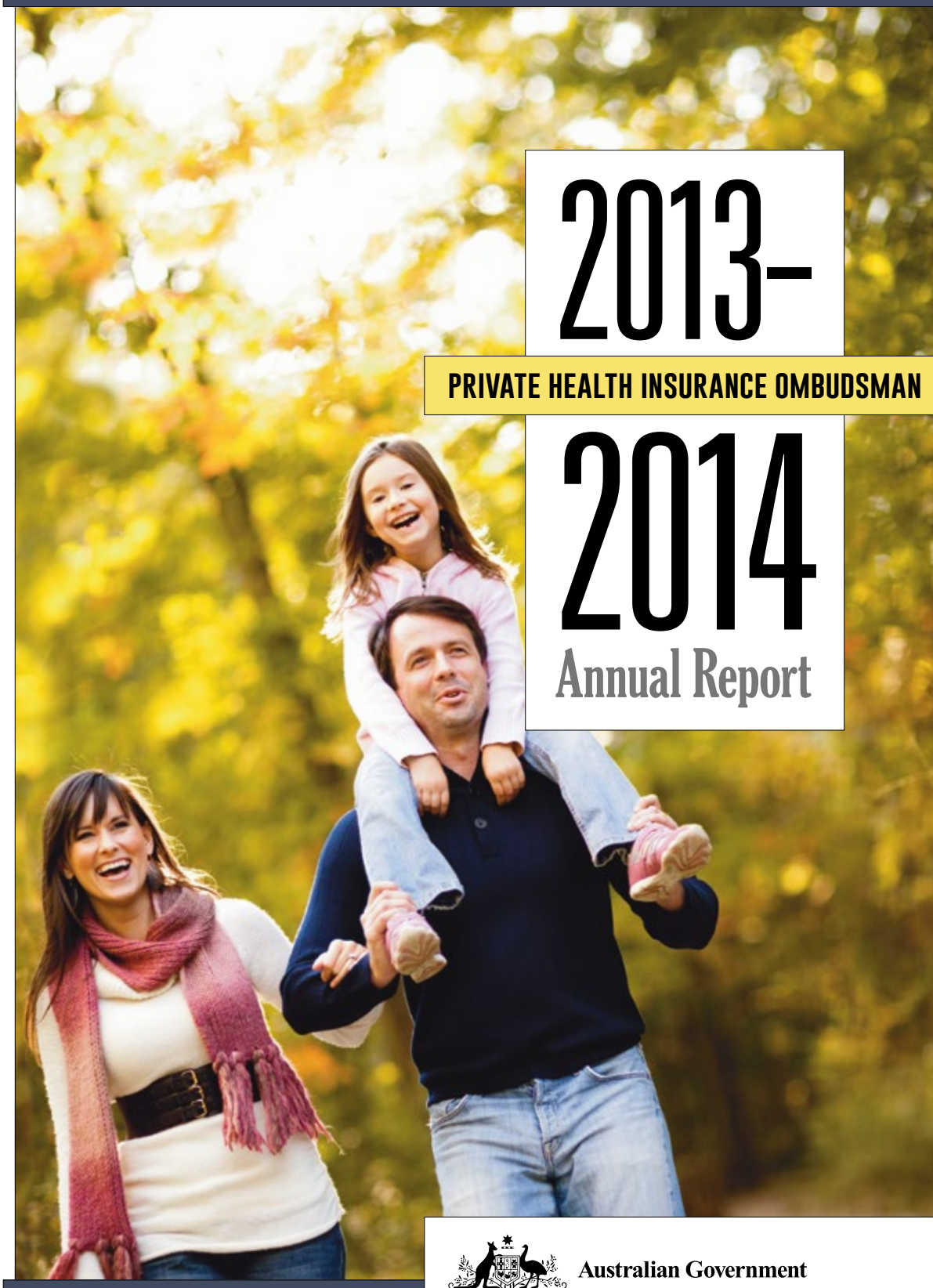


2013–2014 Annual Report

PRIVATE HEALTH INSURANCE OMBUDSMAN

Australian Government

Private Health Insurance Ombudsman


“Protecting the interests of people covered by private health insurance.”
THE PRIVATE HEALTH INSURANCE OMBUDSMAN

Contacts

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

POSTAL ADDRESS

Suite 2, Level 22, 580 George Street
Sydney NSW 2000.

TELEPHONE, FAX AND E-MAIL

ENQUIRIES AND COMPLAINTS

1800 640 695 (free call from landline; higher cost from mobile)
9am to 5pm Sydney time, Monday to Friday.

WEBSITE AND GENERAL ENQUIRIES

1300 737 299 (normal call cost), 9am to 5pm Sydney time, Monday to Friday.

OTHER

E-mail	info@phio.gov.au
Website	http://www.phio.gov.au/
Administration	(02) 8235 8777
Facsimile	(02) 8235 8778
Consumers requiring translators	13 14 50 (Translating & Interpreting Service)
Deaf, hearing or speech impaired	13 36 77 (National Relay Service)

Readers with enquiries about the Ombudsman or this report should contact the Administration Officer at the above address. Information for senators and members of parliament is available from the Private Health Insurance Ombudsman at the above telephone and facsimile numbers.

Annual Report design and production by Surveillance (www.surveillance.net.au).

Contents

Letter of Transmittal

Australian Government
Private Health Insurance Ombudsman

The Hon. Peter Dutton MP
Minister for Health
Parliament House
CANBERRA ACT 2600

Dear Minister,

In accordance with Section 253-50 of the *Private Health Insurance Act 2007*, I am pleased to present you with the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2013 to 30 June 2014.

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

I am satisfied that PHIO has prepared fraud risk assessments and fraud control plans and has in place appropriate fraud prevention, detection, investigation, reporting and data collection procedures and processes that meet the specific needs of the agency and comply with the Commonwealth Fraud Control Guidelines.

Section 34C of the *Acts Interpretation Act 1901* requires you to place a copy of the report before each House of Parliament within 15 sitting days after it is received.

Yours sincerely,

Samantha Gavel

Samantha Gavel
Ombudsman
26 September 2014

Ombudsman's Overview

INTRODUCTION

The Private Health Insurance Ombudsman (PHIO) is the statutory government agency tasked under the *Private Health Insurance Act 2007* (Cth) with protecting the interests of people covered by private health insurance.

PHIO provides independent, objective, accessible and timely complaints handling and advice services to government, industry and Australia's ten million health insurance consumers. In carrying out its role, PHIO promotes confidence in and supports the government's commitment to private health insurance.

Under the *Private Health Insurance Act 2007* (Cth), PHIO's objective is to protect the interests of people covered by private health insurance through a range of functions and services, including:

- Assisting members to resolve disputes through its independent complaints handling service;
- Identifying underlying problems in the practices of private health insurers or health providers in relation to the administration of private health insurance;
- Providing advice to government and industry about issues affecting consumers in relation to private health insurance;
- Mediating between health insurers and healthcare providers in relation to hospital contracting disputes;
- Providing advice and recommendations to government and industry about private health insurance, specifically the performance of the sector and the nature of complaints; and
- Disseminating information about private health insurance and the rights and obligations of insured people.

Private Health Insurance Ombudsman, Samantha Gavel.

In particular, PHIO's consumer information and services have become increasingly important in recent years. Private health insurance has always been a dynamic area of operation and, given the continuing pace of change in the sector, the availability of independent and reliable information to assist consumers to better understand their private health insurance will be increasingly important.

PHIO produces the annual *State of the Health Funds Report*, which provides information on the comparative service and performance of health insurers, to assist both current consumers and those purchasing private health insurance for the first time. PHIO also provides recommendations to insurers about product information and

its presentation to improve both quality and accessibility.

PHIO also has an important consumer information and advice role regarding private health insurance. In support of this role, PHIO produces and publishes a range of tools for consumers, including the consumer website PrivateHealth.gov.au, the annual *State of the Health Funds Report*, the consumer e-bulletin *Health Insurance Insider*, the *Quarterly Bulletin* and a range of brochures and factsheets.

PHIO's powers and functions are set out in Part 6-2 of the *Private Health Insurance Act 2007* (Cth).

PHIO is funded by a levy collected from private health insurers under the *Private Health Insurance Complaints Levy Act 1995* (Cth), which fully recovers the cost of its funding. PHIO is prescribed as an agency under the *Financial Management and Accountability Act 1997* (Cth) and staff are employed under the *Public Service Act 1999* (Cth).

HIGHLIGHTS FOR THE 2013–14 YEAR

- An increase in the level of customer satisfaction with PHIO's complaints handling service, with 86% of those surveyed reporting they were satisfied or very satisfied with the service. This was particularly pleasing, given the higher workload of the office, due to an increase in complaints during the year.
- There was continued strong growth in visits to the consumer website PrivateHealth.gov.au, with a 45% increase in unique visits to the site during 2013–14.
- Continued positive feedback from consumers in relation to the PrivateHealth.gov.au website, with 88% of surveyed consumers reporting they found the website easy to use, 90% found the website visually appealing, 85% were happy with the location of the information and 84% were happy with the quality of the information.
- PHIO received a Highly Commended award for the quality of its 2012–13 Annual Report in the small FMA Act category of the Institute of Public Administration (ACT Division) Annual Report Awards.
- PHIO's social media channel was launched in early 2014.
- The consultation with private health insurers and state/territory health departments to develop a new national private/public Acute Care Certificate was successfully concluded.
- Positive feedback from health insurers to PHIO's series of complaints handling workshops for industry. These were held in a number of states and territories in 2013.

HEALTH INSURANCE COMPLAINTS

During 2013–14, PHIO received 3427 complaints, which represented a 16% increase on the 2955 complaints received in the previous year. While this was a reversal of the trend in recent years towards a decline in complaints to the office, it is important to note that the increase in complaints this year was not industry wide, but was largely attributable to a number of significant product and policy changes made by a large health insurer, which impacted on its members and resulted in higher numbers of complaints to PHIO.

The increase in overall complaint numbers flowed through into the number of higher level complaints requiring investigation by PHIO. In 2013–14, PHIO received 580 higher level complaints which represented a 28% increase on the 450 received in the previous year. Again, this increase in higher level complaints was not industry wide, but was mainly attributable to the changes made by a large insurer which resulted in higher numbers of complaints to PHIO from members of this insurer.

COMPLAINT ISSUES

During 2013–14, the issues causing higher numbers of complaints to PHIO were Oral Information, Hospital Exclusions and Restrictions, the Pre-Existing Condition Waiting Period, Cancellation and General Service Issues.

As there was an overall increase in

complaints to PHIO during the reporting period, this was reflected in increases across most issues and sub-issue categories. There was a decline, however, in complaints about Delays in Payment and Clearance Certificates.

Complaints about Oral Information provided by fund staff over the telephone or in branches increased from 289 in 2012–13 to 410 in 2013–14. Most of this increase is attributable to increased complaints about this issue from members of a large insurer. PHIO has been working with the insurer to reduce complaints from its members about this issue. The main challenge for the insurer in relation to these complaints is to facilitate and encourage good record keeping practices by staff members working in the branch network, so that there is a record of advice given to members visiting the branch. Clear record keeping would make it much easier to resolve complaints from members questioning advice received from staff members.

Generally, record keeping in relation to call centre interactions is much improved in recent years across the industry, due to the introduction of voice recording technology. Where there is a recording of a telephone interaction regarding the advice given to a member, it is much easier for the insurer or for PHIO to resolve a complaint about the advice given.

Complaints about Hospital Exclusions and Restrictions increased from 180 in 2012–13 to 242 in 2013–14. These complaints were from members who found out when they needed treatment that their treatment was partially covered or excluded under their policy. In some cases, the health insurer had added new restrictions or exclusions to existing policies, which resulted in higher levels of complaint from their members about restrictions and exclusions.

PHIO's advice to members is to take out a more comprehensive level of hospital cover and choose a higher excess or lower level of extras cover, rather than a restriction or exclusion on the policy.

Complaints about the Pre-Existing Condition (PEC) Waiting Period have remained at similar levels over the past three years, with 229 complaints recorded in 2013–14, compared with 207 the previous year. The PEC Waiting Period applies in the first twelve months of a new member joining an insurer or an existing member upgrading their policy to any higher level benefits of the new policy. The Waiting Period is designed to protect the long-term members of the fund from the possibility of people joining only when they know or suspect they may need treatment. If a new or upgrading member requires treatment for a condition that is not a PEC, however, they are entitled to receive benefits from their insurer for that treatment.

PHIO's role in investigating complaints about the application of the PEC Waiting Period is to act as an independent third party in reviewing these complaints to ensure the rule has been correctly applied and that the member has been informed about the rule and how it may affect them in their first year of membership.

The rule requires that the fund medical adviser be of the opinion that there were signs or symptoms of the illness, ailment or condition

From left to right: Hilary Bassingthwaighte, Emma Howes, Kaylie Blyton, Jim Robertson, Samantha Gavel, Kate Hocknull, Katie Kwong, David McGregor, Jaye Nang, Henny Oentojo and Alison Leung.

in the six months prior to the member joining the fund. Where there is a complaint about the application of the rule, PHIO will review the decision by the insurer to deny benefits on PEC grounds. If the insurer has applied the rule correctly, PHIO will then review the information provided to the member about the rule by the insurer to ensure the member was given adequate information about the rule on joining the fund and enquiring about treatment in the first twelve months of membership. Where treatment has already occurred, PHIO will also check whether Informed Financial Consent was obtained by the hospital for out-of-pocket costs not covered by the insurer.

PHIO consistently finds that insurers that provide good information to their members about the rule and how it may affect them, as well as the decision to decline benefits based on the rule, have lower levels of complaints about the PEC Waiting Period.

There was a small increase in complaints about Membership Cancellation in 2013–14 (192 to 218), but pleasingly, a decline in complaints about Clearance Certificates (152 to 106). A transferring member requires a Clearance or Transfer Certificate in order to receive continuity of cover with a new insurer. The ability to transfer between insurers is an important consumer right, and having good processes in place for exchanging certificates between insurers in a timely manner is critical to allowing for a smooth transition process for consumers.

The reduction in complaints about clearance certificates was particularly pleasing because the industry has done significant work to improve clearance certificate processes across all insurers, led by the industry's Code Compliance Committee. This year's statistics suggest that the new processes introduced across the industry in late 2013 are now being reflected in lower levels of complaint to PHIO about this issue.

CONSUMER INFORMATION AND ADVICE

PHIO's consumer information services have become increasingly important in recent years. Given the pace of change in the industry itself and government policies that support private health insurance, including the Government Rebate, the availability of independent and reliable information to assist consumers to better understand private health insurance has become, and will remain, increasingly important.

Visits to the consumer website, Private Health.gov.au, continued to grow strongly during the reporting period. The website received 621,865 unique visitors during 2012–13. This figure was surpassed early in 2014, with the final tally at 899,841 unique visits during 2013–14. This was a 45% increase in unique visits on the previous year.

It is very pleasing to see website visits growing so strongly. The website is Australia's leading source of independent information about private health insurance in Australia and provides consumers with access to information about general private health insurance issues, as well as a comparison tool that enables them to review the main features of their current health insurance policy and compare it with other policies they may be interested in purchasing. It also enables consumers who are new to private

health insurance to compare and choose policies that will meet their individual needs.

In early 2014, PHIO introduced a social media channel, in the form of a Facebook page, to the PrivateHealth.gov.au website. The aim of the new channel is to provide greater accessibility for consumers who would like to interact with the office via social media. The new channel has been launched in a low-key way, in order to ensure that the office can manage and resource this method of communication with consumers.

During 2013–14, PHIO continued to produce its consumer newsletter, *Health Insurance Insider*, as well as its *Quarterly Bulletin*, which focuses on providing complaint statistics to government and industry stakeholders.

HOSPITAL CONTRACTING ARRANGEMENTS

Since 1995, health insurers and healthcare providers have been able to contract with each other for the provision of hospital services to members. These arrangements were introduced in order to enhance competition, with the aim of better managing costs within the industry.

Most of the time, these arrangements work well. The agreements allow for members to access a range of private hospitals with no or minimal gaps for accommodation and theatre fees. Agreements are renewed every few years and this is usually a relatively seamless process. These are commercial arrangements and the agreement is negotiated on the basis of the amount the insurer is willing to pay for services across the term of the contract and the amount the provider is willing to accept.

Occasionally, as with any commercial negotiation, the parties encounter difficulties in reaching agreement. If these difficulties cannot be overcome, one or other party will provide notice of termination of the agreement. At this point, both parties will often continue negotiating in the hope of finalising a new agreement. In many cases, the matter is satisfactorily resolved. In a small number of cases, however, the negotiations are unsuccessful. At this point, time may be running out for providing timely information to members about the termination of the contract.

PHIO has legislative power to require disputing parties to attend compulsory mediation in order to resolve contractual disputes of this nature. PHIO has conducted a number of mediations in recent years and in all cases the disputes have been satisfactorily resolved. PHIO was given this power in order to protect the interests of consumers, who may be disadvantaged in the event of a contract termination between their insurer and a hospital they wish to attend.

