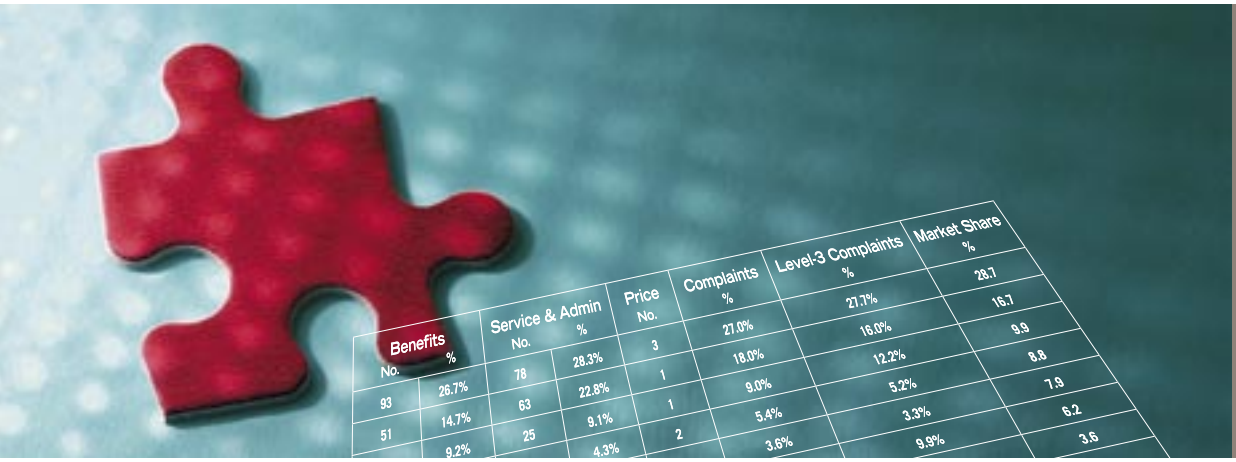
Australian Government

Private Health Insurance Ombudsman



2006

ANNUAL REPORT

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contact details

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

STREET AND POSTAL ADDRESS

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

TELEPHONE, FAX AND E-MAIL

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

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

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

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

FREECALL TELEPHONE HOURS OF OPERATION

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

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

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

 ISSN 1327-5305

& INFORMATION

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Australian Government
Private Health Insurance Ombudsman

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

Dear Minister

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

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2005 to 30 June 2006.

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

Yours sincerely

John Powlay
OMBUDSMAN

29 September 2006

FEWER COMPLAINTS

Last year (2005/06) was the third consecutive year in which the number of complaints about health funds has reduced significantly. This reduction in complaints has occurred despite the number of people covered by private health insurance remaining virtually the same over that period. The number of complaints received by PHIO last year is the lowest since the introduction of major government incentives for private health insurance (rebate, lifetime health cover etc) in 2000/2001.

Does a reduction in complaints about health insurance indicate a better performance by the funds?

Changes in the level of complaints can be a good indicator of changes in performance but care needs to be taken in analysing and assessing such changes.

Other factors that can affect the level of complaints about health insurance (as much or more than improvements or declines in the performance of the funds) are:

- Changes in the insured population;
- Government policies and initiatives on health insurance;
- Consumers' knowledge of available complaint mechanisms;
- the accessibility of the complaint mechanisms and;
- changes in consumers' expectations.

More detailed analysis of the PHIO complaint data does, in fact, suggest that improvements in some aspects of health fund performance are contributing to fewer PHIO complaints. For instance, complaints about service, membership issues, premium payment

John Powlay, Ombudsman

problems and the provision and quality of information have all reduced considerably with no other apparent cause. PHIO is also aware that a number of funds have introduced specific initiatives to improve performance on such aspects.

By far the most significant factor in the decline in consumer complaints last year and over recent years has been the substantial reduction in complaints about premium rises. I have previously commented that improvements in the timing and the way in which yearly premium increases are communicated to consumers has helped to reduce complaints on premium rises.

However, my view is that changing expectations is the main factor behind fewer consumers complaining of premium rises. Consumers appear to expect annual rises in premiums of around 5% to 9% and have some acceptance that such rises are largely unavoidable given rising health costs and increased usage of health services. This is not to say that consumers welcome such increases, just that they see no basis for complaining if their expectations are met. Other consumer research seems to support this view and also suggests that consumers are becoming more aware of other options for dealing with cost increases such as changing health insurance products or funds[1].

[1] *Health Care and Insurance Australia 2005 (A biennial syndicated survey conducted by Ipsos/TQA Research)*

Consumer Awareness of PHIO services

A key function and responsibility of the PHIO is to ensure that the community is aware of the availability of PHIO services. As noted, reduced awareness of PHIO services could, in theory, be a factor in reduced complaint numbers. However, there has not been any significant change in PHIO strategies for ensuring consumer awareness compared to previous years.

PHIO strategies, in this regard, rely to a large extent on intermediaries, health funds and health providers to inform consumers of the range and availability of PHIO services. The aim of this approach is to ensure that consumers are made aware of and are able to access PHIO services (particularly complaint resolution) at the times when they need those services.

PHIO intends to review the effectiveness of its approach to ensuring community awareness of the PHIO role during the coming year. This should complement the range of initiatives to improve consumer information on private health insurance to be implemented over the next year.

The effect of fewer complaints on PHIO workload and performance

In contrast to the significant decline in total complaints received by PHIO over recent years, there has been a significant increase in the number and proportion of complaints requiring more detailed investigation. The decline in overall complaint numbers has therefore not resulted in an equivalent decline in PHIO workload. While the number of complaints dealt with by the PHIO is less, the effort and resources required to finalise complaints has (on average) increased.

This increase in proportion of complaints requiring more detailed investigation may indicate that more consumers are actually complaining about health insurance issues but the health funds are becoming more effective at resolving consumer complaints directly without the need for consumers to take the matter up with PHIO. If so, this is a very positive development, meaning that available PHIO resources can be directed to those more complex complaint issues, where PHIO intervention and investigation can be effective.

INDUSTRY DEVELOPMENTS

Portability and Benefit Limitation Periods

In the last two annual reports, I have commented on industry discussions about the policy of portability of health insurance. I indicated my disappointment that these discussions had not resulted in a clear industry agreement on this key policy issue and that some parties continued to advocate a weakening of consumers' portability rights. I was concerned also that one fund had used benefit limitation period arrangements to undermine the portability rights of consumers requiring psychiatric treatment.

In late 2005 the Minister for Health and Ageing acted to effectively address these issues by imposing a condition of registration on health funds that benefit limitation periods could not be imposed on consumers transferring from one product to another (within the same fund or between different funds). This new condition of registration prevents funds from using benefit limitation periods or similar measures to undermine the intent and effect of portability.
The circular and media release advising of the new condition also indicated the clear and strong government support for portability in private health insurance. This was a very positive development for consumers.

New prostheses funding arrangements

New arrangements for determining the price to be paid by health funds for prostheses and other devices came into effect from November 2005. Under the new arrangements fund benefits for most prostheses are set at levels that mean there is no gap for consumers to pay. There is at least one no-gap prostheses listed for each type of treatment. However, a potential concern with the new arrangements was that some particular brands or types of prostheses would require a gap payment, potentially adding another unexpected gap to consumers' experience of private hospital treatment.

I have been monitoring the introduction of these changes both by noting any complaints and by seeking feedback from health funds, health providers and suppliers. Overall the changes appear to have been implemented very well with no adverse impact on consumers. While there were initially some enquiries from consumers to my office about the new arrangements, very few consumers have been faced with any additional gap and I have had no complaints about that issue. This measure also seems to have contributed significantly to slowing the growth in the costs associated with benefits for prostheses, as intended.

FURTHER DEVELOPMENT OF THE PHIO CONSUMER PROTECTION ROLE

A more comprehensive complaints service on private health insurance

There have been a number of gaps in coverage of the complaints service offered by the PHIO. These have arisen as the scope of private health insurance has expanded and arrangements between health funds and health providers have changed. The legislation had specified that the Ombudsman could deal only with health insurance complaints made by or on behalf of health insurance contributors, health funds, hospitals and doctors and that complaints must be about the actions of health funds, hospitals or doctors. This excluded the Ombudsman from dealing with complaints by or about the wide range of other health providers (eg. dentists, optometrists, physiotherapists etc), health insurance brokers or suppliers of medical equipment or services. All of these professionals and organisations provide services that are covered by private health insurance.

Legislation expanding the coverage of the PHIO complaints service and investigation powers to encompass these additional groups took effect from 1 July 2006. As a result, the PHIO can now provide a more comprehensive service on private health insurance issues, without artificial barriers to the jurisdiction based on the status of the complainant or person or organisation being complained about.

To assist the Ombudsman to deal with issues arising from contractual arrangements between health funds and health service providers, the Ombudsman has also been given an additional power to compel the parties to such arrangements to participate in mediation services as part of alternative dispute settling efforts. Such contractual arrangements between funds and health providers are becoming an increasingly important feature of private health insurance arrangements and can have a significant impact on consumer entitlements. This additional power was also available to the Ombudsman from 1 July 2006.

A clearer focus on the protection of consumer rights

In association with an expansion to the roles and powers on the Ombudsman, changes to the legislation that took effect from 1 July 2006 also included provisions aimed at maintaining a clear focus, in the Ombudsman's activities,

on the protection of the rights of consumers. Industry consultations stressed the importance of maintaining this focus, given the possible increased involvement in commercial / contractual issues between health insurers and providers.

It is not intended that the Ombudsman undertake an additional industry regulation role or intervene to protect the commercial interests of particular parties. The Ombudsman is required to identify possible trade practices issues and refer them to the ACCC. Otherwise, the Ombudsman's involvement in contractual issues between health funds and health providers will be subject to a test of whether there is likely to be a significant impact on consumers' rights under their private health insurance arrangements.

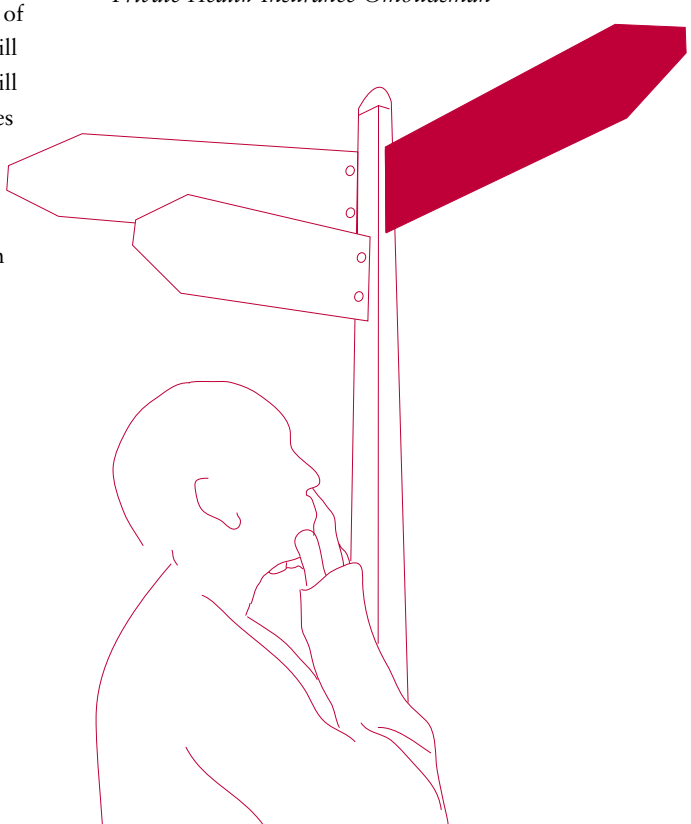
Meeting the need for reliable, independent information for consumers

In April 2006, the Minister for Health and Ageing announced a range of changes to private health insurance that are likely to have a significant impact on the role and focus of the PHIO. The changes, most of which will come into operation this financial year, will include expanding the range of the services that can be covered by hospital health insurance products and providing some additional flexibility in the design, development and administration of health insurance through rationalising the regulatory framework.

