 12D: Credit Risk Exposures

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

The Ombudsman has no significant concentration of credit risk.

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

Private Health Insurance Ombudsman
Notes To and Forming Part of the Financial Statements
for the year ended 30 June 2007

NOTE 13: APPROPRIATIONS

Particulars	Departmental Outputs 2007 $	2006 $
Year ended 30 June 2007		
Balance carried forward from previous year	**0**	0
Appropriation Acts 1 and 3	**2,794,000**	1,160,000
Available for payment of CRF	**2,794,000**	1,160,000
Payments made out of CRF	**2,794,000**	1,160,000
Balance carried forward to next year	**0**	0

This table reports on appropriations made by the Parliament of the Consolidated Revenue Fund (CRF) for payment to the Ombudsman. When received, the payments made are legally the money of the Ombudsman and do not represent any balance remaining in the CRF.

NOTE 14: REPORTING OF OUTCOMES

Note 14A: Outcomes of Private Health Insurance Ombudsman

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

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.

Note 14B: Net Cost of Outcome Delivery

	Outcome 1	
	2007 $	2006 $
Expenses		
Departmental Expenses	1,400,499	1,108,886
Total expenses	**1,400,499**	**1,108,886**
Other external revenues		
Interest	110,212	41,448
Other	57	1,000
Revenue from sale of assets	1,545	0
Total other external revenues	**111,814**	**42,448**
Net cost of outcome	**1,288,685**	**1,066,438**

Note 14C: Departmental Revenues and Expenses by Output Groups and Outputs

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

	Outcome 1				Total	
	Output 1		Output 2			
	2007 $	2006 $	**2007** $	2006 $	**2007** $	2006 $
Operating Expenses						
Employees	**157,206**	159,382	**613,185**	621,674	**770,391**	781,056
Suppliers	**120,148**	63,985	**468,638**	249,575	**588,786**	313,560
Depreciation and amortisation	**7,755**	2,854	**31,019**	11,416	**38,774**	14,270
Write-down of assets	**511**	0	**2,037**	0	**2,548**	0
Total operating expenses	**285,620**	226,221	**1,114,879**	882,665	**1,400,499**	1,108,886
Funded by:						
Revenues from Government	**570,147**	236,711	**2,223,853**	923,289	**2,794,000**	1,160,000
Interest	**22,490**	8,458	**87,722**	32,990	**110,212**	41,448
Other	**13**	204	**45**	796	**57**	1,000
Revenue from sale of assets	**311**	0	**1,235**	0	**1,545**	0
Total operating revenues	**592,960**	245,373	**2,312,855**	957,075	**2,905,814**	1,202,448

INDEX

The objective of the Private Health Insurance Ombudsman is to

"protect the interests of people covered by private health insurance."