INDUSTRY DEVELOPMENTS

SALE OF MEDIBANK PRIVATE

On 26 March 2014, the government announced that Medibank Private would be sold through an initial public offering in the 2014–15 financial year.

Although this will be a significant change in the ownership of Medibank Private, the insurer will still be required to comply with the provisions that protect consumers under the *Private Health Insurance Act 2007* (Cth).

These protections include community rating and the prudential regulation of the industry. They also include the protection of having an independent Ombudsman to assist consumers to resolve complaints and provide advice to the government and industry about issues of concern to consumers.

While PHIO does not have a role in decisions about the ownership or corporate structures of private health insurers, including in relation to the sale of Medibank Private, the agency will be able to monitor and respond to enquiries about the sale and report to the government and industry stakeholders about any issues raised by consumers in relation to this issue.

ACUTE CARE CERTIFICATION

A new National Acute Care Certificate for certifying the provision of acute care to long-stay private patients in public hospitals has been

developed through a consultation process with health insurers and state health departments, led by a Working Group comprising representatives of SA and NSW Health, Medibank Private, BUPA and PHIO.

The development work on the new National Acute Care Certificate — Private Patient/Public Hospital certificate was completed in early 2014 and the certificate distributed to all health insurers and state and territory health departments. The purpose of this new private patient/public hospital acute care certificate is to minimise the transaction costs for public hospitals and health insurers when verifying and paying acute private long stay public hospital charges.

Although there is no legislative basis for imposing this new certificate, PHIO encourages all health insurers and States to fully consider its adoption. It is fit for purpose and a comprehensive uptake would result in a consistent national approach to certifying acute care for long stay private patients in public hospitals.

A review of the new certificate is planned for early 2015.

The development of the new certificate is an encouraging example of a productive collaboration between representatives of state health departments and private health insurers with PHIO's involvement.

The ultimate success of the new National Acute Care Certificate will depend on the extent to which it is voluntarily adopted by all jurisdictions and all health funds. PHIO will continue to monitor the introduction and uptake of the new certificate over the coming year and will also assist in managing the review process for the new certificate.

PHIO TO MERGE WITH COMMONWEALTH OMBUDSMAN

The Government announced in the May 2014 Budget that PHIO would be merged with the Commonwealth Ombudsman from 1 July 2015. Work to progress this merger is currently underway.

THE YEAR AHEAD

PHIO's priorities for the coming year will include a continued focus on ensuring that our complaint handling and information services meet the needs of consumers and that their interests continue to be effectively protected. This includes a continuing dialogue with those insurers whose complaints are higher overall, or have higher numbers of complaints about particular issues, in order to assist those insurers to reduce their complaints.

PHIO will also continue to ensure that independent, reliable and up-to-date information about private health insurance is available to consumers through its information and advice services, including the consumer website PrivateHealth.gov.au. This will include working with PHIO's website contractor to undertake the redevelopment of the website's Content Management System (CMS) and the upgrading of the website's hardware. This will ensure the website's continued reliability and accessibility for consumers and improve ease of use for health insurer staff inputting information into the CMS.

PHIO will work with relevant government stakeholders to ensure a smooth transition of the PHIO agency into the Office of the Commonwealth Ombudsman from 1 July 2015, so that the interests of Australia's ten million health insurance consumers can continue to be effectively protected.

Role and Function

INTRODUCTION

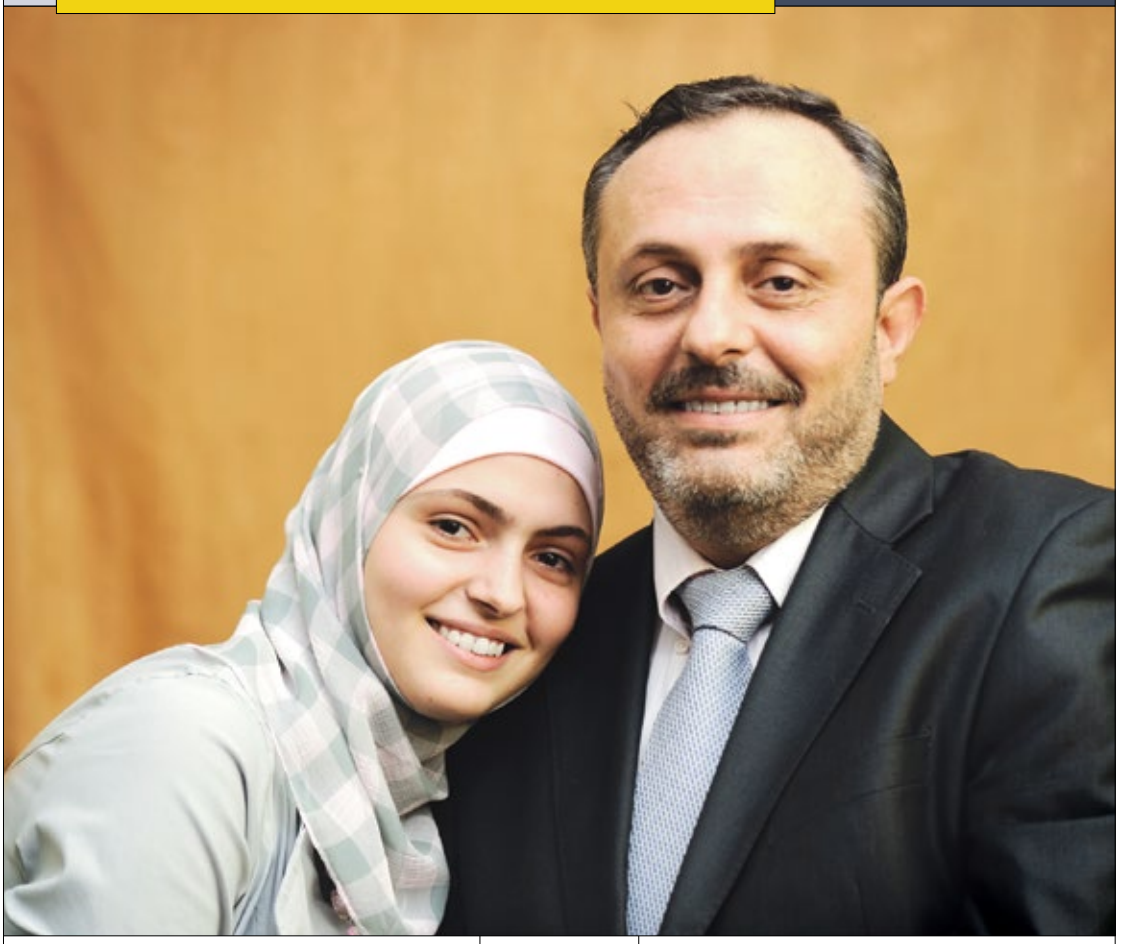
The Private Health Insurance Ombudsman is a statutory agency established under the *Private Health Insurance Act 2007* (Cth). The role of the Ombudsman is to protect the interests of consumers in relation to private health insurance.

FUNCTIONS

The Ombudsman is an independent body that resolves complaints about private health insurance and acts as the umpire in dispute resolution at all levels within the private health industry. The Ombudsman also reports and provides advice to industry and government about issues affecting consumers in relation to private health insurance, and has an important consumer information and advice role.

The functions of the Ombudsman, as outlined in section 238-5 of the *Private Health Insurance Act 2007* (Cth), 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;
- Report to the Minister or the Department about the practices of particular private health insurers, private health providers and private health insurance brokers or other related parties;
- Collect and publish information about complying health insurance products (i.e. manage the consumer website PrivateHealth.gov.au);
- Promote a knowledge and understanding of the Ombudsman's functions; and
- Undertake any other functions that are incidental to the performance of any of the preceding functions.



WHO CAN MAKE A COMPLAINT?

Generally, anyone can make a complaint, as long as the complaint is relevant to private health insurance. The objective of the PHIO 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.

OBJECTS OF COMPLAINT

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

WHAT CAN THE OMBUDSMAN DO WITH A COMPLAINT?

The Private Health Insurance Ombudsman is able to deal with complaints by:

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

The Ombudsman is also able to investigate the practices and procedures of health insurers,

health care providers and health insurance brokers, and the Minister is able to request the Ombudsman to undertake such an investigation.

WHAT HAPPENS AT THE END OF A COMPLAINT OR INVESTIGATION?

At the end of a complaint or investigation, the Ombudsman is able to recommend that:

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

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

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

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

HOW THE OMBUDSMAN'S STAFF RESOLVE COMPLAINTS

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

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

Staff members regularly keep complainants informed of developments about complaints, usually by telephone. The Ombudsman will advise complainants of the outcome of a complaint lodged with the Ombudsman by phone, letter or e-mail.

Complainants may seek a review of their case if they are not satisfied with the response, or seek further clarification of the reasons for a decision.

86%

Percentage of clients that were satisfied or very satisfied with the handling of their complaint in 2013-14.

Performance

PERFORMANCE INDICATORS

The 2013–14 Portfolio Budget Statements (PBS) indicate that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 9, Private Health: Improved choice in health services by supporting affordable quality private health care, including through private health insurance rebates and a regulatory framework.

PHIO contributes to this outcome by protecting the interests of private health insurance consumers. PHIO promotes public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting

PHIO carries out this role through its independent complaints handling service by identifying underlying problems in the practices of private health insurers or health providers relevant to the administration of private health insurance. PHIO provides advice to the Australian Government about issues affecting consumers in relation to private health insurance. PHIO also provides consumers with information and advice regarding private health insurance.

The PBS outlines the Ombudsman's program to promote public confidence in private health insurance. The program objectives are to:

- Protect the interests of private health consumers;
- Improve the quality and accessibility of private health insurance information; and
- Provide an efficient and effective complaints handling service.

The following is a summary of performance outcomes against the program's formal performance indicators in 2013–14:

DELIVERABLES

PROTECT THE INTERESTS OF HEALTH INSURANCE CONSUMERS

Qualitative Deliverable	2013–14 Reference Point or Target	2013–14 Result
Investigate the practices and procedures of health insurers	Investigation and mediation of complaints as required	PHIO staff worked closely with industry stakeholders to identify and address systemic issues causing complaints within a specific insurer or the industry as a whole; PHIO staff members were also involved in mediating complaints between health insurers and healthcare providers.

PROTECT THE INTERESTS OF HEALTH INSURANCE CONSUMERS

Quantitative Indicators	2013–14 Reference Point or Target	2013–14 Result
Number of high-quality and timely advisory services, policy advice, submissions and reports	>12	>12

IMPROVE THE QUALITY AND ACCESSIBILITY OF PRIVATE HEALTH INSURANCE INFORMATION

Qualitative Deliverable	2013–14 Reference Point or Target	2013–14 Result
Publish the annual *State of the Health Funds Report*	The *State of the Health Funds Report* is published by PHIO by 31 March 2014	Report published on 31 March 2014, available at Phio.gov.au.
Provide consumers with accurate and up-to-date information.	Regular and timely updates of the private health consumer website (PrivateHealth.gov.au) and production of private health insurance fact sheets	Website regularly updated in response to industry changes and issues of concern to consumers. Over 80% of surveyed users found the website easy to use and of good quality.

KEY PERFORMANCE INDICATORS

PROTECT THE INTERESTS OF HEALTH INSURANCE CONSUMERS

Qualitative Indicators	2013–14 Reference Point or Target	2013–14 Result
Production of high-quality and timely advisory services, policy advice, submissions and reports	Positive stakeholder feedback on information products	Consumer brochures were sent directly to consumers, accessed online, and also distributed by health insurers, hospitals and providers, with approximately 70,000 brochures distributed throughout the year. The consumer website received 899,841 unique visitors throughout the year, an increase of 45% on the previous year.

IMPROVE THE QUALITY AND ACCESSIBILITY OF PRIVATE HEALTH INSURANCE INFORMATION

Qualitative Indicators	2013–14 Reference Point or Target	2013–14 Result
Provide independent and reliable information to consumers via the private health insurance consumer website (PrivateHealth.gov.au)	Measured by website survey and consumer focus testing which indicates that information provided is viewed as independent and reliable	88% of surveyed website clients rated information as easy to find and 83% rated the information as being of very good or satisfactory quality.

PROTECT THE INTERESTS OF PRIVATE HEALTH INSURANCE CONSUMERS

Quantitative Indicators	2013–14 Budget Target	2013–14 Result
Percentage of recommendations that have resulted in changes to insurer or industry practices	75%	Not applicable as no formal recommendations regarding industry practices were made in 2013–14. One recommendation was made to a hospital regarding a suggested course of action for resolving a complaint. The hospital accepted the recommendation.

DELIVER A CONSUMER COMPLAINTS HANDLING SERVICE

Quantitative Indicators	2013–14 Budget Target	2013–14 Result
Percentage of clients satisfied with complaint handling service	85%	86%

COMPLAINTS

The Ombudsman received 3427 complaints during 2013–14, a 16% increase on the 2955 complaints received in 2012–13. After several years where complaint levels remained steady, this was a significant increase.

Of those complaints, 580 (17%) were classified as Level 3 Disputes, similar to last year's 450 (15%). Level 3 complaints are those where a member of the Ombudsman's dispute resolution staff acts on behalf of a complainant by requesting a detailed report from a health insurer or other object of a complaint. The report is then reviewed and a decision is made as to whether the initial response was satisfactory or whether a further investigation is warranted.

FIGURE 1 shows the distribution of complaints over the four quarters of the 2013–14 financial year. **FIGURE 2** shows the total number of complaints received per year since 1999–2000. The increase in the number of complaints in the 2000–01 year was associated with a large increase in the number of Australians covered by private health insurance following the introduction of the 30% Health Insurance Rebate and Lifetime Health Cover.

The reduction in complaints after 2002–03 is mostly attributable to a decline in complaints about premium increases and improvements to complaint handling processes within the health insurance industry.

FIGURE 1—Complaints by Quarter

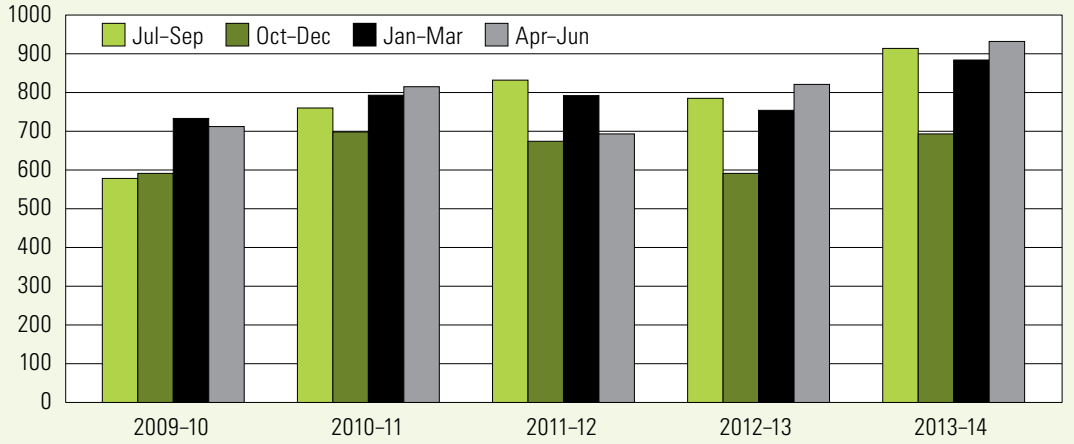
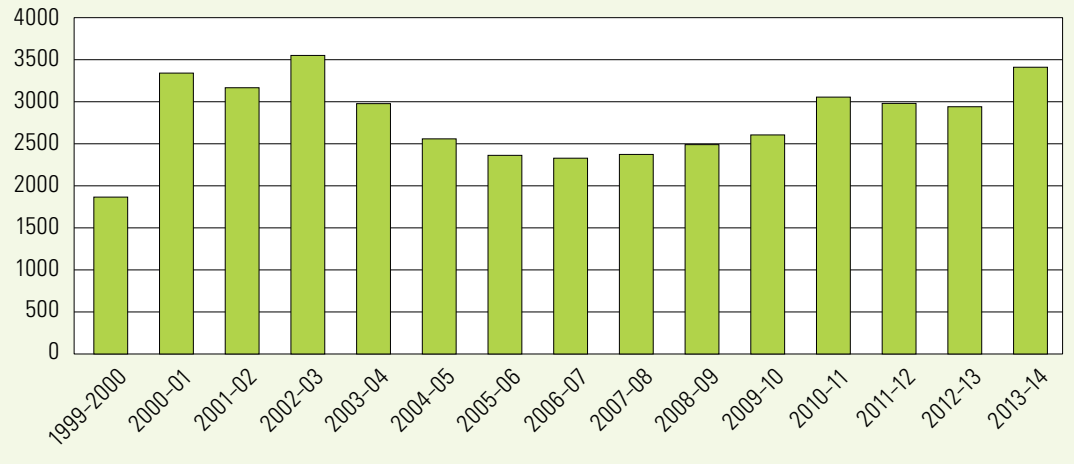


FIGURE 2—Complaints by Year



CONSUMER ENQUIRIES: THE OMBUDSMAN'S CONSUMER EDUCATION FUNCTION

Enquiries are instances where the Ombudsman's staff provide advice or information where the matter does not meet the definition of a complaint. The PHIO recorded a total of 2623 consumer enquiries in 2013–14, compared to 2175 in 2012–13.