Associated with this increased flexibility in product development will be additional requirements for funds to provide standardised product information covering the same key information about products across all funds. The PHIO will play a key role in the dissemination of this standardised information and in the provision of independent information on health insurance through the delivery and management of a new consumer information website. This will build on work already begun by the PHIO in the publication of the annual *State of the Health Funds Report*.

The new consumer information website will allow consumers to get free, independent and reliable information about health insurance arrangements, health funds and the products they offer. It will represent a considerable expansion in PHIO's "consumer information" role.

John Powlay
Private Health Insurance Ombudsman



INTRODUCTION

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

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

FUNCTIONS

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

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

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.

WHAT CAN THE OMBUDSMAN DO WITH A COMPLAINT?

The Ombudsman is able to deal with complaints by:

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

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

WHAT HAPPENS AT THE END OF A COMPLAINT OR INVESTIGATION?

The Ombudsman is able to recommend that:

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

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

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

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

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

HOW STAFF RESOLVE COMPLAINTS

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

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

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

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

OUTPUT PERFORMANCE MEASURES

The 2005/2006 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 2005/2006.

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

Quality indicator: High level of satisfaction with the relevance, quality and timeliness of advice and submissions.

Measurement: No formal mechanism has been established to assess the satisfaction of key stakeholders. Reporting relies on informal discussion.

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

Quantity indicator: Advisory services commensurate with the funds allocated to produce a range of products, including 11- 15 submissions and public presentations.

Measurement: Count of submissions, other written advice and public presentations.

Performance result: 23 submissions and other items of written advice, 13 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)

Quality indicator: Information provided and complaints dealt with accurately and in a timely manner.

Measurement: Analysis of PHIO complaints recording database, client satisfaction survey.

Performance result: Quality meets the standard indicated. (Further details are provided in the following discussion of complaints performance and in the report of the client satisfaction survey included in the *General Issues* section of this report.

Quantity indicator: 75% of complaints resolved within one month.

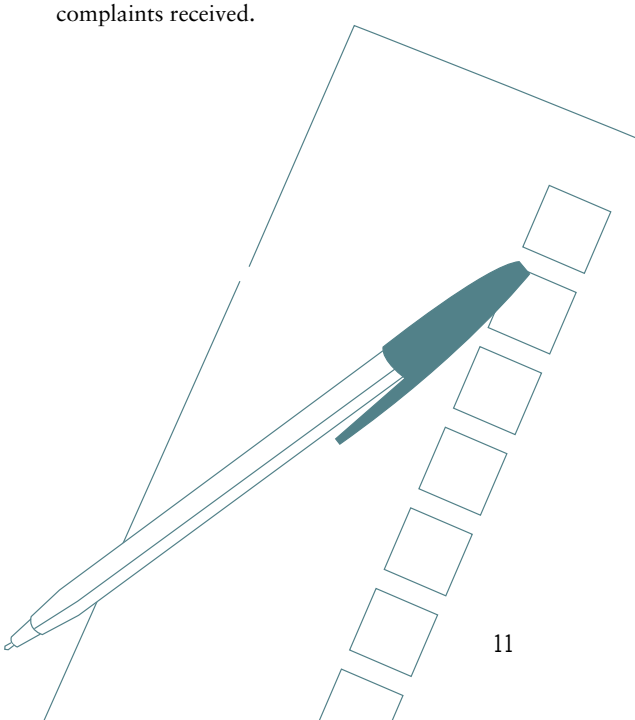
Measurement: Analysis of PHIO complaints recording database.

Performance result: 81% of complaints resolved within one month (83% last year).

Quantity indicator: Number of complaints received.

Measurement: Analysis of PHIO complaints recording database

Performance result: 2374 complaints received.



PERFORMANCE

Decrease Overall in Complaints Received

The Ombudsman received 2374 complaints during 2005/06. This is a decrease of 197 complaints (8%) from the previous year. This is the lowest number of complaints the office has received in the last 6 years.

Despite the overall drop in complaints received, the number of level 3 complaints increased by 134 to 840 complaints in 2005/06 (a 19% increase). 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 fund, or other body.

Figure 1 shows the distribution of complaints through the four quarters of the 2005/2006 financial year.

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

Recording and categorisation of complaints

An approach to the Ombudsman's office is recorded as a complaint when it meets the criteria contained in the *National Health Act 1953*. A complaint must be an expression of dissatisfaction with any matter arising out of or connected with a private health insurance arrangement. Complaints can be made by, and be concerned with, a health fund member, a hospital, a doctor or other practitioner, a health fund or health insurance broker.

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

Figure 1 Total Complaints Received per Quarter

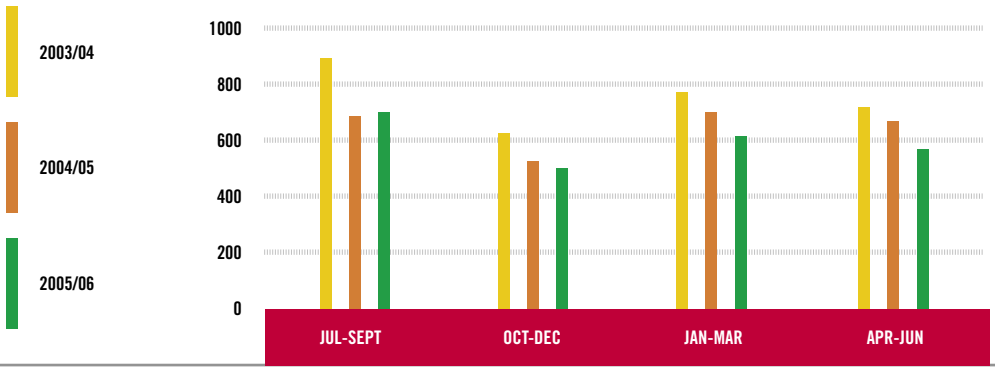
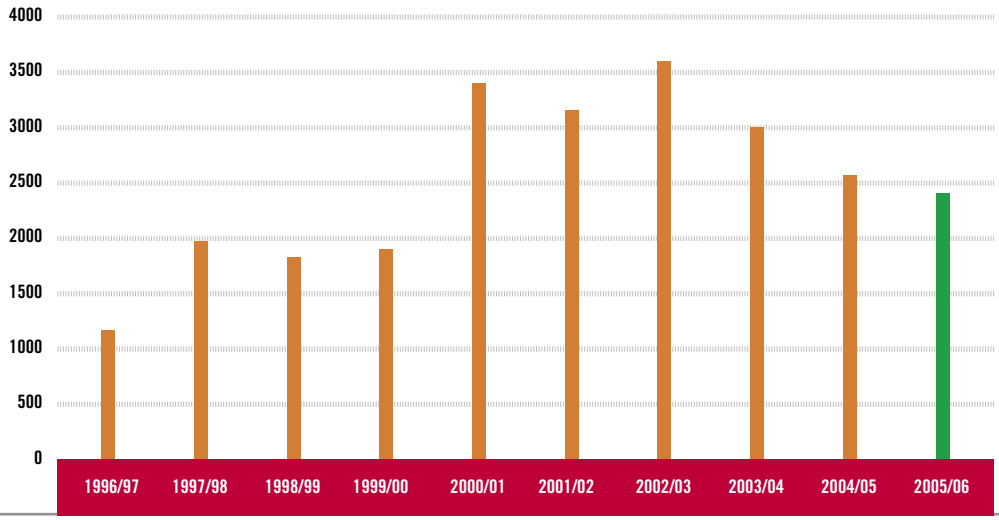


Figure 2 Total Complaints Received per Year



Currently this categorisation is:

- Complaint level 1 (Problems): Moderate level of complaint
  Level 1 complaints are dealt with by referring the complainant back to the health fund, hospital, doctor, other practitioner or 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.

  Sometimes staff will refer a complaint directly on behalf of the complainant as it ensures a quicker turnaround time and ensures the correct person within the organisation is able to assist them. If complainants are still not satisfied after their health fund or other body contacts them; the Ombudsman can then contact the fund 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 product they have purchased, concerns with service levels

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

- **Complaint level 3 (Disputes): Highest level of complaint where significant intervention is required**
  Level 3 complaints are dealt with by contacting the health fund, hospital, practitioner or 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 would include pre-existing ailments, informed financial consent, benefits available on portability of membership, benefits not in accordance with brochure descriptions and contribution errors.

The 2374 complaints recorded in 2005/06 consisted of 840 Level-3 complaints, 745 Level-2 complaints and 789 Level-1 complaints. Figures 3 and 4 show these ratios and indicate a significant reduction in Level-1 and Level-2 complaints and a significant increase in Level-3 complaints. This is a trend that occurred in the previous year as well. The proportion of Level-3 complaints increased from 20% in 2003/04 to 27% in 2004/05 and in 2005/06 it increased to 35%.

COMPLAINTS HANDLING PROCEDURES

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

The majority of complaints handled are from fund members about their own fund. However, there are instances where a complaint needs to be recorded against both the health fund and a provider. This occurs, for example, where the complaint involves

Figure 3 Complaints Received per Year by Category

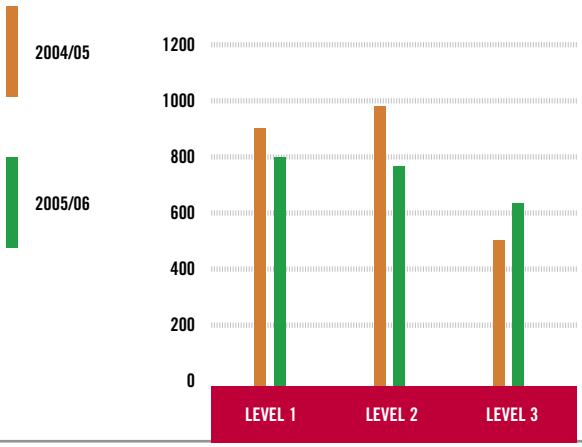


Figure 4 Complaints Category, Percentage

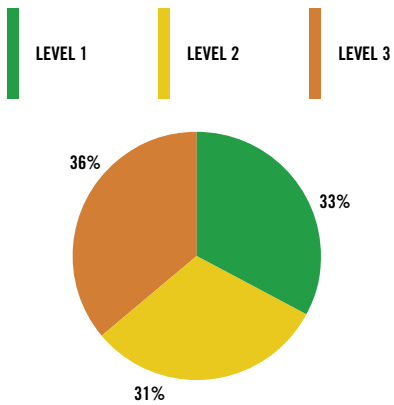


Figure 5 Steps in Handling Approaches to the Ombudsman

LEVEL 3 [DISPUTE]	LEVEL 2 [GRIEVANCE]	LEVEL 1 [PROBLEM]
Timeframe Depends on the nature and complexity of matter and responses from health fund and provider	**Timeframe** Usually within 24 Hours	**Timeframe** Immediate
Action PHIO contacts health fund or provider to obtain a report, then mediates the dispute between the parties or investigates the matter further	**Action** Complainant provided with explanation or information to resolve matter, or if there is no avenue for the Ombudsman to take up the matter	**Action** If complainant has made insufficient effort to resolve the matter with fund or provider, 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

contradictory advice about how much of a hospital bill will be paid by a health fund.

Fund members also lodge complaints about a:

- Hospital (generally about inadequate information to enable informed financial consent);
- Doctor (almost always relating to either the gap between charges and benefits paid through Medicare and the fund, and the failure to inform of the discrepancy before proceeding); or
- Other practitioners (generally about the gap between the charges and the benefit paid through ancillary tables).
- A Health Fund Broker (these were included in the Ombudsman's jurisdiction commencing 1 July 2006).