Over 60% of enquiries were received via the Ombudsman's consumer website PrivateHealth.gov.au. Using the 'Ask a Question' feature on the website, consumers can contact the Ombudsman by filling out a form, and generally receive a response within one to two working days.

An increase in enquiries occurred in March 2014, when health insurers sent out their rate increase letters to members and changes to the Australian Government Private Health Insurance Rebate took effect, and in June 2014, with the commencement of the Department of Health's annual Lifetime Health Cover mailing. These factors caused heightened consumer awareness of private health insurance in those periods. (See the Consumer Website section for more information.)

RECORDING AND CATEGORISATION OF COMPLAINTS

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

Complaints dealt with by the Ombudsman range from simple contacts that do not require investigation and can be referred to the service provider for resolution, through to matters requiring mediation or a formal recommendation under the Act. The Ombudsman's complaints categorisation takes account of the following factors:

- Type of approach;
- Degree of effort required by Ombudsman staff to resolve the matter; and
- Any potential sensitivity.

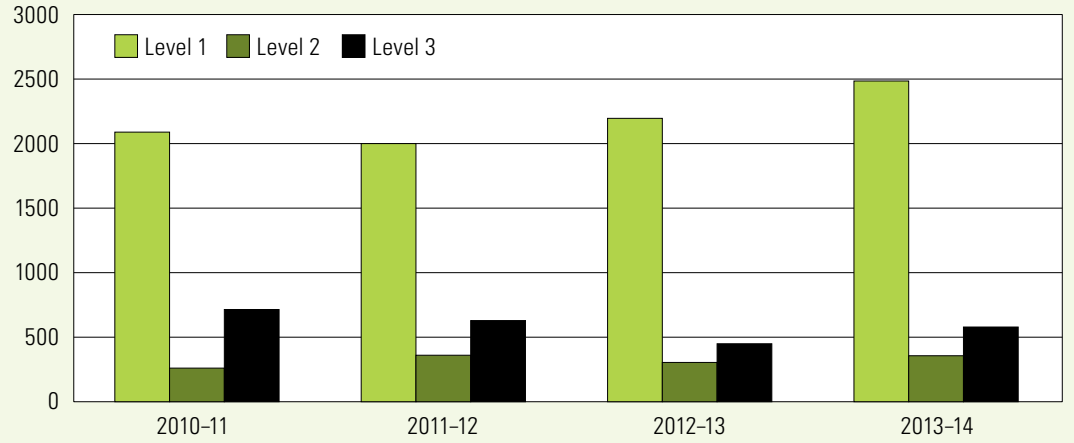
Currently complaints are categorised as follows:

COMPLAINT LEVEL 1 (PROBLEMS): MODERATE LEVEL OF COMPLAINT

Level 1 complaints are dealt with by referring the complainant back to the health insurer, health care provider or health insurance broker which is the object of complaint. 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 of approaching the problem. Issues within this category may fall anywhere across the whole complaint range including product description, benefits paid, informed financial consent, pre-existing ailments and service quality.

In 2013–14, 77% of Level 1 complaints were resolved as 'Assisted Referrals,' where the Dispute Resolution Officer referred a complaint directly to a specifically arranged representative in the insurer or service provider on behalf of the complainant. When this occurs, the officer will counsel the complainant, advise them of the

FIGURE 3—Complaints by Level



complaint process and timeframes, ensure the complaint is responded to by the other party, and offer to investigate the complaint at a later date if the matter is not resolved.

This approach ensures a quicker turnaround time and enables the appropriate person within an organisation to assist the complainant. The Ombudsman's client satisfaction survey indicates that complainants are more often satisfied with the office if assistance is provided by staff members in this way.

Complainants are always advised that if they are not satisfied after their health insurer or health care provider contacts them, the Ombudsman can then contact the other party and ask for a report in order to review the complaint. When this occurs, the complaint is reclassified as a Level 3 complaint.

COMPLAINT LEVEL 2 (GRIEVANCES): MODERATE LEVEL OF COMPLAINT RESOLVED WITHOUT REQUIRING A REPORT FROM THE OBJECT OF THE COMPLAINT

Level 2 complaints are dealt with by staff investigating issues of grievance and providing additional information or a clearer explanation directly to the complainant.

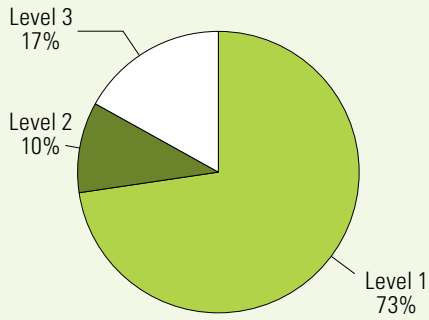
Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy they have purchased, including concerns about service levels provided by the insurer or provider, price increases, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

COMPLAINT LEVEL 3 (DISPUTES): HIGHEST LEVEL OF COMPLAINT WHERE SIGNIFICANT INTERVENTION IS REQUIRED

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

FIGURE 3 and **FIGURE 4** show the ratio of complaints by level. This year, 2490 complaints were classified as Level 1, 357 as Level 2, and 580 as Level 3. While the overall numbers of complaints rose in 2013–14, the proportion of complaints in each level remained steady. Level 3 complaint levels have steadily decreased in recent years, as most cases are resolved by direct referral to the fund.

FIGURE 4—Complaints by Level, 2013-14



COMPLAINT AUDIT AND ESCALATION

During the reporting period, approximately one-quarter of the Level 3 complaints reported were initially recorded as Level 1 complaints. These were upgraded to the higher level category either because the complainant was not satisfied with the insurer's initial response or if further investigation of the matter was required.

A complaint's categorisation may be changed from Level 1 to 3 during the Ombudsman's continuous audit process. Complaints are audited by a senior member of staff, who reviews details of the complaint to ensure the complainant's concerns have been addressed and that the categorisation of complaints is accurate and consistent. If the audit shows, for example, that a complaint initially thought to be a simple (assisted referral) complaint turned out to be a more complex matter requiring further investigation, it is reclassified as a Level 3 complaint.

COMPLAINTS HANDLING PROCEDURES

The process and timeframes for the different complaint categories are shown in **FIGURE 5**. The majority of complaints are from members of health insurers about their own insurer. However, there are instances where a complaint needs to be recorded against both the health insurer and a health care provider. This occurs, for example, where the complaint involves contradictory advice from an insurer and a hospital about how much of a hospital bill will be paid by the insurer.

Health insurer members can also lodge complaints about health care providers, including:

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

FIGURE 5—Steps in Handling Approaches to the Ombudsman

Complaint	Timeframe	Actions	Outcomes
Level 1 (Problem)	Immediate.	If complainant has made insufficient effort to resolve the matter with insurer or provider, refer complaint to insurer on behalf of complaint or empower the complainant to take the matter up directly.	Referral to health insurer or provider. Complainant may also contact PHIO and request a review; these matters may then be upgraded to a Level 3 complaint (Dispute).
Level 2 (Grievance)	Usually within 24 hours.	Complainant provided with explanation or information to resolve matter, or explanation if there is no avenue for the Ombudsman to take up the matter.	Detailed information provided which appropriately resolves the issue.
Level 3 (Dispute)	Depends on the nature and complexity of matter and responses from health insurer and provider.	PHIO contacts health insurer or provider to obtain a report, then mediates the dispute between the parties or investigates the matter further.	Explanation of health insurer's or provider's action; mediated resolution including payment of benefits; or formal recommendation by Ombudsman.

- Doctors (almost always about lack of informed financial consent or the gap between charges and benefits paid through Medicare and the insurer);
- Other practitioners (generally about the gap between the charges and the benefit paid on general treatment policies); or
- Health insurance brokers (usually related to information provided when joining an insurer).

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

WORKLOAD

The office received 3427 complaints in 2013–14. This was an average of 286 complaints per month, compared to 246 the previous year. Of those complaints, 580 were Level 3, compared to 450 the previous year.

The office closed 3047 complaints in 2013–14, or 253 per month, of which 570 were Level 3 complaints. In 2012–13, the office closed 3020 complaints of which 507 were Level 3.

The Ombudsman recorded 2623 consumer enquiries this year, compared to 2175 consumer enquiries the previous year.

FIGURE 6 shows the number of complaints by month and by level. The office tends to receive a high number of contacts during the March quarter each year, due to the annual premium

FIGURE 6—Complaint Level by Month

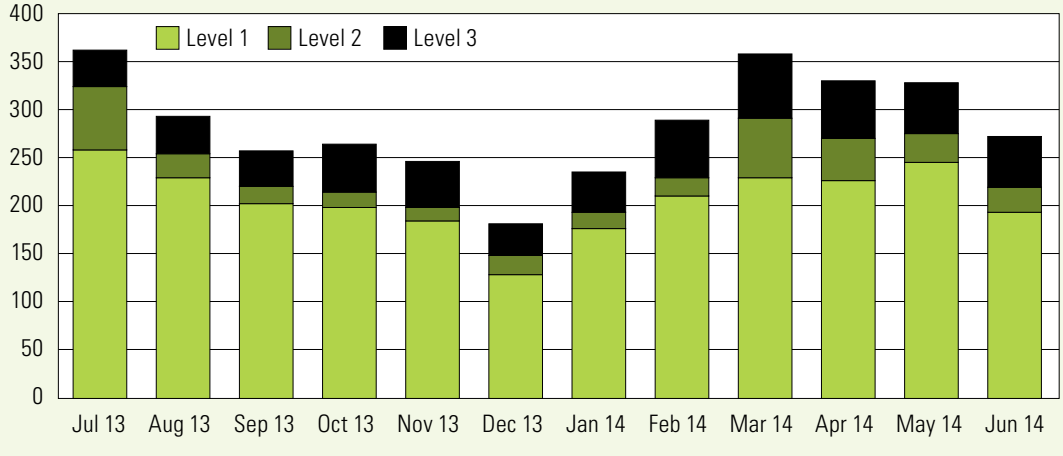
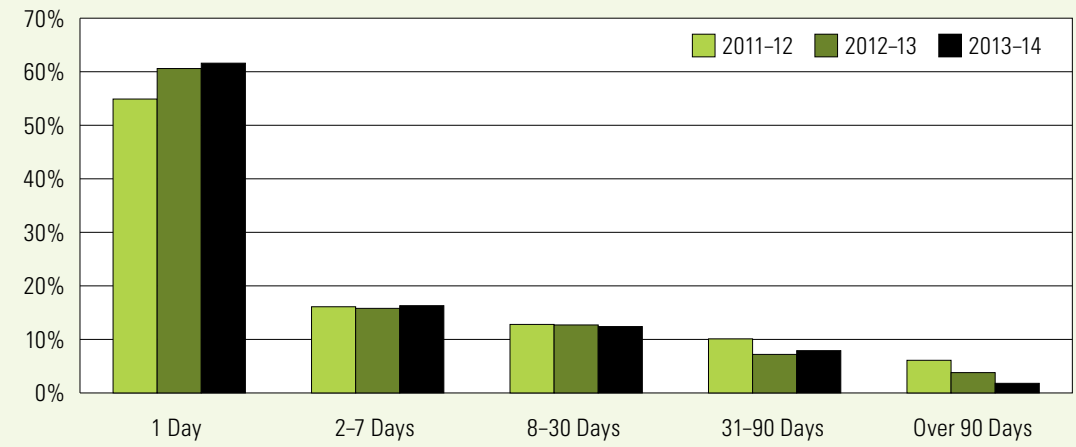


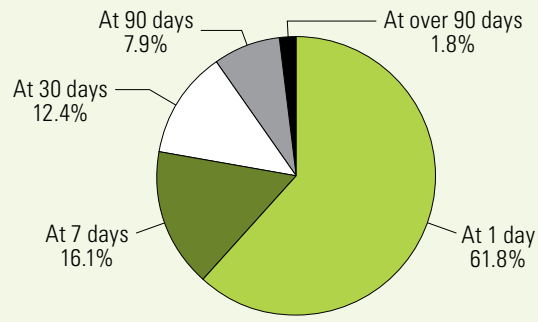
FIGURE 7—Time Taken to Resolve Complaints



increase mailings by all health insurers. However, it's important to note that most complaints concern other issues unrelated to the premium increase—it seems the annual mailings remind consumers to contact their insurer regarding existing matters.

This year there was also a significant level of private health insurance awareness amongst consumers due to health insurance advertising about the Lifetime Health Cover deadline and changes to the Australian Government Private Health Insurance Rebate.

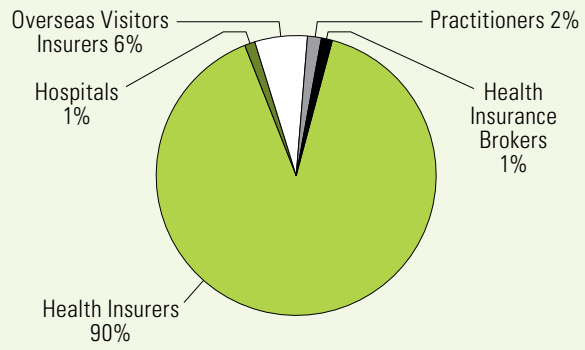
FIGURE 8—Complaints Closed Since Day of Lodgement 2013–14



TIME TAKEN TO RESOLVE COMPLAINTS

FIGURE 7 and **FIGURE 8** provide information on the time taken to resolve complaints this year compared to last year. The office continues to handle the majority of complaints within one month, with 90.3% finalised within 30 days, a similar figure to the 89.1% finalised within 30 days in the previous year.

FIGURE 9—Complaint Objects, 2013–14



WHO WAS COMPLAINED ABOUT

FIGURE 9 shows most complaints (90%) were made about registered health insurers, followed by overseas visitors insurers (6%), practitioners (2% including doctors, dentists and other health care providers), hospitals (1%) and health insurance brokers (1%). These figures remain steady from previous years.

FIGURE 10—Complaints by Health Insurer Market Share (2013–14)

Insurer	Complaints	Percentage of Complaints	Disputes	Percentage of Disputes	Market Share
ACA	1	0.0%	1	0.2%	0.1%
Australian Unity	163	5.6%	21	4.2%	3.2%
BUPA	1040	35.6%	231	46.6%	26.8%
CBHS	28	1.0%	4	0.8%	1.3%
CDH (Cessnock)	0	0.0%	0	0.0%	<0.1%
CUA	27	0.9%	2	0.4%	0.5%
Defence	24	0.8%	3	0.6%	1.7%
Doctors	2	0.1%	0	0.0%	0.2%
GMHBA	50	1.7%	5	1.0%	1.9%
Grand United Corporate	12	0.4%	4	0.8%	0.4%
HBF	90	3.1%	12	2.4%	7.5%
HCI	2	0.1%	0	0.0%	0.1%
Health.com.au	26	0.9%	10	2.0%	0.3%
Health Insurance Fund of Australia	23	0.8%	3	0.6%	0.6%
HealthGuard (GMF/Central West)	5	0.2%	0	0.0%	0.5%
Health-Partners	11	0.4%	0	0.0%	0.6%
HCF (Hospitals Contribution Fund)	357	12.2%	52	10.5%	10.8%
Latrobe	13	0.4%	2	0.4%	0.7%
Medibank (AHM)	622	21.3%	85	17.1%	29.4%
Mildura	3	0.1%	0	0.0%	0.2%
National Health Benefits (Onemedifund)	2	0.1%	0	0.0%	0.1%
Navy	1	0.0%	0	0.0%	0.3%
NIB	307	10.5%	43	8.7%	7.8%
Peoplecare	13	0.4%	2	0.4%	0.5%
Phoenix	2	0.1%	0	0.0%	0.1%
Police	4	0.1%	0	0.0%	0.3%
Queensland Country Health	1	0.0%	0	0.0%	0.3%
Railway and Transport	13	0.4%	3	0.6%	0.4%
Reserve	0	0.0%	0	0.0%	<0.1%
St Lukes	9	0.3%	2	0.4%	0.4%
Teachers Health	49	1.7%	10	2.0%	1.9%
Teachers Union	4	0.1%	0	0.0%	0.4%
Transport	2	0.1%	0	0.0%	0.1%
Westfund	18	0.6%	1	0.2%	0.7%
	2924		**496**		

COMPLAINTS ABOUT REGISTERED HEALTH INSURERS

FIGURE 10 provides a summary of all complaints (Levels 1, 2 and 3) for individual health insurers compared with their market share. This data is also presented for the higher category Level 3 complaints (Disputes). Analysing the information at this further level of detail provides a more realistic picture of the way insurers respond to their members' complaints. A high ratio of Level 3 complaints compared to market share points to a less than adequate internal dispute resolution process for complex issues within the insurer.

COMPLAINTS ABOUT HOSPITALS

The Ombudsman received 40 complaints about hospitals, a slight decrease on the 47 complaints received in the previous year.

Complaints about hospitals usually occur when patients experience unexpected gaps for a hospital admission. In most cases, there are adequate processes in place in private hospitals to ensure the provision of Informed Financial Consent (IFC) to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year. In 2013–14, the office recorded 40 IFC complaints relating to hospital bills, a decrease from the 54 complaints of the previous year.

Most consumers who face hospital gap charges are those who hold policies with restrictions or exclusions on certain treatments, or who were admitted to hospital within their waiting periods. The office also assisted a small number of consumers who were asked to pay unexpected hospital gaps because their health insurer did not have a contractual agreement with the hospital they were intending to visit.

90.3%

Percentage of complaints finalised by PHIO within 30 days.

COMPLAINTS ABOUT PRACTITIONERS

Most complaints about doctors and practitioners concerned medical gap issues and/or a lack of Informed Financial Consent (IFC).

It was pleasing to see that IFC complaints against practitioners (including doctors, dentists and other practitioners) decreased to 25 this year, compared to 41 in the previous year.

COMPLAINTS ABOUT HEALTH INSURANCE BROKERS

Complaints about brokers concern issues relating to the information provided on joining and the level of cover chosen. There were 42 complaints about brokers in 2013–14, compared to 34 complaints the previous year.

The major cause of complaint against brokers was the provision of oral advice to people joining or transferring between health insurers. After switching between funds or joining for the first time, these consumers later found that brokers had supplied incorrect or incomplete details about their new policies, leaving them with unexpected exclusions and restrictions or waiting periods to complete. Administrative delays and service issues for members trying to cancel existing or new policies was also a significant cause of complaint against brokers.

RESOLVING COMPLAINTS

FIGURE 11 shows 25% of all complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint. A further 57% of all complaints were referred directly to health insurers with the assistance of the Ombudsman's staff, on the understanding that the complainant could request a review of the complaint by the Ombudsman if they remained unsatisfied. The Ombudsman's arrangements for assisted referrals are designed to allow complainants and insurers to quickly resolve the majority of complaints using an informal approach, where the Ombudsman may suggest ways for the complaint to be resolved. Complainants are made aware that if they remain dissatisfied with the response they receive via the informal referral process, they are able to approach the Ombudsman again for a review of their case.

Nine per cent of complaints were resolved by standard referral — that is, the complainant obtained advice from the Ombudsman's office and then referred their complaint to the appropriate body themselves. In 3% of cases, the health insurer resolved the issue by making a payment, and 4% were resolved by another satisfactory outcome.

FIGURE 11 — Outcomes — All Complaints

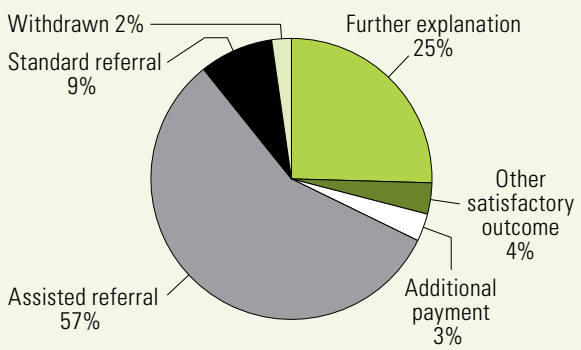
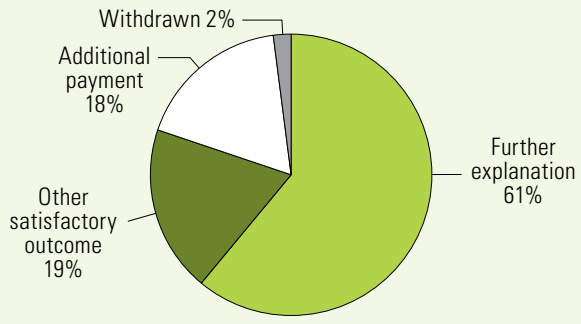


FIGURE 12 — Outcomes — Level 3 Disputes



RESOLVING LEVEL 3 COMPLAINTS

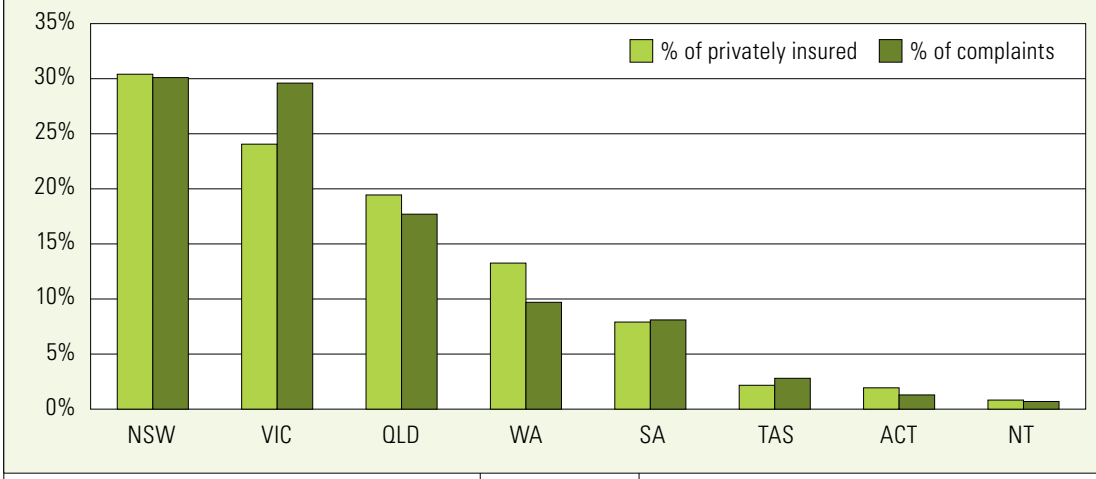
In relation to higher Level 3 complaints investigated by the Ombudsman, **FIGURE 12** shows 61% were resolved by giving a more detailed explanation to the member; 2% were withdrawn by the complainant; and the remaining 37% were resolved by a payment or other satisfactory outcome.

These payments usually followed an investigation by the Ombudsman where the health insurer agreed that a member was entitled to a benefit payment or some other payment. In some cases, payment was made by health insurers on an ex gratia basis; for instance, where the insurer paid a benefit the member was not entitled to under their policy. Some complaints were resolved by a hospital agreeing to reduce an account because Informed Financial Consent to out-of-pocket gaps had not been obtained from the member.

WHO COMPLAINED

The *Private Health Insurance Act 2007* (Cth) allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. The overwhelming majority of complaints were made by health insurance members (3395 or 99%). A further 24 complaints were made by practitioners, 7 by hospitals and 1 from a health insurer.

FIGURE 13—Complaints by Population Covered by State or Territory



HOW COMPLAINTS WERE MADE

Although the majority of complaints continue to be lodged by telephone, the proportion of complaints received online by internet or e-mail has risen steadily. In 2013–14, 59% of complaints were initially made by phone and 40% by internet or e-mail, compared to 60% of complaints being made initially by phone and 38% by internet or e-mail in the previous year.

Other methods of complaint continued to be very low. Complaints by letter dropped from 1.7% to 0.85%; and the remainder of other complaint mediums—including fax, personal visit, and parliamentary representation—comprised less than 0.5%, as in the previous year.

COMPLAINTS BY STATE OR TERRITORY

FIGURE 13 identifies where complaints originate on a state-by-state basis. This data is shown by state and territory, against the percentage of people who have private health insurance coverage. The figures show that, proportionally, Victorians and Tasmanians were more likely to have a health insurance complaint than other states.

INVESTIGATIONS

From 1 July 2012 to 30 June 2013 there were no formal investigations under section 244 of the *Private Health Insurance Act 2007* (Cth).

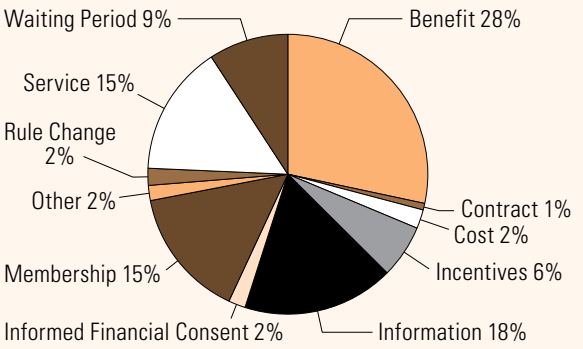
Complaint Issues and Case Studies

INTRODUCTION

Complaints to the Ombudsman must first meet the requirements of section 241-10 of the *Private Health Insurance Act 2007* (Cth), which states that the complaint must be about a health insurance arrangement. For reporting purposes, complaints are classified in terms of broad issues and sub-issues. Most complaints are about benefits, followed by information, service issues, membership issues, and waiting periods. **FIGURE 14** and **FIGURE 15** illustrate the proportion of complaints corresponding to each issue type. **FIGURE 16** shows the number of complaints received for each sub-issue this year compared to the previous year.

The number of complaints registered with the Ombudsman in 2013–14 was higher than the previous year—3427 compared to 2955. Complaints in recent years have remained at higher levels than prior to 2010, but higher level complaints requiring investigation by PHIO have gradually declined. A key function of the Ombudsman's office is to monitor the levels of complaint over time and investigate the causes of consumer dissatisfaction.

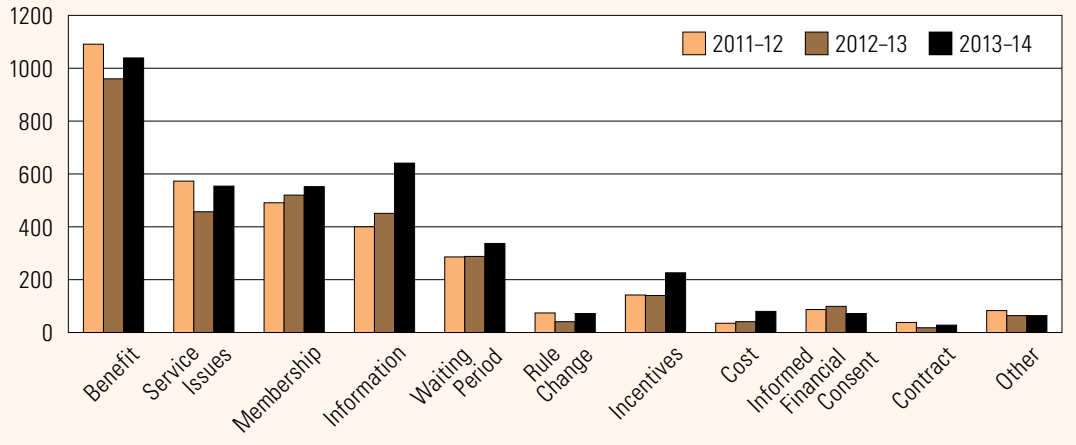
FIGURE 14—Complaint Issues, 2013–14



HOW CASE STUDIES ARE CHOSEN

The following case studies highlight some of the regular complaints received by PHIO, rather

FIGURE 15—Complaint Issues, 2011–12 to 2013–14



than the most difficult or unusual cases. They have been chosen to illustrate the lessons that can be learned from complaints by both health insurers and consumers. The names, references and some details have been changed as needed to protect the privacy and confidentiality of individuals.

BENEFITS AND LEVEL OF COVER

Complaints	Key issues
1039	– Hospital policy exclusions and restrictions – Delays in payment – Insurer rules that limit benefits

The most significant area of complaint to the Ombudsman's office was benefits, with a total of 1039 complaints in 2013–14, up from 960 complaints for 2012–13. The main issues of concern for consumers were hospital policies with unexpected exclusions and restrictions. Some basic and budget levels of hospital cover, in particular, exclude or restrict services that many consumers assume are routine treatments or standard items. Delays in benefit payments and complaints about insurer rules that limited benefits were the other significant areas of complaint. A complete list of the issues classified as benefit complaints is provided in **FIGURE 16** of this Report.

CASE STUDY: PROVIDING INCOMPLETE INFORMATION ABOUT BENEFITS

Some hospital policies have complex rules for the payment of benefits, with some services fully covered and a list of other services paid at a significantly lower level. When a health insurance consumer is seeking information about their hospital benefits, it is important for the insurer to ask the right questions so they can give their member accurate advice. A consumer may not always know what questions they need to ask, so it's important for the insurer to take the initiative to ensure the member is aware of important information about what is covered under their policy.

Anita and her husband were planning on starting a family. After contacting several insurers, they obtained a number of quotes for cover that included pregnancy. Anita made sure she chose a policy that covered pregnancy and fertility treatments, which was lower in price but similar in cover to the more expensive quotes she had received.

The following year, Anita was advised by her doctor that she should undergo some minor investigative procedures because she was having difficulty conceiving. She received an estimate of fees from her doctor, which included a list of three Medicare item numbers that identified the procedures to be performed. Her doctor asked her to check with her health insurer to see what benefits would be payable on those items.

On telephoning the health insurer, Anita was advised that the three Medicare item numbers on her quote would be covered by her policy.

The procedure was performed as planned, but an additional item number for fertility investigations was added to the final bill sent to the insurer. When the insurer assessed the account, it paid only a portion of the charges because procedures deemed to be fertility investigations were restricted on Anita's policy.

Anita received an account for $1100 from the hospital, which advised her that her health insurer had deemed her procedure to be eligible only for restricted benefits. Confused by this information, Anita contacted her health insurer. Her health insurer advised that benefits had been paid correctly, and that during her earlier phone conversation with the insurer in which she had been told she would be covered, she had not quoted the additional item number.

Not satisfied with the health insurer's response, Anita contacted PHIO for assistance. PHIO noted that the policy that Anita had chosen included complex rules for the payment of benefits for pregnancy and fertility services, although the insurer's records clearly showed it had sold her the policy on the basis that she would be covered for such procedures.

In its initial response to PHIO, the insurer agreed that clearer advice could have been provided to Anita. The insurer considered,

FIGURE 16—Complaint Sub-issues

Benefit	2012–13	2013–14
Accident and emergency	15	23
Accrued benefits	7	4
Ambulance	37	36
Amount	32	58
Delay in payment	157	147
Excess	40	48
Gap—Hospital	32	23
Gap—Medical	56	38
General treatment (extras/ancillary)	69	78
High cost drugs	15	11
Hospital exclusion/restriction	180	242
Insurer rule	140	152
Limit reached	22	28
New baby	7	11
Non-health insurance	15	19
Non-health insurance—overseas benefits	9	8
Non-recognised other practitioner	26	16
Non-recognised podiatry	19	15
Other compensation	6	10
Out of pocket not elsewhere covered	16	12
Out of time	15	15
Preferred provider schemes	36	44
Prostheses	12	10
Workers compensation	2	1

Contract	2012–13	2013–14
Hospitals	13	15
Preferred provider schemes	3	9
Second tier default benefit	2	4

Cost	2012–13	2013–14
Dual charging	3	2
Rate increase	38	78

Informed Financial Consent	2012–13	2013–14
Doctors	41	25
Hospitals	54	40
Other	5	7

Incentives	2012–13	2013–14
Lifetime Health Cover	106	163
Medicare Levy Surcharge	12	21
Rebate	10	39
Rebate tiers and surcharge changes	13	5

Information	2012–13	2013–14
Brochures and websites	53	65
Lack of notification	55	96
Oral advice	289	410
Radio and television	1	2
Standard Information Statement	11	5
Written advice	45	66

Membership	2012–13	2013–14
Adult dependents	7	15
Arrears	43	93
Authority over membership	14	16
Cancellation	192	218
Clearance certificates	152	106
Continuity	56	72
Rate and benefit protection	8	5
Suspension	55	41

Service	2012–13	2013–14
Customer service advice	63	52
General service issues	111	207
Premium payment problems	144	141
Service delays	151	164

Waiting Period	2012–13	2013–14
Benefit limitation period	2	5
General	28	34
Obstetric	35	47
Other	16	22
Pre-existing conditions	207	229

FIGURE 16—Complaint Sub-issues (continued)

Other	2012–13	2013–14
Access	0	0
Acute care certificates	1	1
Community rating	0	1
Complaint not elsewhere covered	37	33
Confidentiality and privacy	9	12
Demutualisation/ sale of health insurers	1	2
Discrimination	3	1
Medibank sale	0	1
Non-English speaking background	0	0
Non-Medicare patient	7	3
Private patient election	6	10
Rule change	41	72

however, that Anita should have advised the insurer's staff member that the procedures she was enquiring about were related to fertility treatments.

After investigating the matter, PHIO's view was that it was the staff member's responsibility to ensure they understood the procedure Anita was having done, particularly given the restrictions on the policy. If the staff member was unsure about what the item numbers were for, they should have asked Anita for more information.