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

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

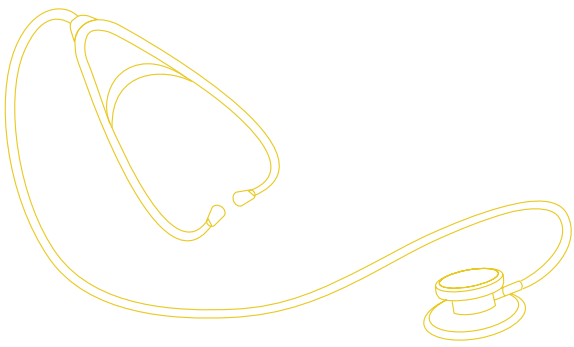
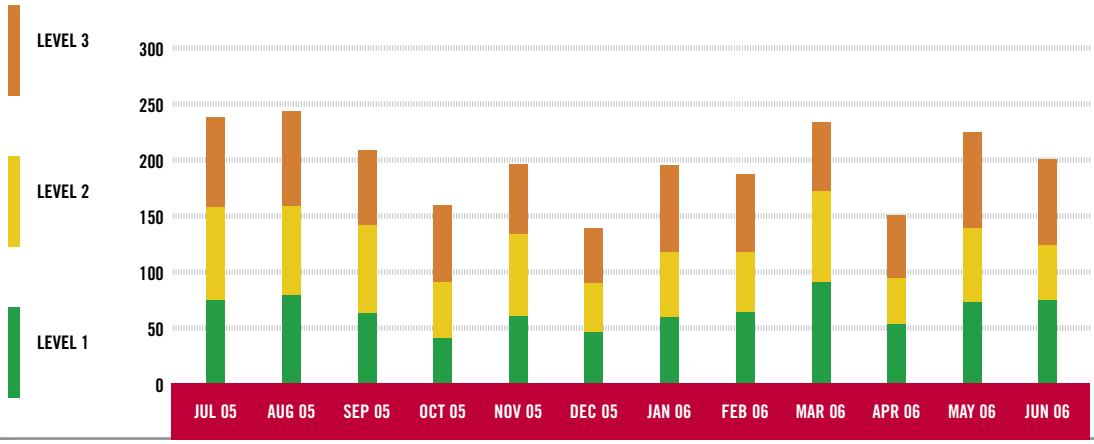


Figure 6 Total Complaints Received by Month



WORKLOAD

The office received 2374 complaints (Levels 1, 2 & 3) in 2005/06, an average of 198 per month compared with 214 complaints per month in the previous year.

The office finalised 2371 complaints during the year; an average of 198 per month, compared with an average 217 complaints finalised per month in the previous year.

The office finalised 840 complaint investigations (Level 3 complaints) during the year, compared to 729 in the previous year.

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

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 significant decline in the timeliness of complaints processing. This is attributable to the increase in the more complex and work intensive Level 3 complaints (from 27% of all complaints to 35%)

WHO WAS COMPLAINED ABOUT

Most complaints were made about registered health funds (2209), followed by hospitals (183) and practitioners (99). The Ombudsman also received 54 complaints from people holding overseas health cover (these are not counted as registered health fund complaints) and 2 complaints about health insurance brokers.

Some complaints concerned one or more health funds, or a health fund as well as a hospital, doctor or dentist. Consequently, the total number of organisations or people being complained about (2547) adds up to more than the total number of individual complainants contacting the Ombudsman (2374).

Figure 7 Time Taken to Finalise Complaints

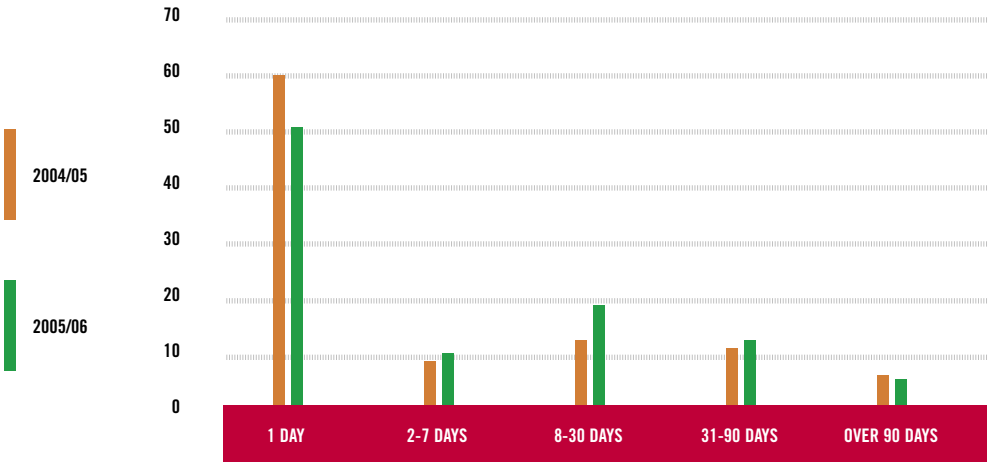


Figure 8 Complaints Completed Since Day of Lodgement

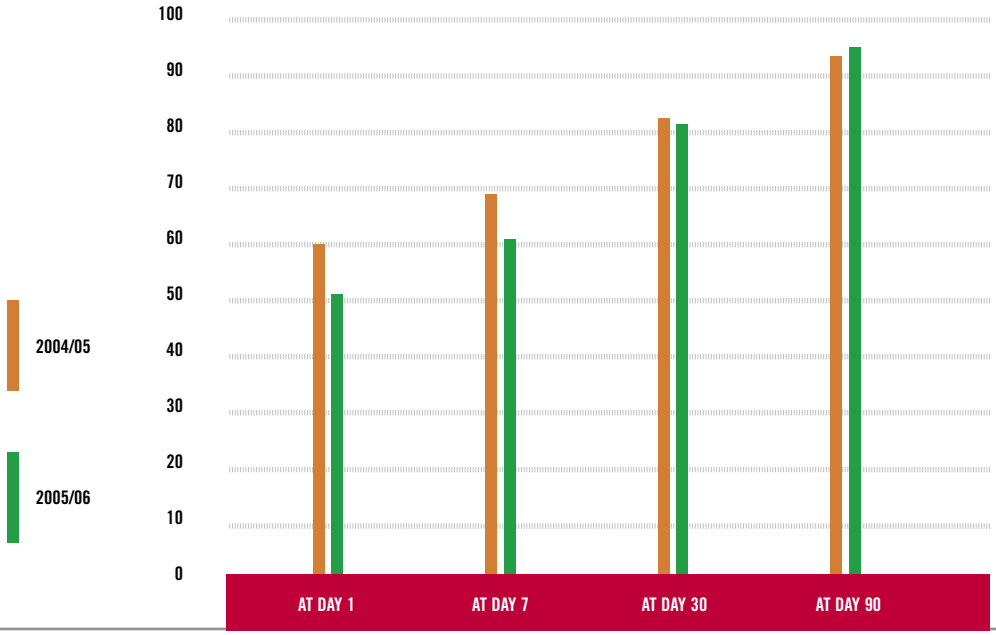


Figure 9 Complaints by Health Fund Market Share 01 July 2005 - 30 June 2006

NAME OF FUND	COMPLAINTS (1)	PERCENTAGE OF COMPLAINTS	LEVEL-3 COMPLAINTS (2)	PERCENTAGE OF LEVEL-3 COMPLAINTS	MARKET SHARE (3)
ACA Health Benefits	1	0	0	0	0.1
AHM	75	3.4	26	3.3	2.4
Australian Unity	144	6.5	57	7.2	3.6
BUPA (HBA)	219	9.9	88	11.1	9.9
CBHS	23	1.0	10	1.3	1.1
CDH (Cessnock District Health)	0	0	0	0	<0.1
Credicare	15	0.7	6	0.8	0.4
Defence Health	54	2.4	20	2.5	1.4
Doctors' Health Fund	1	0	0	0	0.1
Druids Victoria	5	0.2	1	0.1	0.1
GMHBA	36	1.6	13	1.6	1.5
Grand United Corporate Health	21	1.0	6	0.8	0.3
HBF Health	90	4.1	26	3.3	7.9
HCF (Hospitals Cont. Fund)	135	6.1	49	6.2	8.8
Health Care Insurance	0	0	0	0	0.1
Health Insurance Fund of W.A.	8	0.4	6	0.8	0.4
Healthguard	23	1.0	4	0.5	0.6
Health-Partners	13	0.6	2	0.3	0.7
Latrobe Health	10	0.5	3	0.4	0.6
Lysaght Peoplecare	2	0.1	0	0	0.3
Manchester Unity	61	2.8	27	3.4	1.4
MBF Australia Limited	378	17.1	126	15.9	16.7
MBF Alliances	94	4.3	31	3.9	2.2
Medibank Private	569	25.8	189	23.9	28.7
Mildura District Hospital Fund	2	0.1	0	0	0.3
N.I.B. Health	165	7.5	78	9.9	6.2
Navy Health	3	0.1	0	0	0.3
Phoenix Health Fund	0	0	0	0	0.1
Police Health	3	0.1	0	0	0.2
Queensland Country Health	12	0.5	7	0.9	0.2
Railway & Transport Health	7	0.3	2	0.3	0.3
Reserve Bank Health	0	0	0	0	<0.1
St Lukes Health	7	0.3	2	0.3	0.4
Teacher Federation Health	12	0.5	3	0.4	1.6
Teachers Union Health	6	0.3	1	0.1	0.4
Transport Health	1	0	0	0	0.1
Westfund	14	0.6	8	1.0	0.7
TOTAL FOR REGISTERED FUNDS	**2209**	**100**	**791**	**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 2005.

COMPLAINTS ABOUT REGISTERED HEALTH FUNDS

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

COMPLAINTS ABOUT HOSPITALS

During the year, there were 183 complaints registered against hospitals. Of these complaints 113 were Level-3 complaints. Those Level-3 complaints, which required investigation, were likely to result in a hospital accepting a reduced payment for an outstanding hospital account.

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 didn't perform a check of their likely benefits, or because a mistake had been made in advising them of out-of-pocket expenses.

When a privately insured person attends a hospital, the contractual relationship between the health fund and hospital should ensure that the patient is (whenever possible) informed of likely out-of-pocket expenses. In some cases it isn't possible to advise of out-of-pocket costs (due to an emergency admission) but overall, most cases that come to the Ombudsman show inadequate advice has been provided to the patient.

Many of the complaints investigated by the Ombudsman involve conflicting views (from hospital and health fund staff, patients and their relations) as to what the patient was advised and agreed to. When a patient is agreeing to a hospital admission and to paying out-of-pocket expenses, hospitals should seek written consent from the patient to the charges. Verbal advice or open-ended IFC (where a patient is asked to sign a document agreeing to pay whatever the charge turns out to be) is not sufficient. Written, accurate IFC is essential to ensure that there isn't any confusion about what the patient agreed to pay.

In most cases, IFC is being appropriately sought by hospitals and it seems that the number of complaints is decreasing over time. 277 hospital complaints were received in 2003/4, 191 complaints in 2004/5 and 183 this year.

COMPLAINTS ABOUT PRACTITIONERS

Most complaints about doctors and practitioners concerned medical gap issues and/or the lack of *informed financial consent*. During 2005/06 year the office received 125 complaints about medical gap issues, 12 fewer complaints than the previous year. The office registered 99 complaints against practitioners, 24 fewer complaints than the previous year.

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

RESOLVING COMPLAINTS

45% of complaints were resolved by the Ombudsman's office providing an independent and impartial explanation of the health fund member's complaint.

32% of complaints were referred back to the health fund. Many of these complainants were referred with the assistance of the Ombudsman's staff. Alternatively, the Ombudsman was generally able to suggest ways for the complainant to pursue the matter with the health fund themselves.

11% of complaints (30% of the Level-3 complaint category) were resolved following payments by health funds or the *writing-off* of accounts by hospitals. These payments by health funds usually followed an investigation by the Ombudsman and then the health fund agreeing that a health fund member was entitled to a benefit payment or some other payment. In some cases, payment is made by health funds on an ex gratia basis, for instance, where the fund accepts that the member relied on incorrect advice from the fund. Accounts written off by hospitals are usually the result of hospitals accepting responsibility for their failure to adequately inform patients of their costs.

An additional 8% of complaints (22% 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.

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

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

WHO COMPLAINED?

The *National Health Act 1953* allows health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf to lodge complaints. Overwhelmingly, complaints were made by health fund members (2345), followed by hospitals (16), practitioners (12) and a (1) health fund.