When a consumer contacts a health insurer for advice about their policy, they are relying on full advice being provided. The health insurer is in a much better position to understand what information is relevant to a benefit payment. In this case, Anita had correctly answered the questions asked and, through no fault of her own, had received a lower benefit than she expected. The insurer staff member should have advised Anita that the item numbers would only be fully covered if the treatment was not related to fertility treatment or asked her if the treatment was fertility related before providing her with benefit information.

The insurer and hospital agreed to settle the account between them without Anita being required to pay the $1100 she had been billed.

INFORMATION COMPLAINTS

Complaints	Key issues
641	– Oral advice provided by health insurer staff members – Records or sales and benefit quote advice not being kept – Brochures, websites and health insurer notification letters

Information complaints are usually brought to the office by consumers because they have misunderstood oral advice or written information provided by an insurer in relation to benefit amounts or the inclusions and exclusions on a policy. A total of 641 information complaints were received this year, which represented a significant increase on the 451 complaints in the previous year. Oral advice provided by customer service staff at health insurers made up the majority (63%) of these complaints.

As noted in the Ombudsman's Overview, most of the increase in complaints about information issues is attributable to an increase in complaints by members of a large insurer and was not industry wide. The Ombudsman has provided further comment about this issue in her Overview.

MEMBERSHIP ISSUES

Complaints	Key issues
552	– Cancellation of policies and refunds – Obtaining clearance certificates – Premium arrears

Issues with membership and policy administration increased slightly from the previous year, with 552 complaints this year, compared to 520 complaints in the previous year. Almost 38% of these complaints were related to problems experienced by people in processing the cancellation of their health insurance policies. It was pleasing to see a reduction in complaints about difficulties in obtaining Clearance Certificates, down to 19% from last year's figure of 29% of membership complaints. The Ombudsman has also commented on this issue in her Overview.

CASE STUDY: PREMIUM PAYMENT ISSUES AND POLICY CANCELLATION

When a consumer contacts an insurer to request special consideration in relation to payment of a claim or premium payments, it is important for the insurer to be clear about the new terms that will apply. Once an agreement has been made, over the telephone or in writing, it will override any standard rules that insurers generally supply in their membership guides or brochures.

Gerri was having a difficult time keeping up to date with bill payments, particularly her family's private health insurance policy. After reading her insurance brochure which advised calling to discuss payment problems, she telephoned her insurer. She discussed her situation with a staff member at the insurer, and the staff member agreed to allow her to put the payments on hold and to catch up whenever she could.

Unfortunately, in the month following Gerri's phone call, the health insurer's computer system continued to attempt to debit the full premium payment for a month in advance, and then attempted to debit the arrears. As Gerri had insufficient funds in her bank account, the direct debit request was rejected and the insurer sent her a notification letter. Gerri contacted the insurer in response to the letter. The insurer staff member advised her to ignore the letter and that she could still pay her membership payments at a later date.

The following month, however, the health insurer's computer system attempted another direct debit of what was now a large amount of money. When this debit was also rejected, the health insurer sent Gerri a letter advising that her direct debit authority had now ceased.

Shortly afterwards, Gerri contacted the insurer to make some payments to the membership. She was now told that she would be required to pay the whole arrears amount at once. Not happy with this response, given the previous assurances that she could repay her arrears over time, she decided to ignore the customer service officer's advice and went online to make a payment that would cover a large portion of the arrears. The health insurer's online payment system accepted the payment.

Gerri then called her insurer to find out where her membership was now paid up to, following her online payment. During that call, however, she was advised that her membership was now closed and that her online payments would be refunded. The insurer's staff member told her that she had to keep her membership payments up to date in order for the policy to remain active and as she had not done this, her policy had been cancelled. In response to her complaint, the insurer directed her to the membership guide

The Ombudsman's Dispute Resolution team: Emma Howes, Kaylie Blyton, Jim Robertson, Jaye Nang and Kate Hocknull.

where it advised policy holders that premiums must be kept up to date to maintain membership.

Gerri then asked PHIO for assistance. PHIO's dispute resolution officer investigated the first phone call in which Gerri had asked for consideration in relation her premium payments. He noticed that the insurer had agreed to allow Gerri to take her time with her payments, but had failed to advise her of any end date to this agreement or exactly how far in arrears her membership could fall behind before the membership was cancelled.

In PHIO's view, the insurer should have sent a written confirmation of the new agreement it had made with Gerri to allow her membership to fall into arrears. Under the circumstances, Gerri could reasonably assume that the standard membership payment rules cited in her brochure did not apply to her and, in addition, she had been advised on the phone to overlook the direct debit letters.

At PHIO's request, the insurer allowed Gerri to re-instate her policy and to form a new agreement as to when the arrears would be brought up to date.

SERVICE ISSUES

Complaints	Key issues
554	– Customer service issues and administrative delays – Problems associated with direct debit systems

Another significant area of complaint to PHIO was service and payment administration, with 554 complaints, compared to 457 complaints last year. Of these, 25% were premium payment problems, usually associated with direct debit systems. The remainder were general service issues such as customer service issues or delays in service.

Service issues are not usually the sole reason for members' complaints. The combination of unsatisfactory customer service, untimely responses to simple issues, and poor internal escalation processes can cause a member to become more aggrieved and dissatisfied in their dealings with the insurer, until the service itself becomes a cause of complaint as well as the original issue.

WAITING PERIODS

Complaints	Key issues
337	– Pre-existing condition disputes – Compliance with PEC Best Practice Guidelines

Health insurers are able to apply a 12-month waiting period to new members if treatment is for a Pre-Existing Condition (PEC). Details about how the PEC waiting period is applied can be obtained by referring to our brochure 'Waiting Periods' and our factsheet on Pre-Existing Conditions, which are available at Phio.gov.au or by contacting the PHIO office.

PHIO received 229 complaints about the PEC waiting period during the year, which was similar to the previous year. PHIO's role in investigating complaints about this waiting period is to ensure that the insurer has applied the waiting period correctly, and that the insurer and hospital have complied with the PEC Best Practice Guidelines. A copy of the Guidelines is available from the PHIO website.

CASE STUDY: SIGNS AND SYMPTOMS OF A PRE-EXISTING CONDITION

A pre-existing condition is defined as any ailment, illness or condition where, in the opinion of a medical advisor appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of 6 months prior to the person becoming insured under the policy. In order to decline a claim during the first year of membership, the insurer needs to show that the signs or symptom were apparent prior to the commencement of the person's policy or upgrade.

The rule is stricter than many patients and indeed doctors realise — it is not necessary

for the patient or their doctor to know what the condition was and a condition can still be classed as pre-existing even if the patient had not seen their doctor about it before joining. It is only necessary for the sign or symptom to have been present, in the opinion of a medical adviser appointed by the insurer, in the six months prior to the member joining the insurer.

Dora joined her health insurer on 16 April. On 10 May, she consulted with her GP with tiredness and headaches. Her GP referred her to a specialist for tests and scans, and in June a surgeon confirmed surgery was needed to remove an adenoma off her parathyroid gland.

Dora booked her surgery for July. When she contacted her health insurer to confirm her coverage for the surgery, the insurer asked Dora and her doctors to complete Pre-Existing Condition certificates, because she was within her first twelve months of membership and the waiting period applied.

The health insurer's medical advisor reviewed the completed certificates and concluded the condition was pre-existing. The health insurer advised Dora that she would not be covered for the surgery in July. At this point, Dora contacted PHIO.

The reason given by the insurer's medical advisor for declining the claim was that the pertinent symptom was "tiredness consistent with hypercalcaemia resulting from hyperparathyroidism." Dora was dissatisfied with this outcome because she believed tiredness was not shown to be directly linked to her thyroid issue, as many issues can cause tiredness.

As part of Dora's request for a review, she also included further medical evidence including a CT and scan from the previous year. These test results did not show any sign of an adenoma on her thyroid at a point 6 months prior to joining the insurer. As the test for pre-existing conditions is that signs or symptoms of a condition must be present in the 6 months prior to joining the policy, Dora believed that her condition was not pre-existing.

In reviewing the case, PHIO considered the evidence supplied by Dora's doctors as well as the completed Pre-Existing Condition certificates and the medical advisor's decision.

The medical certificate completed by the GP confirmed that Dora had consulted them on 10 May with symptoms of tiredness and headaches that had been present for one month. This consultation consequently led to the specialist consultation in September, which confirmed that Dora was displaying non-specific symptoms of hyperthyroidism.

Although tiredness and headaches may be symptoms of many conditions, in this case, they were specific symptoms of Dora's hyperthyroidism. As the symptoms were present by at least 10 April, prior to Dora joining the health insurer on 16 April, PHIO concluded that the insurer had applied the pre-existing condition rule correctly.

CASE STUDY: PRE-EXISTING CONDITIONS AND CONTINUITY OF MEMBERSHIP

When a person transfers from one health insurance policy to an equivalent policy, their waiting periods are usually carried over with them. For example, if they have completed 9 months of the 12-month waiting period for pre-existing conditions, then they only need to complete the remaining 3 months on the new policy.

This case study relates to a member who holds an Overseas Visitors Cover policy with an insurer that offers continuity of membership from an overseas visitors' cover to a standard domestic policy, if the member becomes a permanent resident of Australia. It should be noted that not all visitors' covers offer new migrants this concession.

Claudia had moved to Australia initially under a working visa which required her to hold a level of Overseas Visitor Cover. Her Overseas Visitor Cover provided benefits that were equivalent to Medicare benefits in Australia's public health care system, as well as private hospital benefits.

After working in her new job for several months, she decided to apply for permanent residency. When this was approved and she became eligible for Medicare, she changed her policy to a standard domestic policy offered by the same insurer.

Two months after changing her policy, Claudia consulted a doctor because she had noticed that one of her breasts was feeling tender. As a marathon runner, she was very careful with her health and always had any illnesses or injuries checked by a doctor.

Unfortunately, the doctor diagnosed that Claudia had breast cancer and advised her to undergo immediate breast surgery to remove the cancer, followed by reconstructive breast surgery. As she was within 12 months of her join date with the insurer, the insurer asked her medical practitioner and specialist to complete paperwork in order to determine when signs or symptoms of her condition had started.

After assessing the paperwork and medical notes, the health insurer's medical adviser determined that Claudia's condition was a pre-existing condition, because the size of the cancer suggested it would have been apparent two months prior to her first visit to the doctor. Accordingly, the insurer declined to pay benefits for Claudia's surgery.

On raising her complaint with PHIO, Claudia argued that she would be unlikely to have noticed a problem with her breast one day and then delay consulting a doctor about the problem for two months, given the publicity about the dangers of breast cancer and the need for self-examination. She also provided letters from her doctors, who explained that there was no lump evident when Claudia presented to them and that Claudia's case was a rare condition which could be considered to be a pre-existing condition.

The health insurer explained that nevertheless, there was sufficient information in the medical information to make it clear that there would have been sufficient signs of the breast problem before her domestic cover commenced.

In an investigation where there are differing medical opinions about when it would be reasonable to expect signs of a condition to be apparent, PHIO will usually make use of the services of an independent medical adviser or specialist. In this case, however, the PHIO dispute resolution officer questioned why the health fund was assessing Claudia's condition as pre-existing based on two months of signs and symptoms—that is, the date she had obtained Australian residency and transferred her health insurance to a domestic policy.

Previous to holding her Australian health insurance, Claudia had held an Overseas Visitor Cover policy, which had the same level of hospital benefits as her later policy. PHIO considered that the start date of Claudia's policy should be considered to be seven months prior to the date she visited the doctor's surgery with the breast tenderness the first time. Based on this,

the health insurer's medical adviser reassessed her case and concluded that there were no signs or symptoms of her condition seven months before she visited her doctor.

Based on this reassessment, Claudia's health insurer paid her claims and confirmed that her continuing treatment would be covered.

INFORMED FINANCIAL CONSENT

Complaints	Key issues
77	– Unexpected costs for hospital admission – Gaps for medical and doctors' fees

Complaints about hospitals usually occur when patients experience unexpected costs for a hospital admission, or "hospital gaps". In most cases, private hospitals have good processes in place to ensure the provision of Informed Financial Consent (IFC) to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year. In 2013–14, the office recorded 40 IFC complaints against hospitals, down from 54 the previous year.

In Australia, doctors are free to decide how much to charge for their services. Fees vary because doctors have to take into account their particular costs in delivering services and may have differing views about what represents a reasonable return for their time and skill. If a doctor charges more than the health insurer and Medicare cover, then the remainder is the patient's own cost—this is known as the "gap". Complaints about medical gaps have remained low in recent years, reflecting efforts made by doctors and medical service providers to inform patients about potential gaps whenever practicable, and health fund "gap cover" schemes, which can help to minimise out-of-pocket expenses for patients. PHIO received 25 complaints about medical gaps in 2013–14 compared to 41 the previous year.

RULE CHANGES

Complaints	Key issues
72	– Detrimental changes to policies – Adequate notice to consumers

PHIO received 72 complaints about rule changes, up from 41 rule change complaints in 2012–13. The most common complaints concerned detrimental changes to hospital policies, where the list of services that is covered by a policy is reduced by one or more services. Health insurers are permitted to alter the terms of health insurance policies, so long as the changes comply with the requirements of the *Private Health Insurance Act 2007* (Cth) and the insurer gives adequate notice of the change to consumers.

Giving adequate notice to consumers is an important obligation for insurers, as there is an opportunity for a consumer to transfer to a different health insurance policy if he or she wants to maintain cover for a benefit that would otherwise be reduced or removed. It's important for insurers to communicate detrimental policy changes in clear and unambiguous language, and without diluting the message by interspersing unrelated promotional material.

Legislation requires insurers to always provide a Standard Information Statement to a consumer whenever a detail of a policy has changed. This allows consumers to easily compare their current policy to others in the market, assisting the individual consumer and others by increasing competition in the marketplace.

CASE STUDY: FUND RULE CHANGE AND RESTRICTION OF PSYCHIATRIC BENEFITS

PHIO sometimes receives calls from patients in a vulnerable position who are attempting to access psychiatric treatment, but have been advised that there is a problem with their health insurance. The problem for this particular type of medical service is that it can be difficult for a

person to access the public system if they find that their private cover is inadequate. In addition, because of the nature of psychiatric illness, a person will find it difficult to predict when he or she will require psychiatric care.

PHIO's strong advice to consumers is not to take a policy that restricts psychiatric care unless they have carefully considered the consequences of not being covered for this service. It is important to bear in mind that psychiatric care is used to treat broad range of conditions, including depression and drug and alcohol rehabilitation. About one in five Australians will experience a mental illness at some stage in their lives and the need for psychiatric care can affect almost all age groups. The cost of paying for psychiatric treatment in a private facility can be high, if the health insurance policy restricts psychiatric treatment.

Tony was aware that he had an existing mental health issue, so he double-checked that full benefits for psychiatric treatment were included on his hospital policy when he joined five years ago.

Early this year, Tony experienced a deterioration of his symptoms and was advised to undergo in-hospital psychiatric treatment for several weeks. During the admission process at the hospital, however, he was surprised to learn that he was not fully covered for psychiatric care and that he would be required to pay approximately $600 a day towards the cost of his treatment.

Tony contacted his health insurer to ask why the hospital was asking for such a large amount of money. He was advised that during the last 12 months, his health insurance policy had imposed a restriction on benefits for psychiatric care . Tony questioned his health insurer and later PHIO about whether his health insurer was able to restrict benefits for psychiatric care on his cover.

Health insurance is a regulated industry and health insurers are required to notify policyholders of any detrimental change to their policy. Consumers are not always aware that this type of change can be made to their policy and don't always carefully read policy documents that are sent to them by their insurer. This means that they may misunderstand or overlook important letters advising them of changes to their policies.

Tony asked PHIO to investigate his complaint and to explain whether his insurer was able to make this change to his cover.

Tony's health insurer provided records showing that they had sent a letter to Tony advising of the change, as well as a revised Standard Information Statement. In addition, the health insurer had attempted to follow up with Tony via a phone call. PHIO could only conclude that the insurer had complied with its obligations under the legislation to advise Tony of the change.

Fortunately, Tony was able to delay his treatment for a short time, and the waiting period to upgrade to full psychiatric cover is only two months. The lower two month waiting period for psychiatric care, as opposed to the 12-month waiting period, which applies all other pre-existing conditions, is an important safeguard for consumers. As noted above, however, PHIO recommends that consumers give careful consideration to taking any policy which restricts benefits for psychiatric care.

HEALTH INSURER PREMIUM INCREASES

Complaints	Key issues
78	– Premium increases

The Ombudsman receives a relatively low number of premium increase complaints each year. This year, PHIO received 78 complaints about premium increases, compared to 38 in the previous year, possibly due to higher than average premium increases by several insurers. The proportion of complaints about premiums remains low, however, comprising only about 2% of all complaints.