HOW COMPLAINTS WERE MADE

85% of complaints were made initially by telephone, 8% were lodged by email, 6% by letter, 1% by fax. The remainder were made by personal visit, or by Parliamentary Representation.

Figure 10 Outcomes of Finalised Complaints

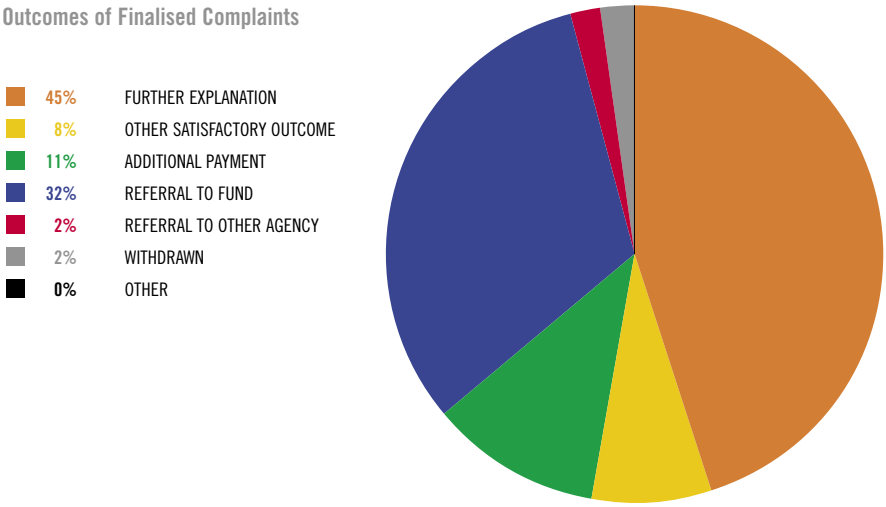


Figure 11 Outcomes of Finalised Disputes

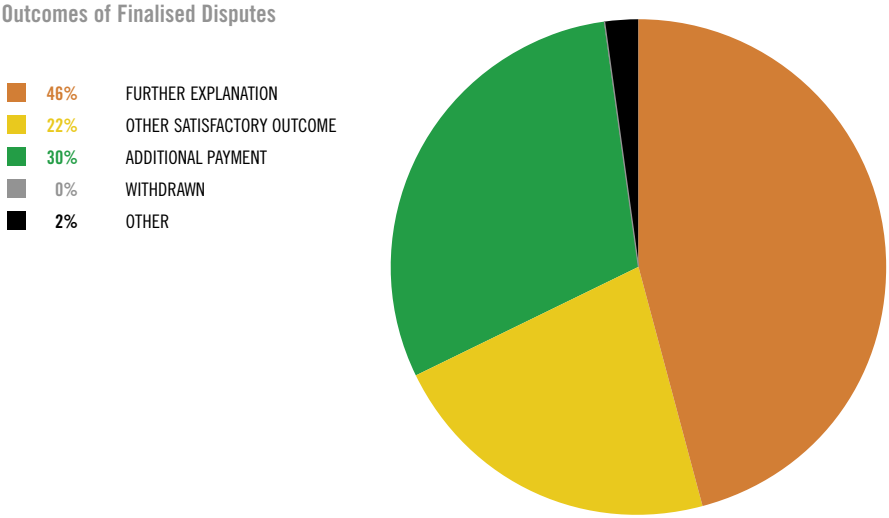
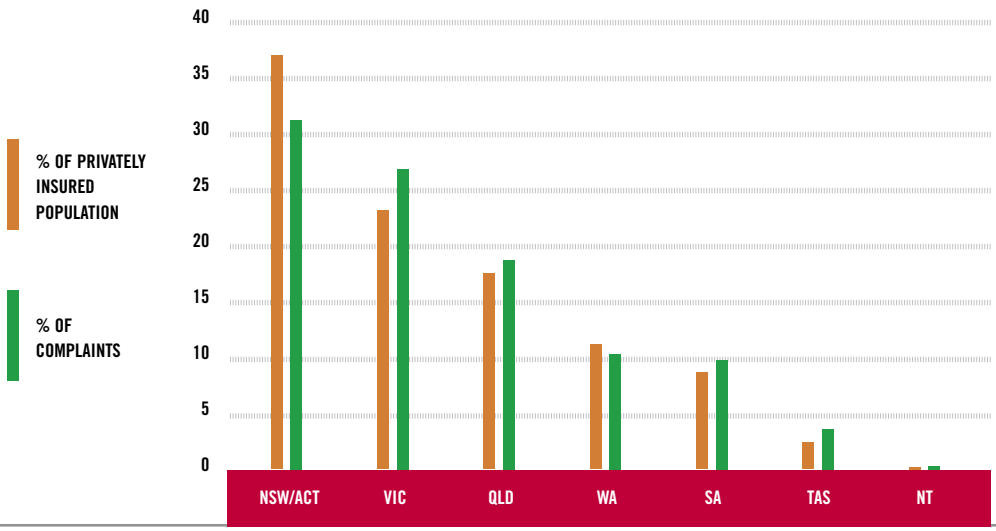


Figure 12 Complaints by Population Covered by State & Territory



COMPLAINTS BY STATE/TERRITORY

Figure 12 identifies, on a state-by-state basis, where complaints originate. This data is shown by State, against the percentage of people who have private health insurance coverage. Generally, there was a greater proportion of complaints coming members in Victoria, South Australia, Queensland and Tasmania. The proportion of complaints coming from each state in 2005/2006 was similar to the previous year.

INVESTIGATIONS INTO HEALTH FUND PRACTICES AND PROCEDURES

During 2005/06 the Ombudsman initiated one investigation into health fund practices and procedures under section 82ZT of the *National Health Act 1953*. This investigation related to the administration by MBF of requests for benefits to cover the costs associated with the provision of insulin pumps.

An ongoing investigation into health fund practices relating to the portability of hospital insurance under section 82ZT, which was commenced in 2003/04, was finalised in 2005/06 with the following outcomes:

- promulgation of the Ombusman's protocols for heath funds and health providers on transitional arrangements and communications when purchaser provider agreements change;
- input to the policy and wording of a revised "condition of registration" relating to Benefit Limitation Periods; and
- publication by the PHIO of a revised "Right to Change" brochure providing updated guidance on the portability rights of health insurance consumers.

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

INTRODUCTION

Complaints to the Ombudsman must first meet the requirements of the Section 82Z of the *National Health Act 1953*. Embodied in that section is the requirement that a complaint be about a health insurance arrangement. For reporting purposes complaints are classified in terms of broad issues and sub issues.

Surgery Performed by Podiatric Surgeons

At the end of the 2004/05 year, the Government changed health insurance rules to provide encouragement for health funds

Figure 13 Complaints Issues - Percentage of Each Issue

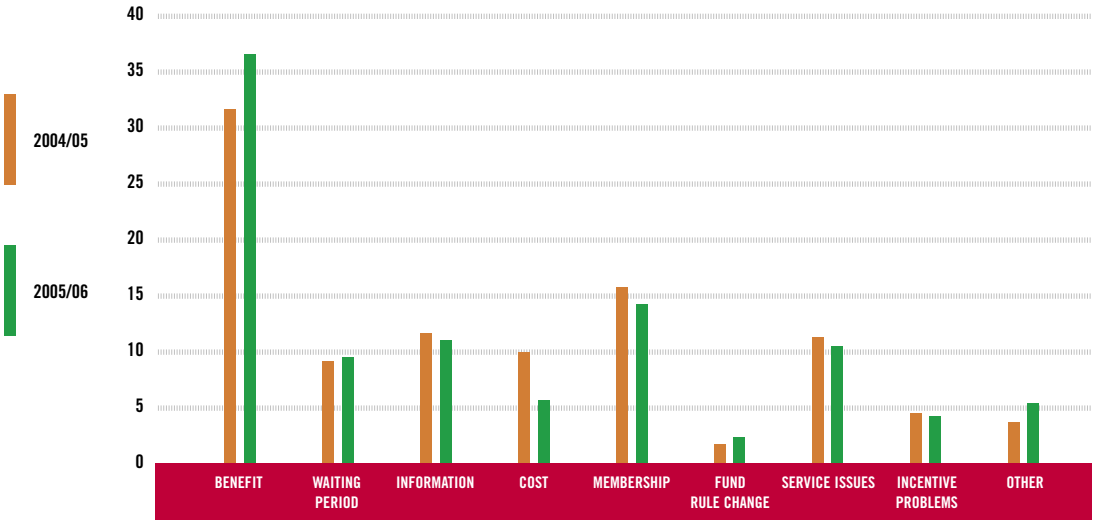
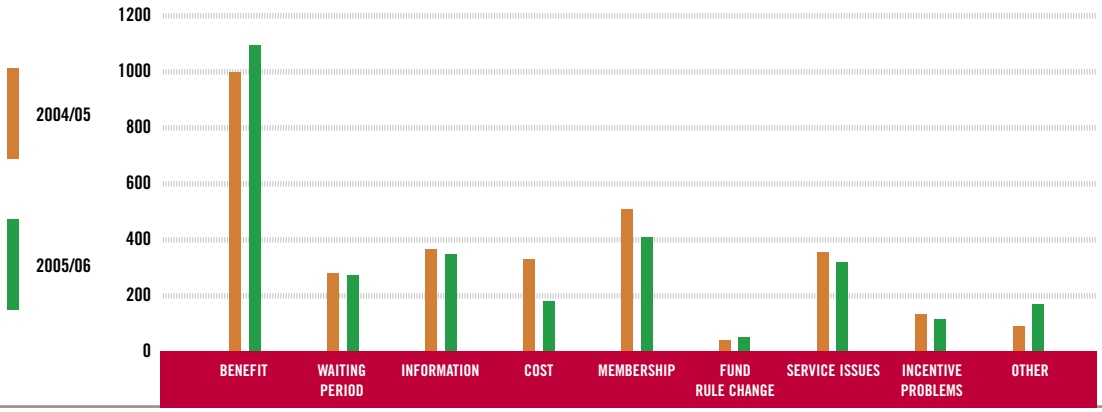


Figure 14 Complaints Issues - Numbers of Matters Registered



to pay benefits towards surgery performed by registered podiatric surgeons. Under the regulations "The role of the Private Health Insurance Ombudsman includes monitoring the operation of provisions relating to accredited podiatrists within this Act and the *Health Insurance Act 1973* and reporting and acting on complaints."

During the year the Ombudsman ensured that each health fund reviewed its benefits in relation to podiatric surgery, both under hospital and ancillary tables. The Ombudsman ensured that information to consumers made clear how (or if) benefits were payable under different covers.

The Ombudsman received 108 complaints about this issue during the 2005/06 year. Most complaints involved explaining to complainants that health fund benefits for podiatric surgeon's fees were not automatically covered by health funds' policies. Other complaints involved clarifying information provided by the health fund, hospital or podiatric surgeon. Out of the 108 complaints, 10 resulted in a health fund providing an additional benefit.

Overseas Visitors Health Cover

The Ombudsman assisted 64 consumers with complaints concerning *overseas visitors cover* (for visitors to Australia). This type of health insurance is not a registered health insurance product and is consequently not counted in the list of complaints against health funds.

This type of insurance is required to be taken out to comply with visa requirements under some circumstances.

The most common types of complaints investigated by the office 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 after cancelling policies that were paid in advance and difficulties with policies that apply a 2-month waiting period on all benefits except for accidents (and the exact definition of what constitutes an "accident").

The office received a number of visits from student visitors who had difficulties contacting their health fund because the only contact details provided to them were a general phone and post office box number and PHIO's office address in Sydney.

Health Fund Premium Increases

During the year, the Ombudsman received only 87 complaints concerning premium increases, which is a 62% reduction on the previous year and significantly lower than previous years.

In previous years, many of the complaints about premium increases were related to the way in which increases were announced.

The reduction in premium increase complaints suggests an improvement in the way health funds communicate premium increases and deal with complaints from their members. Although the reduction would also be the result of smaller (overall) premium increases this year. The percentage of average premium increases for each fund for 2006 are detailed in figure 15.

Corrigendum
This table replaces figure 15 on page 25 of PHIO Annual Report 2006

CASE STUDIES

1. Pre- Existing Ailments and Informed Financial Consent

The Ombudsman received 281 complaints about waiting periods in 2005/06, which is about 10% of all complaints received. Most of these complaints were about the application of the twelve-month waiting period for pre-existing ailments and conditions.

Under the *National Health Act 1953*, a 12-month *pre-existing ailment* waiting period applies to all people who join a hospital cover or who upgrade their cover to a higher level of hospital cover. This rule exists to protect the interests of people who already have private health insurance and whose contributions make up the benefits which health funds are able to pay.

A pre-existing ailment is defined by law as any ailment, illness or condition where there were signs or symptoms during the six months before the member joined a hospital table or upgraded to a higher hospital table. It is not necessary that the member or their doctor knew what the condition was or that there had been a diagnosis.

A doctor appointed by the health fund decides whether the member's ailment is pre-existing, based on information provided by the member's treating doctors. The health fund doctor must consider the opinion of the treating doctor, but is not bound to agree with them.

Some members and their doctors are under the impression that if the condition had not been diagnosed prior to joining the fund, the pre-existing ailment rule will not apply. Many of the complaints to the Ombudsman are based on this misunderstanding. The Ombudsman is able to investigate the fund's application of the pre-existing ailment rule to ensure it is being correctly applied. In the majority of cases, the fund is applying the rule in accordance with the law.

Figure 15 Reported Private Health Insurance Premium Increases 2006[1]

NAME OF FUND	AVERAGE INCREASE ACROSS THE FUND (%)W
ACA Health Benefits	6.17
AHM	3.90
Australian Unity	5.44
BUPA (HBA)	4.92
CBHS	6.24
CDH (Cessnock District Health)	6.94
Credicare	7.97
Defence Health	5.77
Doctors' Health Fund	6.03
Druids Victoria	4.25
GMHBA	7.82
Grand United Corporate Health	9.00
HBF Health	5.70
HCF (Hospitals Cont. Fund)	5.68
Health Care Insurance	4.89
Health Insurance Fund of W.A.	6.79
Healthguard	5.07
Health-Partners	8.62
Latrobe Health	3.00
Lysaght Peoplecare	3.43
Manchester Unity	6.37
MBF Australia Limited	5.77
MBF Alliances	6.71
Medibank Private	5.88
Mildura District Hospital Fund	6.99
N.I.B. Health	4.85
Navy Health	4.42
Phoenix Health Fund	6.96
Police Health	8.08
Queensland Country Health	5.04
Railway & Transport Health	6.66
Reserve Bank Health	9.55
St Lukes Health	3.73
Teacher Federation Health	7.40
Teachers Union Health	4.98
Transport Health	6.45
Westfund	4.07

[1] Source: *Private Health Insurance Report on Premium Increases For the Quarter Ending 31 March 2006 Tabled in Parliament on 13 June 2006*

If the member proceeds with treatment and the fund denies benefits on pre-existing ailment grounds, the member can find themselves responsible for paying the hospital and medical costs themselves. In some cases, this can amount to many thousands of dollars.

The Ombudsman therefore places significant emphasis on hospitals conducting membership eligibility checks prior to the patient being admitted, to ensure there are no restrictions on the payment of benefits by their fund. If there is a possibility that the member will not be covered because they are within waiting periods, both the fund and hospital have a responsibility to ensure they do not proceed with hospital treatment unless they have been made aware of the possible cost of the admission and had the opportunity to give informed financial consent to incurring that cost.

If the member does not believe they can afford the cost of the admission if their fund denies benefits, this also gives them the opportunity to discuss other treatment options with their doctor, such as being admitted as a public patient.

Emergency admissions make membership eligibility checking more difficult, but there is still an onus on the fund and hospital to ensure the member is given informed financial consent as soon as practicable.

The following case study illustrates that, even where health funds and hospitals comply with the recommended administrative procedures, failure to communicate clearly and directly between all the parties can give rise to significant problems.

Mrs V had been diagnosed with an ischaemic toe on her left foot. She had joined a health fund about 6-months before being advised by a specialist that she may need to have her toe amputated.

Mrs V's daughter, Ms W, was looking after her mother's affairs when she was advised that her mother required urgent admission to hospital. She says she contacted her mother's health fund to enquire whether she would be covered on two occasions. On both occasions, she says she was advised that her mother would be covered unless the condition was pre-existing.

Mrs V was admitted through accident and emergency because her condition worsened. The next day, hospital staff contacted the fund for a membership eligibility check. Fund staff advised that the member was within waiting periods and the pre-existing ailment rule would apply to the admission. Hospital staff advised Mrs V and her daughter that the claim might not be paid if it were considered pre-existing; however Ms W assured the hospital that she had spoken to the fund and her mother's ailment would not be considered a pre-existing ailment.

It appears that Ms W believed that her mother's condition was not pre-existing because of incorrect advice provided to her by her mother's medical practitioner or hospital or health fund staff. The Ombudsman's investigation was unable to establish which. The Ombudsman's view is that medical practitioners, hospitals and health fund staff should always exercise caution in advising patients whether a condition is pre-existing or not, because the ultimate decision is made by a fund medical practitioner.

The hospital simply accepted Ms W's statement that her mother's condition was not pre-existing. In doing so they essentially took the view that Ms W (on behalf of her mother) was taking on any risk that the fund benefits would not be paid and Mrs V would have to meet any out of pocket

costs. However the hospital did not give Ms W any indication of the likely costs involved and therefore any real understanding of the risk that she was taking on. Most consumers seriously underestimate the potential costs involved in private hospital treatment.

Mrs V's procedure was performed about a week later, but unfortunately there was a complication that necessitated a much longer stay in hospital. The hospital bill eventually reached almost $20 000. Ms W was shocked when she was advised that the fund had declined benefits on pre-existing ailment grounds and that her mother would be responsible for paying the account. She requested the Ombudsman to investigate why her mother's condition had been deemed to be a pre-existing ailment.

The Ombudsman's investigation concluded that the fund was applying the pre-existing ailment rule correctly. Although Ms V was admitted as an emergency patient, the fund doctor had concluded there were signs and symptoms of the peripheral vascular disease that led to her condition in the six months prior to her joining the fund. However, there was still a question as to why she was not given the opportunity to provide informed financial consent by the hospital.

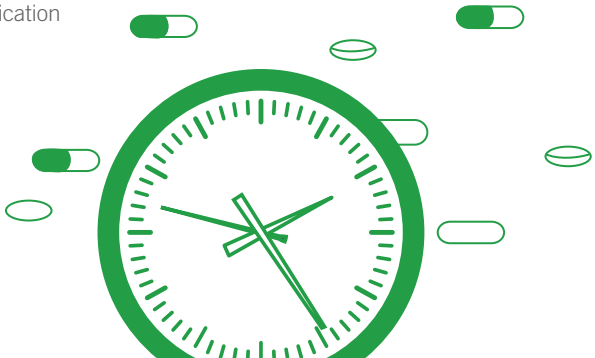
In a case like this, where a person is within the pre-existing ailment waiting period, a number of steps need to be taken by the member, the hospital and the health fund to ensure that everyone understands the implications of proceeding with a hospital admission. The hospital should not have accepted a verbal assurance that Mrs V was covered without making Ms W aware of the financial implication of not being covered.

A written estimate of the cost of the hospital stay, signed by the patient, ensures that there is no misunderstanding as to what the hospitalisation will cost if the fund does not pay benefits. Many people do not realise the cost of a hospital admission in a private hospital and if they are clearly advised of this cost on admission, they have the choice to proceed with admission or discuss other treatment options with their doctor.

If a fund eligibility check reveals the member is within the pre-existing ailment waiting period, the fund should immediately send out medical certificates for completion by the member's treating doctors. This then enables the fund medical adviser to undertake the medical assessment to determine whether benefits are payable.

In Mrs V's case, the Ombudsman's investigation showed that the medical certificates were not sent out until the claim was received, after Mrs V was discharged from hospital. This may have contributed to her remaining in a private hospital and accumulating a larger bill than if the assessment had been commenced at the time of admission.

In this case, the Ombudsman felt that the actions of all parties to the complaint had contributed to some extent towards the unexpected hospital bill. The hospital agreed to reduce the outstanding bill by 50%, the health fund agreed to pay a benefit of 25% and Mrs V was asked to pay the remainder (and the medical gap bills which were not eligible for benefits).



2. High Cost Drugs and Hospital Contracts

Health funds are required to cover the cost of pharmaceutical drugs listed on the Pharmaceutical Benefits Schedule (PBS) which are supplied to a member who is an admitted in-patient of a hospital.

Where the member's doctor prescribes a pharmaceutical drug that is not listed on the PBS, all health funds have their own policies and procedures relating to the payment of benefits. In some cases, the fund's Hospital Purchaser Provider Agreement with the hospital will specify how and when such payments are to be made.

Mr M had been recommended a high cost drug by his oncologist. The drug was relatively new and not listed on the Pharmaceutical Benefits Schedule (PBS). The drug needed to be administered over the course of several hospital admissions; the cost of each dose was just over $2000 and the total cost of the course of treatment over $8000.

Mr and Mrs M were on a high level of hospital cover and on the advice of their treating doctor, asked their health fund whether their cover would cover these costs.

Mrs M arranged for the specialist to fax details of the drug and why it was needed for special consideration by the fund. This request was made on a standard form called "Request for Special Consideration". The health fund processed the request in accordance with its guidelines for such "special consideration".

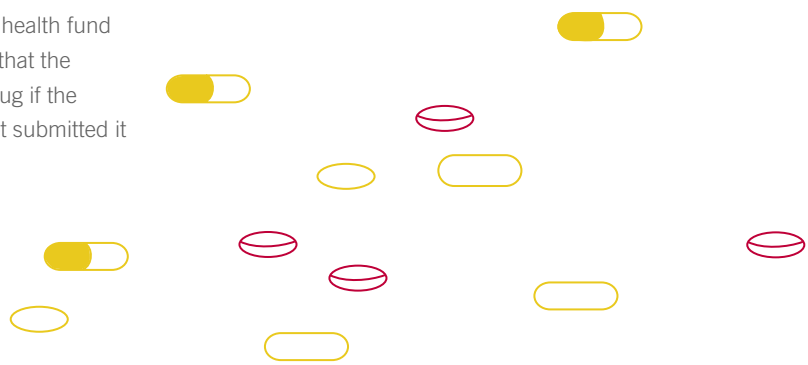
The request was declined by the health fund citing cover guidelines that state that the fund will not pay benefits for a drug if the pharmaceutical company had not submitted it for consideration under the PBS.

Mrs M complained to the health fund CEO by letter. She received a response from the fund's complaint area saying that their Clinical Claims Unit had reviewed the drug in question and declined benefits for the same reason as before, but adding that benefits would be paid "for treatment in an agreement hospital whereby the drug meets the costing criteria outlined in the fund/hospital agreement".

At this stage Mrs M contacted the Ombudsman's office because she was still not satisfied with the fund's answer. Investigations revealed that the proposed treatment was to be provided in an agreement hospital and therefore the fund/hospital agreement contract might allow for it to be paid. During a meeting between the hospital and health fund it was pointed out that a provision for high costs drugs was included in their agreement, up to certain limits. It seemed that the health fund, including its clinical claims unit, had made an error in refusing benefits.

Meanwhile, during the weeks that the complaint was being discussed by the hospital and health fund, Mr M had decided not to delay his treatment and had paid for four courses of treatment, at another facility, which turned out to be $2500 each.

The fund apologised to Mr and Mrs M and agreed to pay $10 000 to cover the cost of this treatment. In addition, the fund fully reviewed its assessment procedures for high cost drugs.



3. Complaints about Service Issues

The Ombudsman received 315 complaints about the level of service provided by funds in 2005/06, which represents almost 11% of complaints received. While this level of complaint is not high, given the thousands of customer contacts each year between funds and their members, on some occasions, the problems encountered by the member can be significant, as the following case study shows.