Overseas Visitors Health Cover

Each year, the Ombudsman assists a number of consumers with complaints about Overseas Visitors Health Cover (OVHC) and Overseas Student Health Cover (OSHC) policies for visitors to Australia. These policies are not domestic 'complying health insurance policies' under the Act and these complaints are therefore not included in **FIGURE 10**, which lists complaints against each registered health insurer.

This year, the Ombudsman assisted 207 consumers with complaints about OVHC and OSHC, up from the 138 complaints received in 2012–13. Of those complaints, 44 were investigated as Level 3 Disputes, compared to 32 last year.

Most overseas visitors to Australia have no access to Medicare. Some have limited access, if they are from a country with which Australia has a Reciprocal Health Care Agreement. For visitors with no or limited Medicare access, purchasing Overseas Visitors Health Cover or an international health plan from an Australian or international provider is the only way they can be insured for services that Australians have covered under Medicare (e.g. medical services received outside of hospital and the Pharmaceutical Benefits Scheme) and private patient hospital admissions.

Unlike Australians, who have the option of using the public Medicare system if they are not covered for a treatment under their private health insurance policy, most visitors to Australia have no choice about whether they are treated at private patient rates. A public hospital admission for an uninsured, non-Medicare patient can cost over $1500 a day for the accommodation alone, in addition to which they will also incur medical fees for the doctors. Pharmaceutical items can also cost far more for visitors than they do for Medicare-eligible Australian residents, who can usually benefit from subsidised prices under the government's Pharmaceutical Benefits Scheme.

For this reason, PHIO always recommends that visitors to Australia should consider purchasing Overseas Visitors Health Cover or an international health plan.

Benefits, waiting periods, membership costs, and eligibility can vary greatly between insurers, so the Ombudsman recommends that anyone looking to take out OVHC should take care to ensure the policy they select is suitable for their needs. Information to assist overseas visitors with selecting health insurance is available at PrivateHealth.gov.au.

WHO WAS COMPLAINED ABOUT?

Some complaints were made against hospitals and providers, but the majority of complaints were registered against a small number of insurers who offer these policies. The number of complaints made for each insurer over the past three years can be seen in **FIGURE 17**.

As market share information for overseas

visitor cover is unavailable, the number of complaints against each insurer should be treated as indicative only, as the proportion of complaint numbers cannot be compared against the number of policies held. It is reasonable to expect that insurers with a higher number of policies will be the object of a higher number of complaints.

COMPLAINT ISSUES

Complaints investigated by PHIO in relation to OVHC are similar to those received about domestic policies, except for a higher proportion of complaints about waiting periods and other restrictions on the policy.

The major issues causing complaints in 2013–14 were delays in benefit payments, which comprised 15% of complaints this year compared to 10% last year, and problems with policy cancellation, which rose to 13% compared to last year's 7%. Oral advice (9%) and the pre-existing condition waiting period (11%) continued to cause a significant portion of complaints. A full list of the complaint issues and sub-issues is included in **FIGURE 18**.

FIGURE 17— Overseas Visitors Cover Complaints by Fund[1]

Insurer	2011–12	2012–13	2013–14
Australian Unity	7	15	11
BUPA	41	30	84
HBF	1	1	1
HCF	1	0	1
HIF	0	3	2
Medibank Private	37	43	44
NIB	12	11	25
Worldcare/Allianz (Lysaght Peoplecare)	29	30	32
Total	**128**	**133**	**200**

1. Complaint figures for different overseas visitors cover providers are not directly comparable to each other as market share data is not available. These figures show the number of complaints over time and it can be assumed market share numbers are relatively similar to registered domestic providers and do not greatly change from year to year.

OVERSEAS STUDENT HEALTH COVER

Overseas Student Health Cover (OSHC) was introduced in March 1989 to provide self-insured medical and hospital cover for overseas students and their dependants. Five insurers hold Deeds of Agreement with the Department of Health to offer OSHC, including Australian Health Management, BUPA Australia, Lysaght Peoplecare (formerly OSHC Worldcare, subcontracting to Allianz Global Assistance), Medibank Private and NIB.

The OSHC Deed sets minimum coverage requirements which OSHC insurers are required to meet for all types of OSHC policies. It is government policy that overseas students should be insured at no, or minimal cost, to the Australian taxpayer, so that the potential for unpaid accounts to Australian hospitals, doctors and other health professionals is minimised, while ensuring that the costs of health insurance does not serve as a disincentive to prospective overseas students.

In 2011–12, changes to the Deed of Agreement provided for new requirements for students to take out cover for the length of their overseas student visa at the time of visa application, to ensure students are appropriately covered by health insurance while they are in Australia.

CASE STUDY: OVERSEAS VISITORS HEALTH COVER AND HIGH COST DRUGS

Most visitors to Australia do not have access to Medicare or the Pharmaceutical Benefits Scheme (PBS). This means they are charged the full cost of pharmacy items that Australians normally access at a subsidised price — this includes chemotherapy drugs, which can cost many thousands of dollars per treatment and generally are administered over a long period of time. Due to the expensive nature of such treatment, many OVHC policies don't automatically provide cover for high cost drugs and require patients to submit applications to the insurer before treatment can commence.

In such cases, it's important for insurers to

FIGURE 18—Overseas Visitors Cover Complaints by Sub-issues

Benefit	2012–13	2013–14
Accident and emergency	1	5
Ambulance	1	1
Amount	2	6
Delay in payment	15	33
Gap—Hospital	5	2
Gap—Medical	1	2
General treatment (extras/ancillary)	2	1
High Cost Drugs	0	3
Hospital exclusion/restriction	9	11
Insurer rule	10	11
Limit reached	0	1
New baby	1	3
Non-recognised other practitioner	1	0
Out of pocket not elsewhere covered	0	1

Contract	2012–13	2013–14
Hospitals	0	1

Cost	2012–13	2013–14
Rate increase	1	0

Incentives	2012–13	2013–14
Medicare Levy Surcharge	3	4

Information	2012–13	2013–14
Brochures and websites	4	0
Lack of notification	6	4
Oral advice	13	19
Written advice	4	0

Informed Financial Consent	2012–13	2013–14
Doctors	3	0
Hospitals	7	8

Membership	2012–13	2013–14
Arrears	1	2
Cancellation	10	28
Continuity	4	4
Suspension	1	0

Other	2012–13	2013–14
Confidentiality and privacy	1	1
Non Medicare patient	0	1
Not elsewhere covered	0	1
Rule change	1	0

Service	2012–13	2013–14
Customer service advice	2	4
General service issues	9	5
Premium payment problems	4	6
Service delays	4	16

Waiting Period	2012–13	2013–14
General	1	7
Obstetric	4	5
Other	0	1
Pre-existing condition	14	25

give clear information about high cost drugs and to provide this information in a timely fashion. In cases where treatment such as chemotherapy is required, the member needs to have the information as soon as possible so they can make an informed decision about their future treatment.

Unlike an Australian citizen or permanent resident, who can opt to use the public system if they find they aren't covered for a particular treatment privately, members on OVHC don't have this option available to them. They are faced with potentially far more expensive and difficult choices. If they stay in Australia, they will pay very high fees for their treatment, as costs are generally much higher for non-Medicare and non-PBS eligible patients. If they relocate to their home country, they will often incur significant expenses and potentially lose their visa eligibility or their employment.

Maria and her family came to Australia from the USA on a working visa. In January 2014, Maria was diagnosed with breast cancer and underwent a double mastectomy. This surgery was covered by her OVHC insurer.

As follow-up to her surgery, Maria began chemotherapy treatments. In February, she called the insurer to enquire about her coverage for chemotherapy. She advised the insurer of the drugs being used, the associated medical item codes, and that the cost was approximately $3600 per treatment. Her treatment would be necessary once every three weeks for 12 months and the treatment would commence in May. The insurer told Maria she would be fully covered for any costs relating to cancer treatment including in-hospital drugs.

In March, Maria's hospital called the insurer to confirm her coverage for the chemotherapy treatment. The insurer advised the hospital that the treatment would be covered, although the hospital would need to submit an application for funding to cover the cost of high-cost chemotherapy drugs. The insurer told the hospital that as long as the drugs were for cancer treatment, the application would definitely be approved — "as long as it's related to breast cancer, she's fine."

Satisfied that her treatment would be covered, Maria started her first course of chemotherapy treatments, receiving two treatments in March. However, when the claims were submitted for payment, the insurer only paid $475 towards each admission, which only covered the accommodation cost at the hospital. This left Maria with an out-of-pocket cost of almost $9200 for the chemotherapy drugs, and with more treatments to come.

Maria contacted her insurer to find out why the claims had not been paid in full. The insurer advised her that, in fact, her policy did not automatically cover high cost drugs and she hadn't been approved for benefits on the chemotherapy drugs. Under her policy, it was necessary to have submitted an application for funding prior to the commencement for treatment, and not all applications were approved.

The insurer offered to pay for the $9200 in costs she had already incurred, but stated that in future, she would not be covered for her ongoing treatment. The insurer also stated that the hospital should have submitted its funding application earlier in the process, rather than waiting until the second course of treatment. The insurer suggested that Maria return to the USA and continue her treatment there.

At this point, returning to the USA was not a realistic option for Maria — aside from the disruption of relocating her family and children, she would have to interrupt her current treatments without any guarantee of immediately finding a new physician and hospital to continue the chemotherapy. Knowing that she had 11 months of treatments to complete and that she could face delays of up to 12 months if she returned to the USA, Maria contacted PHIO for assistance.

On reviewing the case, PHIO's view was that Maria had decided to proceed with her treatment in Australia based on the insurer's incorrect advice. Therefore the insurer should continue to pay for her treatment.

Records showed that, prior to the commencement of chemotherapy, the insurer had given clear advice to both Maria and her hospital that her treatment would be covered. The insurer had failed to warn either Maria or the hospital that a funding application would need to be submitted prior to the commencement of treatment, and had wrongly indicated that such an application was only a formality.

The membership guide for this policy did indicate that significant out-of-pocket expenses might be incurred if a member required high cost drugs, but in PHIO's view it would not be clear to many consumers that chemotherapy drugs were included in this definition.

After reviewing the case, the insurer agreed to pay for Maria's continued treatment in Australia, and to review the information provided to their OVHC members in both written material and over the phone about the requirements for high cost drug treatment.

General Issues

ACCESS AND PUBLIC AWARENESS

The Private Health Insurance Ombudsman was established primarily for the benefit of health insurance members. It is therefore important that they know about their right to approach the Ombudsman for assistance, and for all members to be able to access the office's services.

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

People who are deaf, hearing or speech impaired can contact the office through the National Relay Service by telephoning 133 677.

People who are non-English speakers can contact the office through the Translating and Interpreting Service by telephoning 131 450.

To raise public awareness of the services provided by the Ombudsman, the following strategies were employed during 2013–14:

- Details of the Ombudsman's services were referenced in various government publications and in publications produced by other agencies and consumer bodies;
- Health insurers provided information about the availability of the Ombudsman's services and contact details in brochures, publications and in some correspondence to their members. These details were also included on health insurers' websites;
- The Ombudsman also contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites;
- The Ombudsman published a regular quarterly report which was distributed in both printed format and on the PHIO website;
- The Ombudsman hosted an internet site where consumers could access a range of brochures, consumer bulletins, quarterly bulletins, annual reports and factsheets. The site enabled consumers to make enquiries, lodge complaints and request printed copies of brochures. Website users could also subscribe to updates via an e-mail newsletter or through RSS feeds. The website also linked to other useful sites. The website is located at Phio.gov.au;
- The Ombudsman conducted a number of media interviews and spoke at several health

industry conferences during the year.

- Ombudsman staff members attended Seniors' Day at the Sydney Royal Easter Show, where they promoted the office's information and advice services, and answered questions from the public.

CLIENT SURVEY

The Ombudsman regularly carries out a postal survey of randomly selected complainants. Each fortnight, surveys are posted to a sample of complainants whose cases have been closed during the previous period. The office received 161 responses (30%)—a good participation rate for a postal survey of this kind.

The aim of the survey was to gauge how well PHIO was meeting its clients' needs and to identify any areas where improvements could be made. Overall, 86% of clients were satisfied or very satisfied with the handling of their complaint. The Ombudsman's office will continue to focus on achieving a similar or higher satisfaction rating in the upcoming year.

Analysis of the results has shown that for complainants who obtain a payment or other outcome from a health insurer, satisfaction levels with the office were at 95%. This indicates there is a strong correlation between the ratings of our service to the financial or other outcome that the office is able to achieve for the complainant, regardless of whether they are satisfied with the way the Ombudsman's staff members deal with their complaint.

The challenge for the Ombudsman's office is to improve satisfaction levels for the complainants who did not obtain the outcome they wanted from the complaint process. This involves ensuring complainants feel their concerns were addressed and a good, and fair, explanation was provided to them.

This year, 84% of respondents were happy with the time taken to resolve complaints, similar to the 83% of respondents in the previous year.

For a summary of the client survey results, see **TABLE 1**.

TABLE 1—Client Survey Results

Areas of improvement	2011–12	2012–13	2013–14
Overall satisfaction	90%	85%	86%
Agreed that staff listened adequately	96%	94%	89%
Satisfied with staff manner	91%	88%	88%
Resolved complaint or provided adequate explanation	90%	88%	88%
Thought PHIO acted independently	90%	89%	86%
Would recommend PHIO to others	94%	90%	89%
Happy with time taken to resolve complaint	85%	83%	84%

89%

Percentage of respondents who would recommend PHIO to others.

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 compliance with established rules and laws.

Some significant activities included:

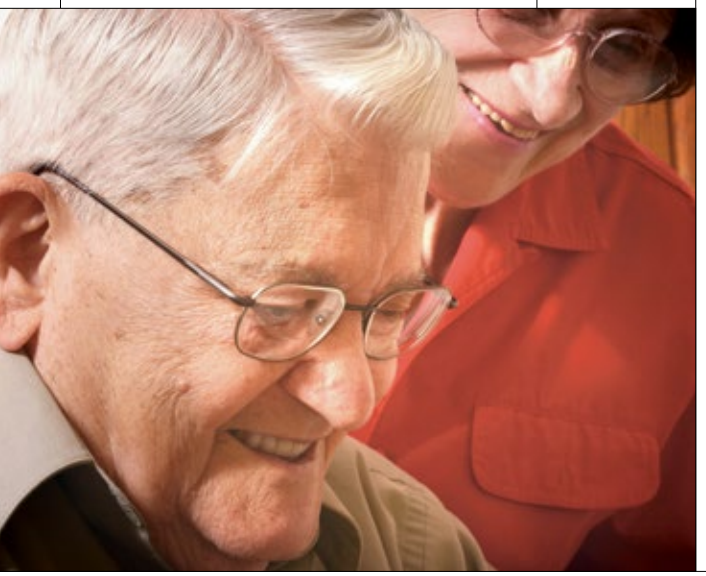
- Submission to the ACCC's report to the Senate on Anti-Competitive and Other Practices by Health Funds and Providers in

relation to private health insurance;
- Provision of advice to the Private Health Insurance Industry Code Compliance Committee in relation to the voluntary industry code;
- Consultation with state health departments, public hospitals and health insurers in relation to acute care certification processes for long-stay private patients in public hospitals; and
- Consultation with the Overseas Student Ombudsman and private health insurers regarding issues relating to private health insurance for overseas students.

RELATIONS WITH STAKEHOLDERS

The Ombudsman seeks to work in a collaborative way with its stakeholders in order to achieve the best outcome for consumers. The Ombudsman maintains regular contact with health insurer, hospital and consumer organisations. During the last year, the Ombudsman gave regular presentations to industry conferences and meetings of industry, consumer and other stakeholder associations.

In July 2013, PHIO staff presented Complaint Handling Workshops for health fund staff in several cities, on topics such as PHIO's role and function, challenges in complaint handling, and current complaint issues such as pre-existing conditions, privacy and Freedom of Information issues. The goal of the workshops was to assist health fund staff in improving complaint handling processes and to provide an understanding of the broader context of health fund industry complaints. The workshops enabled networking between insurers and PHIO staff to improve complaints management.



The Ombudsman produces a *Quarterly Bulletin* containing general information about current issues and health insurance complaint statistics that is published online at the Ombudsman's website Phio.gov.au

Health Insurance Insider is the Ombudsman's consumer e-bulletin, which is published online at Phio.gov.au on a six-monthly basis. Recent topics have included what consumers need to know about government surcharges and regulations, such as the Government Rebate, Lifetime Health Cover and the Medicare Levy Surcharge; and information on the health fund premium increase process.

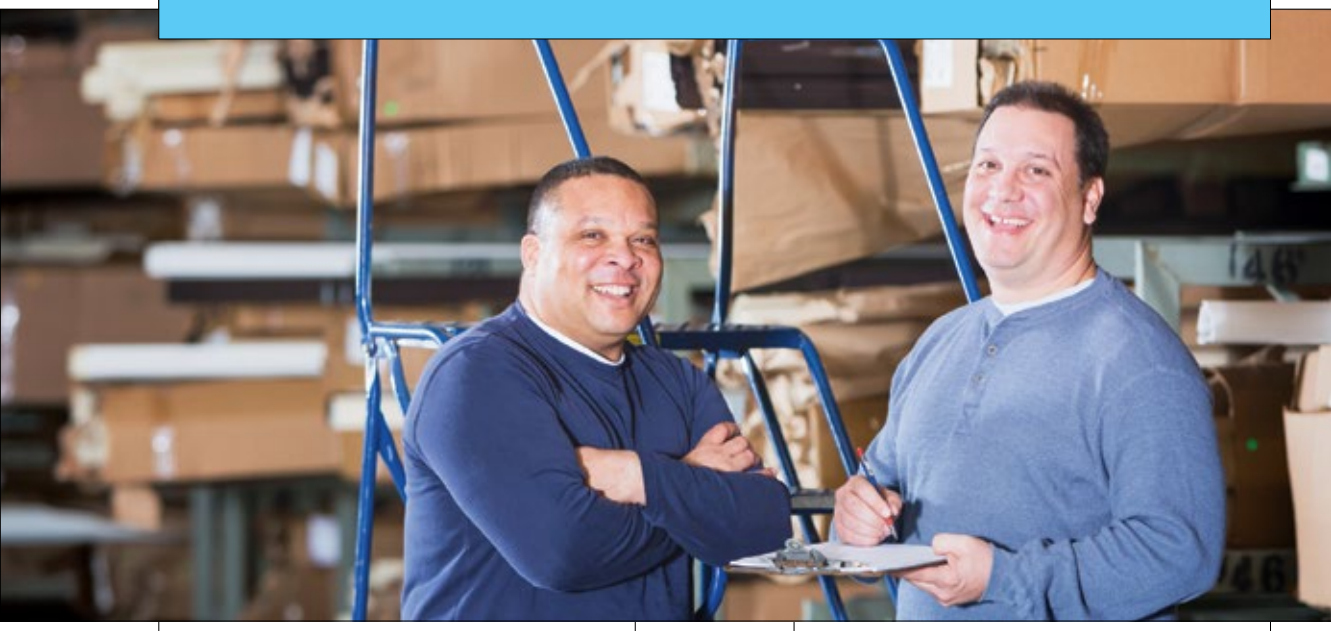
The Ombudsman website's Facts and Advice section provides factsheets about topics which are regularly raised by consumers, such as why and how health premiums are increased, and how to plan to be covered for pregnancy and obstetrics services. This area will continue to be reviewed and updated in response to consumer needs.

Each year the Ombudsman produces a *State of the Health Funds Report* to assist consumers to compare insurers and make decisions about their health insurance. The report and individual health insurer report cards can be viewed online at Phio.gov.au and PrivateHealth.gov.au.

To subscribe to e-mail updates about the *Quarterly Bulletin*, *Health Insurance Insider*, the *State of the Health Funds Report* and other online publications by the Ombudsman, please register at Phio.gov.au.

The Ombudsman chairs a Website Reference Group which meets quarterly and comprises representatives of health insurers, the Department of Health and the Consumers' Health Forum. The Reference Group provides advice to the Ombudsman about issues relating to the consumer website PrivateHealth.gov.au.

Consumer Website PrivateHealth.gov.au



The consumer website PrivateHealth.gov.au is Australia's leading source of independent information about health insurance for consumers. The website lets consumers view a Standard Information Statement (SIS) for their own policy and compare it with other policies available for purchase. The website is regularly reviewed in response to feedback from consumers' contacts with the Ombudsman's office through enquiries and complaints, and to take account of industry changes.

The website's major features include:

- Compare Policies: consumers can use the Compare Policies feature to easily compare SISs. This is the only independent website that has information on every health insurance policy available from any health insurance fund in Australia, comparing over 20,000 policies;
- Health Insurance Explained: comprehensive and independent information on all aspects of private health insurance including government surcharges and incentives;
- Lifetime Health Cover Calculator: consumers can calculate how much Lifetime Health Cover (LHC) loading applies to their hospital policy premiums; or if they already have a loading they can calculate if they have completed enough time to have the loading removed;
- Agreement Hospitals Locator: check which funds and hospitals have agreements, meaning out-of-pocket expenses for consumers are minimised; and
- Average Dental Charges: the website publishes information on the average cost of the most common dental procedures.

USAGE

The website received 899,841 unique visitors throughout the year, an increase of 45% on the previous year.

FIGURE 19— PrivateHealth.gov.au Unique Visitors 2013–14

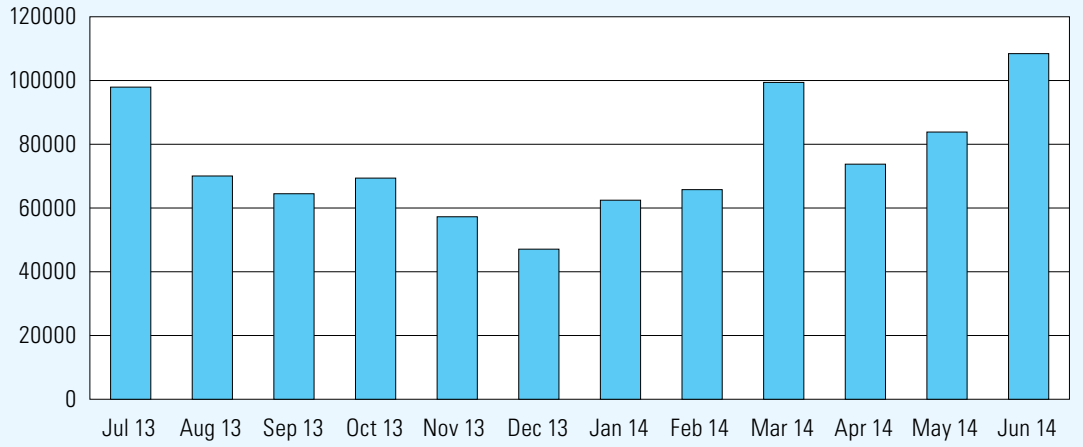


FIGURE 20— PrivateHealth.gov.au Visitors by Year

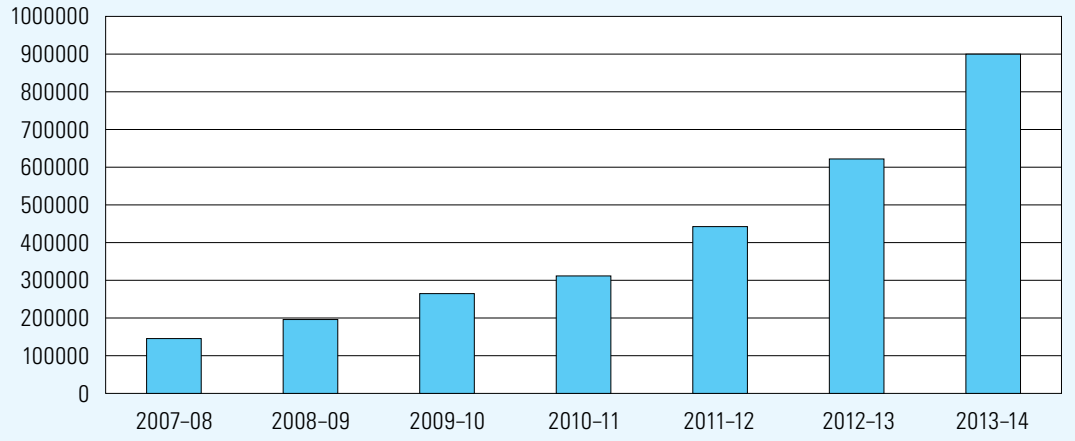
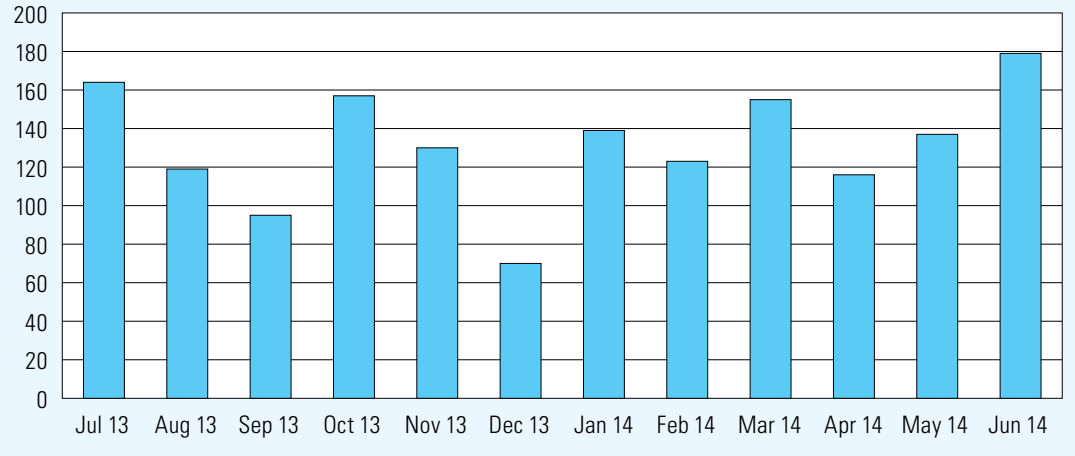


FIGURE 21— PrivateHealth.gov.au Consumer Enquiries 2013–14



In March and June 2014, the website experienced a higher level of traffic as seen in **FIGURE 19**. An increase in enquiries is typical in March each year, as this is the period when health insurers send out their rate increase letters to members. This year, changes to the Australian Government Private Health Insurance Rebate also increased enquiries at this time. In June 2014, the commencement of the Department of Health's annual Lifetime Health Cover mailing, as well as heightened consumer awareness due to the impending close of the financial year and potential Medicare Levy Surcharge implications, caused a similar spike in visitors.

FIGURE 20 shows that website usage has continued to grow annually since the website's launch in 2007. Analysis of the available data suggests that general growth of the site's usage can be attributed to the site becoming better known via recommendations and search results, PHIO's own initiatives to promote the website to consumers, and regular reminders of the site's existence in annual mailings of SISs and LHC letters.

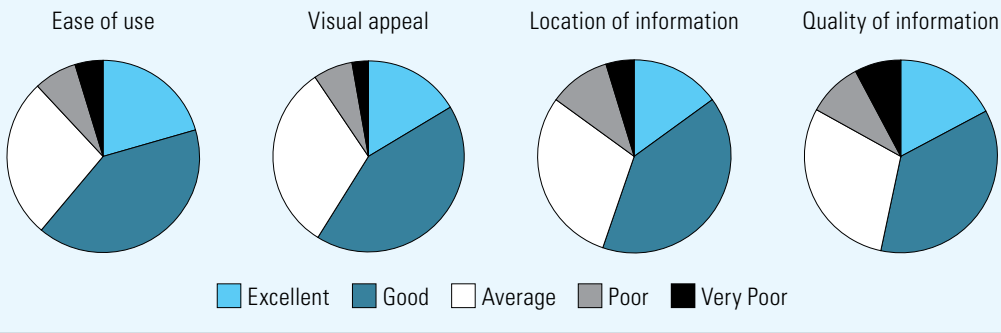
WEBSITE ENQUIRIES

The 'Ask a Question' feature allows consumers to ask quick questions by completing a web form. Consumers can also call for an answer on the enquiries line 1300 737 299. This service is used by consumers who are seeking answers for general health insurance questions beyond what they can find elsewhere on the website or by contacting individual health funds.

As seen in **FIGURE 21**, the office responded to 1584 consumer enquiries through the website, compared to 1480 in the previous year. Approximately 60% of the enquiries received by the office are received via the consumer website, either by e-mail or telephone. The most frequently raised questions are about the following topics:

- Lifetime Health Cover, especially regarding how this affects new migrants to Australia and Australians returning from overseas. The LHC rules determine how much a person pays for hospital insurance;
- The Medicare Levy Surcharge for high income earners and how to avoid the Surcharge by purchasing appropriate private hospital insurance;
- The Australian Government Private Health Insurance Rebate—in recent changes, from the 1st of July 2013, the Rebate does not apply to the Lifetime Health Cover portion of hospital premiums; and from the 1st of April 2014, annual rebate increases are based on a weighted average ratio;
- Waiting periods for people who are currently uninsured;
- How to use the website, locate information and compare policies;
- How to choose a health insurance policy; and
- Overseas Visitors Health Cover, especially for Subclass 457 visa holders and overseas student visa holders.

FIGURE 22—User Survey Ratings for PrivateHealth.gov.au in 2013–14



SURVEY RESULTS

During the year, 542 users completed a survey about the website. The key ratings for the site are summarised in **FIGURE 22**. Survey results are used to highlight areas where improvements can be made to the website, to track satisfaction with the site and whether changes have been successful.

Since July 2010, when the website re-launched in its current form, consumer satisfaction for major rating criteria has remained consistently high, especially for 'visual appeal'. PHIO will continue to monitor user feedback and work on improving survey results.

WEBSITE DEVELOPMENTS

PHIO continued to develop and improve the website and the behind-the-scenes system insurers use to keep their policy information accurate, in response to changes in the private health insurance industry and feedback from consumers and stakeholders. Developments in 2013–14 included:

- Standard Information Statements and Rebate Changes: effective from the 1st of April 2014, the Australian Government Private Health Insurance Rebate increases are based on a weighted average ratio, using a formula which takes into account growth in the Consumer Price Index and the industry weighted average premium increase. The SIS was modified to remove references to the older rebated premiums, and the explanatory notes on the SIS and the website were modified accordingly;
- Improvements to the website Content Management System to assist funds with more clearly distinguishing between 'closed' and 'withdrawn' products, grouping products for updates, and other technical improvements; and
- Policy search feature adjusted to allow for more accurate excess search options and an altered workflow for users encountering a 'zero results' outcome on their search criteria.

Appendix: Statutory Reporting Information

MANAGEMENT OF HUMAN RESOURCES AND ORGANISATIONAL STRUCTURE

The core function of the office is to resolve complaints from consumers, practitioners, hospitals and health insurers with respect to health insurance arrangements. This involves the resolution of individual complaints, and development of strategies to assist in identifying and resolving the underlying issues which lead to complaints. The office is also responsible for regular reporting to government and industry, and the provision of advice and information about private health insurance to consumers. 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 insurance industry.

The core business of complaint handling and dispute resolution is managed by the Dispute Resolution team (currently five staff members). Dispute Resolution staff are responsible for the day-to-day management of individual complaints and for bringing potential and actual issues which require broader investigation to the attention of the Ombudsman and the Director of Policy & Client Services.

The Project & Policy team (currently three staff members) manages consumer and website enquiries, website updates, and PHIO reports and publications. This team also reports to the Director of Policy & Client Services.

The Director of Policy & Client Services, Principal Policy Officer and Director of Programmes & Education comprise the management level of the organisation which handles complex disputes and mediations, industry liaison, policy development, staff training, and compliance issues. These positions report directly to the Ombudsman.

Administrative matters and corporate services are handled by the Office Manager and Financial Controller, also reporting directly to the Ombudsman.

TABLE 2 shows the permanent staff employed by the Private Health Insurance Ombudsman in 2014 as compared to 2013.

TABLE 2—Permanent Staff

Full-time and part-time employees	At 30 June 2014			At 30 June 2013		
	Female	Male	EFT[1]	Female	Male	EFT[1]
SES 2	1	–	1.0	1	–	1.0
EL 2	1	1	1.4	1	1	1.4
EL 1	3	–	2.4	3	–	2.3
APS 6	2	–	2.0	2	–	2.0
APS 5	4	1	4.2	3	1	4.8
APS 4	1	–	0.7	1	–	0.7
APS 3	–	–	–	1	–	0.7

1. EFT = Equivalent full-time employee.

STATUTORY POSITIONS

The Private Health Insurance Ombudsman comprises one statutory office holder (see **TABLE 3**).

TABLE 3—Statutory Positions

Officer	Position	Term	Expiry Date
Ms Samantha Gavel	Ombudsman	1 year	2015

STAFF EMPLOYMENT STATUS

All Ombudsman staff members are employed under the provisions of the *Public Service Act 1999* and are required to adhere to the Public Service Values and Code of Conduct. All staff members, other than Senior Executive Service staff, are covered under an Enterprise Agreement in accordance with the *Fair Work Act 2009* and in compliance with Australian Public Service Commission recommendations. The PHIO Enterprise Agreement came into effect on 21 September 2011, following a staff ballot.

TABLE 4 shows rates of pay under the Enterprise Agreement.

The Ombudsman is committed to providing a safe working environment that supports the rights, responsibilities and legitimate needs of all staff. The Ombudsman is also 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 in balancing their work and family responsibilities effectively. This includes flexible working arrangements (flextime) and work from home arrangements. As a result, the PHIO has a high retention rate and low staff turnover, with total staff members remaining almost unchanged over the past three years.