Ms C had been a member of a fund for over 30 years, but had recently changed health funds to find a cover that better suited her needs. A few months into her new membership, she realised her new fund did not cover massage therapy, so she changed to a third health fund which did cover it. Changing funds seemed to be an easy process for her, until she encountered problems a few weeks later on.

Firstly, she was initially charged, without any warning, a large monthly amount on her credit card because her new fund had not obtained details to confirm that she was previously covered and that the Lifetime Health Cover loading did not apply to her. The fund advised that they would remove the loading on her premiums only after a clearance certificate (which confirms a person's previous health fund coverage) was received and processed.

While waiting for this to be done, she needed a hospitalisation. At the pre-admission interview at the hospital, she was told that she was not going to be covered by her fund because she had not been with the fund for more than 12-months. She contacted her fund again to find out why they had told the hospital she would not be covered and they explained that they were still waiting on details from her previous health fund. They suggested that because they had not received them she would need to get them herself.

Ms C contacted her previous funds and quickly obtained the certificates and sent them to her fund one day before the admission. The health fund confirmed that she was indeed covered previously, and would either be covered at her new cover, unless benefits under her old cover were lower and the condition was pre-existing. On entering the hospital, she paid a $250-excess (similar to her old fund) and a $78 co-payment, because she wanted a private room and this cost more. Ms C's procedure went well and she recovered well.

Three weeks later, she opened a letter from her health fund full of forms and a letter saying that her claim would not be paid unless she and her doctors completed and returned the forms. The forms for the doctors needed to be completed by both her general practitioner and her specialist and therefore required a considerable amount of time, effort and possibly cost to get them completed. She tried to call the person who wrote the letter, but was told that she could only discuss her concerns with the call centre staff. Given that she was previously told she would be covered and the other problems in dealing with the fund so far, she contacted PHIO for assistance.

PHIO investigated the matter and questioned why she had been asked to complete medical forms to prove she did not have a pre-existing condition. Her previous cover was a similar level to her new cover, apart from a $250 excess; her new cover had a $300 excess. This meant that the new $300 excess applied from the time she took the new cover, regardless of whether her condition was pre-existing or not. There was therefore no need for the fund to conduct a pre-existing ailment assessment.

While Ms C was at home recovering from her hospitalisation, she received another letter from her health fund. This time, the fund was rejecting an optical claim she had made for a

set of spectacles. Apparently, the health fund required a copy of the prescription written for her glasses before she could make a claim. This surprised Ms C, as she had not required a script to claim for glasses with her previous fund. At this point, Ms C decided to cancel her membership (forgoing her optical claim in the process).

A few days later she received another letter in the mail from the fund. This time she needed to complete a form to cancel her membership. At this stage she requested that PHIO forward her cancellation letter to the fund, as she wanted to ensure that the membership was cancelled (after only 4 months). We understand she is now back with her original health fund and has had no further problems.

The problems experienced in this case are indicative of the range of problems members can experience when changing health funds. There are a range of reasons that contribute to the specific problems but virtually all would not occur if health funds were reasonably timely in issuing "clearance certificates" on request.

4. Two Year Limit on Claims

Health funds are able to refuse claims if they are not lodged within two years of the date of service. This is specified in their rules and funds have a number of valid reasons for placing this limit on claims. These include the difficulty of verifying older claims and of budgeting for claims expenses if claims are submitted late.

PHIO receives a few complaints each year from people who, for various reasons, did not make a claim in time. Many funds will consider individual reasons for not lodging on time and will pay some types of claims; however, funds have different guidelines for payment of late claims and some funds are stricter than others in applying the rule.

Mr H submitted some claims on behalf of his mother, because he had discovered them amongst her papers shortly after obtaining Power of Attorney over her affairs. She had been suffering short-term memory loss for some time and her affairs were somewhat disorganised by the time he obtained Power of Attorney.

Mrs H's claims were initially rejected because they were over the 2-year time limit. Mr H contacted the fund and they asked him to write a letter and re-submit the claims. So he wrote back with a full explanation of why the claims were late.

The fund sent him a standard letter rejecting the claims once more, so he raised the complaint with this office. PHIO queried the fund as to what their rule was for considering claims more than two-years old and they explained they would consider them only if the member was in an unconscious medical state or incarcerated during the time they were required to lodge the claim; or if documents required to make the claim had been seized by a court.

Given that health funds are not required to pay claims over 2-years old, PHIO did not have grounds for pursuing the matter further with the fund. However, while PHIO understands the need for funds to place time limits on claims, in this case it appeared that the fund could have provided Mr H with more information about its rules for considering late claims before requiring him to write formally on the matter.

5. Membership Issues Relating to Relationship Breakdown

Sometimes family arrangements make it easier to cover children on two policies if there has been a relationship breakdown and the parents are separated. The *National Health Act 1953* does not prevent a person from taking out two separate policies with different health funds. Many funds will allow this to occur under their rules as long as a person does not claim more than 100% of the cost of any benefit. Other funds have rules that do not allow a person to be covered by another fund. PHIO believes it is in the interests of both funds and members to be flexible with membership arrangements in these circumstances to prevent problems between the parties escalating.

Mrs B had been a member of her fund for some time. She had recently married her husband, who had a daughter from a previous marriage. On contacting the fund to add her husband and step-daughter to her membership she was advised that she could not add her step-daughter unless she could verify that she was not insured with another health fund.

In particular, the fund wanted written verification from the child's natural mother that she was not covered under another health insurance policy. In Mrs B's situation, the breakdown of the previous marriage was not amicable and the natural mother would not speak to her.

Mrs B became frustrated with the fund for asking for verification which she could not obtain, and thereby preventing her step-daughter from being covered, so she contacted PHIO.

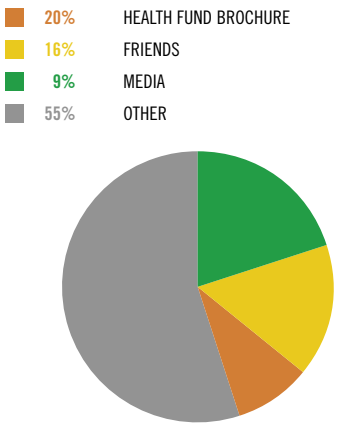
PHIO's investigation revealed that this fund had a rule that prevented a person from taking up cover if they were already covered with another fund. This did raise the question of how the fund could ever practically verify that a person was not covered twice.

After negotiating with the fund, it was agreed that the fund would accept the step-daughter as a member, on the basis that a copy of the father's custody papers were provided.

ACCESS AND PUBLIC AWARENESS

Because the Private Health Insurance Ombudsman was established primarily for the benefit of health fund members, it is important that they know about their right to approach the Ombudsman for assistance. The 2006 Client Satisfaction survey asked complainants to indicate how they found out about PHIO.

Figure 16 How did you find out about PHIO?



To further raise awareness of the service provided by the Ombudsman, the following strategies were employed during 2005/06:

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

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

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

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

Relations with Stakeholders

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

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

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

CLIENT SURVEY

About the Survey

In May 2006, the office carried out a postal survey of a randomly selected 300 complainants who had lodged complaints during the period December 2005 to April 2006. 120 (40%) clients responded to the survey.

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

Comparing Client Satisfaction to Last Survey

Last year's survey showed a significant improvement in satisfaction on previous years. This year, many individual levels of client satisfaction have declined but overall satisfaction levels have improved. 88% of clients answered that they were satisfied with the overall handling of their complaint. This is a small improvement on the previous year when 87% of clients said that they were satisfied.

In Summary, of the respondents to the survey;

- 94% said that staff listened to their concerns; a decrease from 98% last year. .
- 85% said that staff explained what sort of assistance we could provide, a decrease from 91% last year.
- 87% said that our staff were easy to understand; a decrease from 90% last year.
- 86% said that they were satisfied or mostly satisfied with the manner in which staff handled their complaint, this is a decrease from 87% last year.
- 74% said that we had resolved their complaint or provided an adequate explanation, an increase from 70% last year.
- 87% said that PHIO was independent in dealing with their complaint, an increase from 83% last year.
- 82% said that they would recommend us to others or use PHIO again, a decrease from 83% the year before.
- 76% of those whose cases lasted more than a week said that they were happy with the time taken resolving their complaint. This is a decrease from 78% the previous 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:

- A continuation of work with the Australian Medical Association on development of policies and procedures for providing for informed financial consent, including comment on material developed as part of the AMA IFC educational campaign.
- Comment on proposed policy and wording of a new condition of registration relating to Benefit Limitation Periods.
- Submissions to Parliamentary committees on Health Funding and Mental Health.
- Finalisation of protocols for health funds and health providers on transitional measures and communication responsibilities when hospital/ health fund agreements are terminated.
- Providing statistics on complaint issues for inclusion in the ACCC's Report to the Senate on *Anti-competitive and other practices by health funds and providers in relation to private health insurance.*

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

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

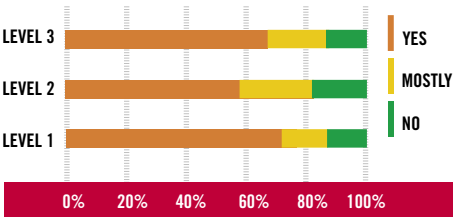
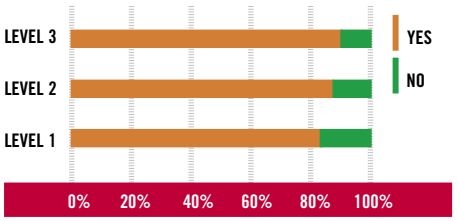
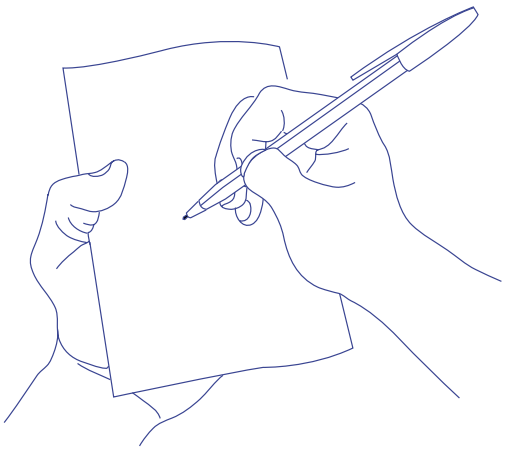


Figure 18 In your view, was the Ombudsman independent?





Corporate Governance

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

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

Management of Human Resources

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

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

Staff Details

As at 30 June 2006, the staff employed by the Private Health Insurance Ombudsman comprised:

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

Statutory Positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

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

Mr Powlay was reappointed for a second term as Private Health Insurance Ombudsman in November 2005. The Ombudsman's remuneration is determined by the Remuneration Tribunal.

Staff Development and Training

During the 2005/06 financial year $14 327 was spent directly on PHIO staff attending training courses, conferences and seminars. During the financial year the Ombudsman continued its internal staff development and training program for dispute resolution staff.

Staff Employment Status

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

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

The following table shows the numbers and status of staff who were employed on 30 June 2006.

Occupational Group	Women	Men	Total Staff	NESB1
SES		1	1	-
Other	6	3	9	3
Total	**6**	**4**	**10***	**3**

Note:

SES	Senior Executive Service
Other	All other staff - temporary and permanent
NESB1	Non-English speaking background, 1st Generation
*	Includes part time employees. Actual EFT = 8.5

Performance Appraisal

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

Industrial Democracy

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

Accounting

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

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

Outcomes and Outputs

The 2005/06 Portfolio Budget Statement indicates that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 8, *Choice Through Private Health*.

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

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

Consultants Engaged

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

Neill Buck & Associates were engaged to review the Ombudsman's risk management plan. Hall & Chadwick (accountants) and Resolution Consulting Services Pty Ltd were consulted during the year by the Ombudsman.

Information Systems

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

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, 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 2006.

Establishment

The Private Health Insurance Ombudsman (the Ombudsman) is established under the *National Health Act 1953* to resolve complaints about any matter arising out of, or in 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:

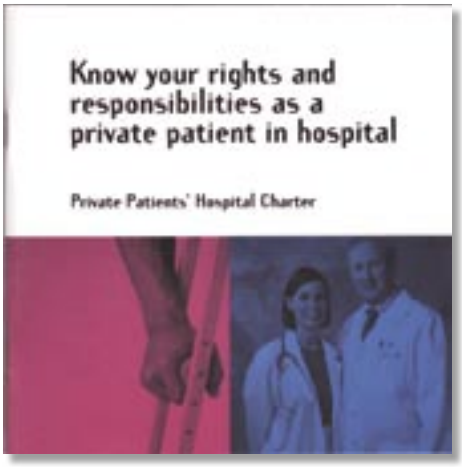
- A series of consumer brochures produced by the Office
- A booklet and brochure "Private Patients' Hospital Charter"
- Complaints Register and Complaints files
- Correspondence and working papers relating to the administration of the Ombudsman, including personnel and financial papers
- Other guidelines 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 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.)


Know your rights and responsibilities as a private patient in hospital
Private Patients' Hospital Charter


TEN GOLDEN RULES


ABOUT OUR SERVICE


DOCTORS' BILLS


MAKING A COMPLAINT

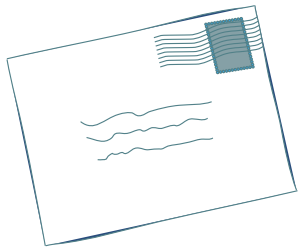

THE RIGHT TO CHANGE


WAITING PERIODS

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 www.phio.org.au

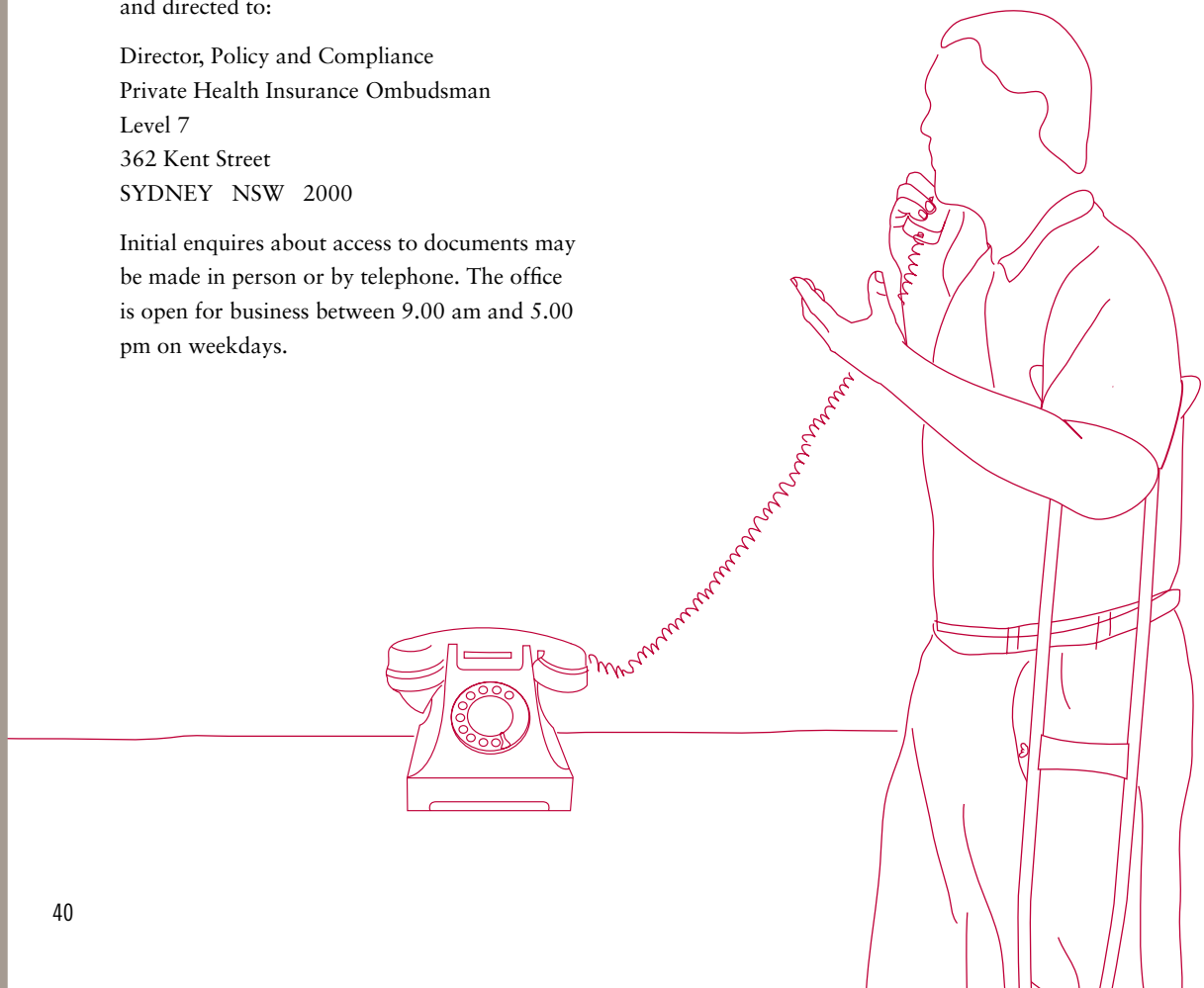


Information and procedures for Freedom of Information Act requests

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

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

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



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

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

Courts

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

Commonwealth Ombudsman

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

Other

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

Service Charter

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

13 September 2006

Mr John Powlay
Private Health Insurance Ombudsman
Level 7
361 Kent Street
SYDNEY NSW 2000

Dear Mr Powlay

PRIVATE HEALTH INSURANCE OMBUDSMAN
2005-2006 FINANCIAL STATEMENT AUDIT

Please find enclosed the audit opinion and a copy of the signed financial statements for the year ending 30 June 2006.

A copy of the financial statements and the audit opinion has been forwarded to the Minister for Health and Ageing.

I would like to take this opportunity to express the Australian National Audit Office's appreciation for the assistance and cooperation provided by your staff to our auditors during the course of the audit.

Yours sincerely

Australian National Audit Office

P Hinchey
Senior Director

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

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Ageing

Scope

The financial statements and Ombudsman's responsibility

The financial statements comprise:

- Statement by Ombudsman;
- Income Statement, Balance Sheet and Statement of Cash Flows;
- Statement of Changes in Equity;
- Schedules of Commitments and Contingencies; and
- Notes to and forming part of the Financial Statements

of the Private Health Insurance Ombudsman for the year ended 30 June 2006.

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

Audit Approach

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

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

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

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

The audit opinion is based on these procedures, which included:

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

Independence

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

Audit Opinion

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

(a) have been prepared in accordance with Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*; and
(b) give a true and fair view of the Private Health Insurance Ombudsman's financial position as at 30 June 2006 and of its performance and cash flows for the year then ended, in accordance with:
    (i) the matters required by the Finance Minister's Orders; and
    (ii) applicable Accounting Standards and other mandatory financial reporting requirements in Australia.

Australian National Audit Office

P Hinchey
Senior Director
Delegate of the Auditor-General

Sydney
13 September 2006

PRIVATE HEALTH INSURANCE OMBUDSMAN
STATEMENT BY THE OMBUDSMAN.

In my opinion, the attached financial statements for the year ended 30 June 2006 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.....
John Powlay
Ombudsman

11 September 2006

Private Health Insurance Ombudsman Income Statement

FOR THE YEAR ENDED 30 JUNE 2006

	Note	2006 $	2005 $
INCOME			
Revenue			
Revenues from government	3A	**1,160,000**	1,165,000
Interest	3B	**41,448**	33,485
Other	3C	**1,000**	14,049
Total Revenue		**1,202,448**	1,212,534
Gains			
Net Gains from disposal of assets	3D	**0**	404
Total Gains		**0**	404
TOTAL INCOME		**1,202,448**	1,212,938
EXPENSES			
Suppliers	4A	**313,560**	308,168
Employees	4B	**781,056**	695,285
Depreciation and amortisation	4C	**14,270**	24,438
Write down and Impairment of assets	4D	**0**	93
TOTAL EXPENSES		**1,108,886**	1,027,984
OPERATING RESULT		**93,562**	184,954

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

Private Health Insurance Ombudsman Balance Sheet

AS AT 30 JUNE 2006

	Note	2006 $	2005 $
ASSETS			
Financial assets			
Cash and cash equivalents	5A	**267,608**	140,443
Investments under s18 of the CAC Act	5B	**500,000**	500,000
Total financial assets		**767,608**	640,443
Non-financial assets			
Infrastructure, plant and equipment	6A,B,C,D	**64,732**	59,636
Total non-financial assets		**64,732**	59,636
TOTAL ASSETS		**832,340**	700,079
LIABILITIES			
Payables			
Suppliers	7A	**33,342**	20,512
Total payables		**33,342**	20,512
Provisions			
Employees	8A	**201,219**	175,350
Total provisions		**201,219**	175,350
TOTAL LIABILITIES		**234,561**	195,862
EQUITY			
Retained surpluses or (accumulated deficits)		**597,779**	504,217
Total equity		**597,779**	504,217
Current Assets		**767,608**	640,443
Non-current assets		**64,732**	59,636
Current liabilities		**100,497**	76,760
Non-current liabilities		**134,064**	119,102

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

Private Health Insurance Ombudsman Statement of Cash Flows

FOR THE YEAR ENDED 30 JUNE 2006

	Note	2006 $	2005 $
OPERATING ACTIVITIES			
Cash Received			
Appropriations	3A	**1,160,000**	1,165,000
Interest	3B	**41,448**	33,485
Other	**3C**	**1,000**	14,453
Total cash received		**1,202,448**	1,212,938
Cash Used			
Suppliers	4A, 10	**(300,730)**	(286,830)
Employees	4B, 10	**(755,187)**	(665,539)
Total cash used		**(1,055,917)**	(952,369)
Net cash from operating activities		**146,531**	260,569
INVESTING ACTIVITIES			
Cash used			
Purchase of Investments		**0**	(200,000)
Purchase of property, plant and equipment		**(19,366)**	(18,592)
Total cash used		**(19,366)**	(218,592)
Net cash used by investing activities		**(19,366)**	(218,592)
Net increase in cash held		**127,165**	41,977
Cash at the beginning of the reporting period		**140,443**	98,466
Cash at the end of the reporting period		**267,608**	140,443

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

Private Health Insurance Ombudsman Statement of Change in Equity

FOR THE YEAR ENDED 30 JUNE 2006

ANALYSIS OF EQUITY

Item	Accumulated Results		Asset Revaluation Reserve		Total	
	2006 $	2005 $	2006 $	2005 $	2006 $	2005 $
Opening balance	**504,217**	319,263	-	4,299	**504,217**	323,562
Income and Expense Revaluation Adjustment	-	-	-	(4,299)	-	(4,299)
Subtotal income and expenses recognised directly in equity	-	-	-	(4,299)	-	(4,299)
Net Operating Result	**93,562**	184,954	-	-	**93,562**	184,954
Total income and expenses	**93,562**	184,954	-	(4,229)	**93,562**	180,655
Closing balance at 30 June 2006	**597,779**	504,217	-	-	**597,779**	504,217

Private Health Insurance Ombudsman Schedule of Commitments

AS AT 30 JUNE 2006

	2006 $	2005 $
BY TYPE		
Other commitments		
Operating Leases	**40,424**	101,060
Total other commitments	**40,424**	101,060
Commitments receivable	**3,675**	(9,187)
Net commitments by type	**36,749**	91,873
BY MATURITY		
Operating lease commitments		
One year or less	**40,424**	60,636
From one to five years	**0**	40,424
	40,424	101,060
Commitments receivable	**3,675**	(9,187)
Net commitments by maturity	**36,749**	91,873

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	Lease payments are subject to annual increase of 4%. The lease is current for 1 year with an option to renew for a further 3 years.

Private Health Insurance Ombudsman Schedule of Contingencies

AS AT 30 JUNE 2006

There were no contingent losses or gains as at 30 June 2006.

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

NOTE 1:
SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Basis of Preparation of the Financial Statements

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

The 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 statements have been prepared in accordance with:

- Finance Minister's Orders (being the *Commonwealth Authorities and Companies Orders)(Financial Statements for reporting periods ending on or after 1 July 2005)*);
- Australian Accounting Standards issued by the Australian Accounting Standards Board that apply for the reporting period; and
- Interpretations issued by the AASB and UIG that apply for the reporting period.

This is the first financial report to be prepared under Australian Equivalents to International Financial Reporting Standards (AEIFRS). The impacts of adopting AEIFRS are disclosed in Note 2.

The Income Statement, Balance Sheet and Statement of Changes in Equity have been prepared on an accrual basis and are in accordance with the historical cost convention, except for certain assets and liabilities, which as noted, are 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, assets and liabilities are recognised in the Balance Sheet when and only when it is probable that future economic benefits will flow and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under agreements equally proportionately unperformed are not recognised unless required by an Accounting Standard. Liabilities and assets that are unrecognised are reported in the Schedule of Commitments and the Schedule of Contingencies.

Unless alternative treatment is specifically required by an accounting standard, revenues and expenses are recognised in the Income Statement when and only when the flow or 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

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

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

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

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.

1.5 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' and termination benefits due within twelve months 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 and the Public Sector Superannuation Scheme.

The CSS and PSS are defined benefit schemes for the Commonwealth.

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

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

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

1.6 Leases

A distinction is made between finance 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.

1.7 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.

1.8 Property, Plant and Equipment

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

Revaluations

Basis
Plant and equipment are carried at fair value, being revalued with sufficient frequency such that the carrying amount of the asset is not materially different, at reporting date, from its fair value. Valuations undertaken in each year are as at 30 June.

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

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

Following initial recognition at cost, valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets do not differ materially with 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 profit and loss. Revaluation decrements for a class of assets are recognised directly through profit and loss 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 balance date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

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

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

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

Impairment
All assets were assessed for impairment at 30 June 2006. 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.

1.10 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 7 to 10 years (2004-05: 7 to 10 years).

All software assets were assessed for indications of impairment as at 30 June 2006.

1.11 Taxation

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

Revenues, expenses, assets and liabilities 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:
THE IMPACT OF THE TRANSITION TO AEIFRS FROM PREVIOUS GAAP

There was no AEIFRS impact on the Ombudsman's accounting and disclosure requirements.

		2006 $	2005 $
NOTE 3:			
INCOME			
Revenues			
Note 3A:	Revenues from Government		
	Appropriation for outputs	**1,160,000**	1,165,000
	Total revenue from government	**1,160,000**	1,165,000
Note 3B:	Interest		
	Interest on Deposits	**41,448**	33,485
	Total Interest revenue	**41,448**	33,485
Note 3C:	Other Revenues		
	Seminar Income	**1,000**	7,230
	Other	**0**	6,819
	Total Other Revenues	**1,000**	14,049
Gains			
Note 3D:	Net Gain from Sale of Assets		
	Property Plant and Equipment:		
	Proceeds from disposal	**0**	404
	Net book value at sale	**0**	0
	Selling Expenses	**0**	0
	Net gain from disposal of property, plant & equipment	**0**	404
NOTE 4:			
OPERATING EXPENSES			
Note 4A:	Suppliers expenses		
	Supply of Goods and Services - all external	**261,083**	251,561
	Operating Lease Rentals	**52,478**	56,607
	Total suppliers expenses	**313,560**	308,168
Note 4B:	Employee expenses		
	Wages and Salaries	**582,078**	534,027
	Superannuation	**104,610**	97,602
	Leave and other entitlements	**25,932**	60,274
	Other employee expenses	**68,436**	3,382
	Total employee expenses	**781,056**	695,285

		2006 $	2005 $
NOTE 4:			
OPERATING EXPENSES (Continued)			
Note 4C:	Depreciation and Amortisation		
	Depreciation		
	Depreciation of plant and equipment	**13,778**	24,438
	Total Depreciation	**13,778**	24,438
	Amortisation		
	Amortisation - Lease Fitout	**492**	0
	Total depreciation and amortisation expense	**14,270**	24,438
	The aggregate amounts of depreciation or amortisation expensed during the reporting period for each class of depreciable asset are as follows:		
	Leasehold Improvements	**492**	0
	Plant and equipment	**13,778**	24,438
	Total depreciation and amortisation	**14,270**	24,438
Note 4D:	Write-Down and Impairment of Assets		
	Plant & Equipment written down	**0**	93
	Total write-down of Assets	**0**	93
NOTE 5:			
FINANCIAL ASSETS			
Note 5A:	Cash and cash equivalents		
	Cash at Bank	**267,348**	140,393
	Cash on Hand	**259**	50
	Total cash and cash equivalents	**267,608**	140,443
Note 5B:	Investments under s18 of the CAC Act		
	Money on Deposit	**500,000**	500,000
	Total investments	**500,000**	500,000
	Money on deposits are with the Ombudsman's bank and earn an effective interest rate of 5.7% (2005: 5.25%). Interest is payable monthly.		

		2006 $	2005 $
NOTE 6:			
NON-FINANCIAL ASSETS			
Note 6A:	Buildings		
	Lease Fitout at valuation	**4,915**	4,915
	Accumulated depreciation	**(1,053)**	(561)
	Total Buildings (non-current)	**3,862**	4,354
Note 6B:	Infrastructure, Plant and Equipment		
	Infrastructure, plant and equipment		
	- at cost	**19,366**	0
	- accumulated depreciation	**(1,861)**	0
	- at 2005 valuation (fair value)	**55,282**	55,282
	- accumulated depreciation	**(11,917)**	0
	Total Infrastructure, Plant and Equipment	**60,870**	55,282
Note 6C:	Intangibles - at cost		
	Intangibles	**17,412**	17,412
	Accumulated depreciation	**(17,412)**	(17,412)
	Total intangibles	0	0

Note 6D:

RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT

Item	Leasehold Improvements $'000	Plant & Equipment $'000	Intangibles $'000	Total $'000
As at 1 July 2005	4,915	55,282	17,412	77,609
Gross Book Value	(561)	0	(17,412)	(17,973)
Accumulated Depreciation/amortisation				
Opening Net Book Value	**4,354**	**55,282**	**0**	**59,636**
Additions:	**0**	19,366	**0**	19,366
By Purchase				
Depreciation/amortisation expense	(492)	(13,778)	0	(14,270)
As at 30 June 2006	4,915	74,648	17,412	96,975
Gross Book Value	(1,053)	(13,778)	(17,412)	(32,243)
Accumulated Depreciation/amortisation				
Closing Net Book Value	**3,862**	**60,870**	**0**	**64,732**

	2006 $	2005 $

NOTE 7:
PAYABLES

Note 7A: Suppliers

Trade creditors - current	**25,062**	16,226
Accruals - current	**8,280**	4,286
Total supplier payables	**33,342**	20,512

NOTE 8:
PROVISIONS

Note 8A: Employee Provisions

Salaries and Wages	**2,069**	2,133
Annual Leave	**65,085**	54,115
Long Service Leave	**134,065**	119,102
Total Employee Provisions	**201,219**	175,350
Current	**67,154**	56,248
Non-Current	**134,065**	119,102
Total Employee Provisions	**201,219**	175,350

NOTE 9:
CASH FLOW RECONCILIATION

Reconciliation of cash per Income Statement to Statement of Cash Flows

Cash at year end per Statement of Cash Flows	**267,608**	140,443
Statement of Financial Position items comprising above cash: 'Financial Asset - Cash'	**267,608**	140,443

Reconciliation of operating result to net cash from operating activities

Operating result	**93,562**	184,954
Depreciation/amortisation	**14,270**	24,438
Net write down of non-financial assets	**0**	93
(Increase)/decrease in net receivables	**0**	6,460
(Increase)/decrease in prepayments	**0**	4,105
Increase/(decrease) in employee provisions	**25,869**	29,747
Increase/(decrease) in supplier payables	**12,830**	10,772
Net cash from/(used by) operating activities	**146,531**	260,569

		2006 $	2005 $
NOTE 10:			
NOTE 10: EXECUTIVE REMUNERATION			
		Number	Number
The number of senior executives who received or were due to receive total remuneration of $130,000 or more:			
$175,000 - $189,999		**0**	1
$205,000 - $219,999		**1**	0
	Total	**1**	1
		$	$
The aggregate amount of total remuneration of executives shown above		**208,724**	183,018
NOTE 11:			
REMUNERATION OF AUDITORS		**$**	$
The cost of the financial statement audit services provided to the Ombudsman were:		**6,500**	6,000
No other services were provided by the Auditor-General during the reporting period.			
NOTE 12:			
AVERAGE STAFFING LEVELS		**2006**	2005
The average staffing levels for the Ombudsman during the year were:		**9**	9

NOTE 13:
FINANCIAL INSTRUMENTS

Note 13A: 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 2005-2006 are net 14 days (2004-05: 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 13B: Interest Rate Risk

Financial Instruments	Notes	Floating Interest Rate		Non-Interest Bearing		Total		Weighted Average Effective Interest Rate	
		2006 $	2005 $	2006 $	2005 $	2006 $	2005 $	2006 %	2005 %
Financial Assets									
Cash at bank		**267,348**	140,443	**0**	0	**0**	140,443	**5.25**	4.95
Investments - term deposits		**500,000**	500,000	**0**	0	**0**	500,000	**5.70**	5.25
Receivables for goods and services (gross)		**0**	0	**0**	0	**0**	0	**n/a**	n/a
Total		**767,348**	640,443	**0**	0	**0**	640,443		
Total Assets		**832,174**	700,029			**0**	700,079		
Financial Liabilities									
Trade and other Creditors		**0**	0	**33,062**	20,512	**33,062**	20,512	**n/a**	n/a
Total		**0**	0	**33,062**	20,512	**33,062**	20,512	**n/a**	n/a
Total Liabilities		**234,281**	195,862			**234,281**	195,862		

Note 13C: 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 13D: 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.

NOTE 14:
APPROPRIATIONS

Particulars	Departmental Outputs	
	2006 $	2005 $
Year ended 30 June 2005		
Balance carried forward from previous year	**0**	0
Appropriation Acts 1 and 3	**1,160,000**	1,165,000
Available for payment of CRF	**1,160,000**	1,165,000
Payments made out of CRF	**1,160,000**	1,165,000
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 Authority and do not represent any balance remaining in the CRF.

NOTE 15:
REPORTING OF OUTCOMES

Note 15A: 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 15B: Net Cost of Outcome Delivery

	Outcome 1 2006	2005
Total expenses	**1,108,886**	**1,027,984**
External revenues		
Interest	41,448	33,485
Other	1,000	14,049
Revenue from sale of assets	0	404
Total external revenues	**42,448**	**47,938**
Net cost of outcome	**1,066,438**	**980,046**

Note 15C: Departmental Revenues and Expenses by Output Groups and Outputs

PHIO's revenues, expenses, assets and liabilities are attributable to two outputs (refer to note 15A).

	Outcome 1				Total	
	2006 $	2005 $	**2006 $**	2005 $	**2006 $**	2005 $
Operating Expenses						
Employees	**159,382**	141,625	**621,674**	553,405	**781,056**	695,285
Suppliers	**63,985**	62,885	**249,575**	245,283	**313,560**	308,168
Depreciation and amortisation	**2,854**	4,887	**11,416**	19,551	**14,270**	24,438
Write-down of assets	**0**	19	**0**	74	**0**	93
Total operating expenses	**226,222**	209,416	**882,665**	818,312	**1,108,886**	1,027,984
Funded by:						
Revenues from						
Government	**236,711**	237,731	**923,289**	927,269	**1,160,000**	1,165,000
Interest	**8,458**	6,833	**32,990**	26,652	**41,448**	33,485
Other	**204**	2,867	**796**	11,181	**1,000**	14,049
Revenue from sale of assets	**0**	82	**0**	323	**0**	404
Total operating revenues	**245,373**	247,513	**957,075**	965,425	**1,202,448**	1,212,938

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