TABLE 5 shows the numbers and status of staff who were employed on 30 June 2014.

TABLE 4—Rates of Pay

Classification	July 2012	July 2013
Executive Level 2	$105,575–$123,407	$108,742–$127,109
Executive Level 1	$90,238–$98,845	$92,945–$101,810
APS 6	$73,430–$82,839	$75,633–$85,324
APS 5	$66,563–$70,256	$68,560–$72,364
APS 4	$61,199–$64,663	$63,035–$66,603
APS 3	$54,016–$59,872	$55,636–$61,668
APS 2	$46,287–$50,512	$47,676–$52,027
APS 1	$39,606–$44,478	$40,794–$45,813

TABLE 5—Numbers and Status

Occupational Group	Women	Men	Total	NESB1
SES	1	0	1	0
Other	11	2	13	3
Total	**12**	**2**	**14***	**3**

SES = Senior Executive Service, Ombudsman. Other = All other staff—temporary and permanent. NESB1 = Non-English speaking background, first generation.

* Includes part-time employees and those on maternity leave. Actual EFT = 11.7

STAFF DEVELOPMENT AND TRAINING

During the 2013–14 financial year, $38,596 was spent directly on the Ombudsman's staff attending training and development courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff.

Staff training and development ensures staff members have the appropriate skills and knowledge to provide high-level advice and services to consumers, as well as providing for staff career development, satisfaction and retention.

Attendance at conferences and seminars allows staff to keep up to date with industry changes and to engage with their peers across the private health insurance, health services, and government sectors. Training and development courses enable staff to develop skills that empower them to more effectively manage their work in areas that include leadership in the the workplace, managing and working within teams, and best practice in customer complaints handling.

PERFORMANCE APPRAISAL

The Ombudsman has a Performance Development Program to measure staff performance and provide for staff training and

development. The program is used to assist the Ombudsman with general staff management and annual salary reviews.

All staff members are subject to a half-yearly and an annual performance appraisal. Salary and promotion advancement is based on performance and productivity. A total of $47,607 in performance bonuses was paid in 2013–14; this figure has been aggregated to preserve employees' privacy.

In accordance with the *Private Health Insurance Act 2007* (Cth), the Ombudsman's remuneration is determined by the Remuneration Tribunal, an independent statutory body that handles the remuneration of key Commonwealth offices. For more information, please refer to the note regarding Senior Executive Remuneration in the Financial Statements of this report.

INDUSTRIAL DEMOCRACY

Staff members 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.

CORPORATE GOVERNANCE

As a small office with duties specified by the *Private Health Insurance Act 2007* (Cth), 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.

EXTERNAL REVIEW AND SCRUTINY

The office subjects itself to regular review of its performance by conducting a survey of complainants. Detail of the review for this year is provided in the body of this Report (see Client Survey on page 41).

During this year, there were no judicial decisions, decisions of administrative tribunals or decisions by the Australian Information Commissioner which had a significant impact on the operations of the PHIO. There were no reports on the operations of the office by the Auditor-General, a Parliamentary committee, the Commonwealth Ombudsman or agency capability reviews.

There were no other reviews conducted of the PHIO.

FRAUD CONTROL

Staff members 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. The Ombudsman has reported the office's fraud data to the Australian Institute of Criminology in accordance with the Commonwealth Fraud Control Guidelines.

ACCOUNTING AND AUDIT

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 has an Audit Committee, chaired by an independent Chair, Mr Neill Buck, which holds regular meetings to ensure appropriate oversight of the office's compliance with the requirements of the *Financial Management and Accountability Act 1997* (Cth).

CONSULTANCY SERVICES

The PHIO engages consultants where it lacks specialist expertise or when independent research, review or assessment is required. Consultants are typically engaged to investigate or diagnose a defined issue or problem; carry out defined reviews or evaluations; or provide independent advice, information or creative solutions to assist in PHIO's decision-making.

Prior to engaging consultants, PHIO takes into account the skills and resources required for the task, the skills available internally, and the cost-effectiveness of engaging external expertise. The decision to engage a consultant is made in accordance with the FMA Act and related regulations including the Commonwealth Procurement Guidelines (CPGs) and PHIO's procurement policies.

Annual reports contain information about actual expenditure on contracts for consultancies. Information on the value of contacts and consultancies is available on the AusTender website Tenders.gov.au.

During 2013–14, PHIO did not engage any consultancy services of $10,000 or more.

Consultants engaged by PHIO:

- Complete GST Solutions/BuildSmart Bookkeeping provided financial, accounting and reporting assistance to the office.
- P T & A Health provided services on an ad hoc basis as medical referees on cases requiring a medical opinion.
- Human Solutions was awarded a one-year contract for the provision of maintenance, support and hosting services for the consumer website (PrivateHealth.gov.au) after an open tender process in 2014. The contract commenced on 1 June 2014.

INFORMATION SYSTEMS

The Ombudsman's information system is based on a Windows 2008 Network Server and the Microsoft Office suite. Accounting software used is MYOB Accounting and Asset Manager. In addition, the Ombudsman has a purpose-built Complaints Management and Reporting system on-site.

PAYROLL SERVICES

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

SERVICE CHARTER

In line with requirements for all Australian Government agencies, the Ombudsman has a Service Charter which was last reviewed in 2010–11. The Service Charter covers all of the Ombudsman'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 key performance standards listed in the Service Charter are: Accessibility, Timeliness, Courtesy and Sensitivity, and High-Quality Advice.

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

PHIO staff attend a weekly case meeting, which enables Disputes Resolution Officers to seek input from peers and senior staff on their cases. Disputes Resolution Officers are encouraged to discuss their cases with peers and senior staff on a more informal basis, to ensure the best approach is used for each matter.

If a complainant requests for their call to PHIO to be escalated, they can be referred to the Senior Dispute Resolution Officer or other delegated person. If a complainant is not happy with how their case has been handled, they can request a review by the Senior Dispute

Resolution Officer or the Manager, Dispute Resolutions.

Client survey results showed that in 2013–14, 89% of consumers found PHIO staff listened to their concerns adequately and 88% were satisfied with the manner in which PHIO staff handled their cases. Overall, 89% of clients were happy to recommend PHIO's services to others. These results are generally consistent with the previous two years of survey results.

WORK HEALTH AND SAFETY

The Ombudsman complies with all provisions of the *Work Health and Safety Act 2011* (Cth). The staff include a First Aid Officer, an Occupational Health and Safety Officer, and two Fire Wardens. All staff received an ergonomic assessment during 2013–14 to ensure their workstations are optimised for good health. No reportable incidents occurred and no investigations were conducted during the year.

EQUAL EMPLOYMENT OPPORTUNITY

The Ombudsman is committed to the principles outlined in the *Disability Discrimination Act 1992* (Cth) and the *Equal Employment Opportunity (Commonwealth Authorities) Act 1987* (Cth).

ADVERTISING AND MARKET RESEARCH

Under section 311A of the *Commonwealth Electoral Act 1918* (Cth), the Ombudsman is required to disclose payments of $12,100 or more (inclusive of GST) to specific types of organisations. These organisations are advertising agencies, market research organisations, polling organisations, media advertising organisations, and direct mail organisations. PHIO did not conduct any advertising or market research in 2013–14.

ECOLOGICALLY SUSTAINABLE DEVELOPMENT AND ENVIRONMENTAL PERFORMANCE

The Ombudsman is committed to the ecologically sustainable development goals of the *Environment Protection and Biodiversity Conservation Act 1999* (Cth). The Ombudsman promotes reduction in use of resources through the provision of recycling bins, ecologically mindful purchasing guidelines, and implementation of office processes that reduce the unnecessary consumption of electricity and water.

The Ombudsman's office is located in a building that has achieved 3.5 Stars under the National Australian Built Environment Rating: Water and 5 Stars under the National Environment Building Rating: Energy.

GRANT PROGRAMS

The Ombudsman did not administer any grant programs during the 2013–14 financial year.

CHANGES TO DISABILITY REPORTING

Since 1994, Commonwealth departments and agencies have reported on their performance as policy adviser, purchaser, employer, regulator and provider under the Commonwealth Disability Strategy. In 2007–08, reporting on the employer role was transferred to the Australian Public Service Commission's State of the Service Report and the APS Statistical Bulletin. These reports are available at Apsc.gov.au. From 2010–11, departments and agencies have no longer been required to report on these functions.

The Commonwealth Disability Strategy has been overtaken by a new National Disability Strategy 2010–2020 which sets out a 10-year national policy framework to improve the lives of people with disability, promote participation and create a more inclusive society. A high-level two-

yearly report will track progress against each of the six outcome areas of the Strategy and present a picture of how people with disability are faring. The first of these reports will be available in late 2014, and can be found at Dss.gov.au.

FREEDOM OF INFORMATION AND INFORMATION PUBLICATION SCHEME

Agencies subject to the *Freedom of Information Act 1982* (Cth) (FOI Act) are required to publish information to the public as part of the Information Publication Scheme (IPS). This requirement is in Part II of the FOI Act and has replaced the former requirement to publish a section 8 statement in an annual report.

Each agency must display on its website a plan showing what information it publishes in accordance with the IPS requirements. The PHIO IPS and FOI Requests—Disclosure Log can be found at Phio.gov.au.

Informal requests for access to information held by the Ombudsman's office can be made by telephone, e-mail, personal visit or by letter. People can make the request either via the Dispute Resolution Officer allocated to their case or that person's supervisor.

If a person wishes to make a formal request under the FOI Act, requests can be made in writing and directed to:

Director, Policy & Client Services
Private Health Insurance Ombudsman
Suite 2, Level 22
580 George Street
Sydney NSW 2000

PHIO PUBLICATIONS

The following brochures published by PHIO are available free of charge upon request:

BROCHURES

- 'Making a Complaint'
- 'Ten Golden Rules of Private Health Insurance'
- 'About Our Service'
- 'Doctors' Bills'
- 'The Right to Change—Portability in Health Insurance'
- 'Waiting Periods'
- 'Health Insurance Choice'
- 'PrivateHealth.gov.au'

REPORTS

- The *State of the Health Funds Report*
- Individual summaries for each insurer of *State of the Health Funds Report*.

REQUESTING PUBLICATIONS

To request publications, please contact PHIO:

- By post at Suite 2, Level 22, 580 George Street, Sydney NSW 2000;
- By phone on (02) 8235 8777 or 1800 640 695;
- By fax on (02) 8235 8778;
- By e-mail to info@phio.gov.au; or
- Via the website Phio.gov.au

Selected PHIO publications available for request.

Financial Information

INDEPENDENT AUDITOR'S REPORT

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

I have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2014, which comprise: a Statement by the Ombudsman; Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments; Schedule of Contingencies; and Notes to the Financial Statements comprising a Summary of Significant Accounting Policies and other explanatory information.

Private Health Insurance Ombudsman's Responsibility for the Financial Statements

The Ombudsman is responsible for the preparation of financial statements that give a true and fair view in accordance with the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, including the Australian Accounting Standards, and for such internal control as is necessary to enable the preparation of financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

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

GPO Box 707 CANBERRA ACT 2601
19 National Circuit BARTON ACT 2600
Phone (02) 6203 7300 Fax (02) 6203 7777

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

Independence

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

Opinion

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

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

(b) give a true and fair view of the matters required by the Finance Minister's Orders, including the Private Health Insurance Ombudsman's financial position as at 30 June 2014 and its financial performance and cash flows for the year then ended.

Australian National Audit Office

Puspa Dash
Executive Director

Delegate of the Auditor-General

Canberra
3 September 2014

STATEMENT BY THE OMBUDSMAN

Australian Government
Private Health Insurance Ombudsman

STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2014 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, as amended.

Signed Samantha Gavel

Samantha Gavel
Chief Executive and Chief Financial Officer

3 September 2014

STATEMENT OF COMPREHENSIVE INCOME

For the period ended 30 June 2014

	Notes	2014 ($)	2013 ($)
EXPENSES			
Employee benefits	3A	**1,384,226**	1,261,893
Supplier	3B	**766,937**	980,130
Depreciation and amortisation	3C	**292,789**	382,006
Finance costs	3D	**1,644**	418
Total expenses		**2,445,596**	2,624,447
LESS:			
OWN-SOURCE INCOME			
Own-source revenue			
Sale of goods and rendering of services	4A	–	31,916
Other revenue	4B	**1,882**	156,612
Total own-source revenue		**1,882**	188,528
Gains			
Other	4C	**17,800**	16,000
Total gains		**17,800**	16,000
Total own-source income		**19,682**	204,528
Net cost of (contribution by) services		**2,425,914**	2,419,919
Revenue from government	4D	**2,203,000**	2,052,000
Deficit		**(222,914)**	(367,919)
OTHER COMPREHENSIVE INCOME			
Other comprehensive income		–	–
Total other comprehensive income		–	–
Total comprehensive loss		**(222,914)**	(367,919)

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 2014

	Notes	2014 ($)	2013 ($)
ASSETS			
Financial Assets			
Cash and cash equivalents	6A	**90,023**	79,016
Trade and other receivables	6B	**55,161**	1,805,166
Total financial assets		**145,184**	1,884,182
Non-Financial Assets			
Leasehold improvements	7A,C	**94,755**	126,679
Property, plant and equipment	7B,C	**43,241**	54,885
Intangibles	7D,E	**509,890**	650,738
Other non-financial assets	7F	**26,486**	36,518
Total non-financial assets		**674,372**	868,820
Total assets		**819,556**	2,753,002
LIABILITIES			
Payables			
Suppliers	8A	**106,078**	65,415
Other payables	8B	**52,694**	73,400
Total payables		**158,772**	138,815
Provisions			
Employee provisions	9A	**358,944**	388,357
Other	9B	**41,632**	39,988
Total provisions		**400,576**	428,345
Total liabilities		**559,348**	567,160
Net assets		**260,208**	2,185,842
EQUITY			
Contributed equity		**679,321**	2,382,041
Reserves		**99,981**	99,981
Retained surplus		**(519,094)**	(296,180)
Total equity		**260,208**	2,185,842

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

STATEMENT OF CHANGES IN EQUITY

For the period ended 30 June 2014

	Retained surplus		Asset revaluation reserve		Contributed equity		Total equity	
	2014 ($)	2013 ($)	2014 ($)	2013 ($)	2014 ($)	2013 ($)	2014 ($)	2013 ($)
Opening balance								
Balance carried forward from previous period	**(296,180)**	71,739	**99,981**	99,981	**2,382,041**	2,322,041	**2,185,842**	2,493,761
Adjusted opening balance	**(296,180)**	71,739	**99,981**	99,981	**2,382,041**	2,322,041	**2,185,842**	2,493,761
Comprehensive income								
Deficit for the period	**(222,914)**	(367,919)	–	–	–	–	**(222,914)**	(367,919)
Total comprehensive income	**(222,914)**	(367,919)	–	–	–	–	**(222,914)**	(367,919)
Transactions with owners								
Contributions to/by owners								
Contributions repealed by Statute Stocktake	–	–	–	–	**(1,762,720)**	–	**(1,762,720)**	–
Departmental capital budget	–	–	–	–	**60,000**	60,000	**60,000**	60,000
Sub-total transactions with owners	–	–	–	–	**(1,702,720)**	60,000	**(1,702,720)**	60,000
Closing balance as at 30 June	**(519,094)**	(296,180)	**99,981**	99,981	**679,321**	2,382,041	**260,208**	2,185,842

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

CASH FLOW STATEMENT

For the period ended 30 June 2014

	Notes	2014 ($)	2013 ($)
OPERATING ACTIVITIES			
Cash received			
Appropriations		**2,203,000**	2,172,000
Sales of goods and rendering of services		**2,390**	31,270
Net GST received		**16,575**	117,976
Total cash received		**2,221,965**	2,321,246
Cash used			
Employees		**1,451,838**	1,202,022
Suppliers		**714,983**	1,002,872
Other		**(34,236)**	566
Total cash used		**2,132,585**	2,205,460
Net cash from operating activities	10	**89,380**	115,786
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**5,763**	14,471
Purchase of intangibles		**102,610**	173,750
Total cash used		**108,373**	188,221
Net cash used by investing activities		**(108,373)**	(188,221)
FINANCING ACTIVITIES			
Cash received			
Contributed equity		**30,000**	60,000
Total cash received		**30,000**	60,000
Net increase (decrease) in cash held		**11,007**	(12,435)
Cash and cash equivalents at the beginning of the reporting period		**79,016**	91,451
Cash and cash equivalents at the end of the reporting period	6A	**90,023**	79,016

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

SCHEDULE OF COMMITMENTS

As at 30 June 2014

	2014 ($)	2013 ($)
BY TYPE		
Commitments receivable		
Net GST recoverable on commitments	**66,950**	86,118
Total commitments receivable	**66,950**	86,118
Commitments payable		
Other commitments		
Operating leases	**491,477**	785,724
Other	**244,972**	161,572
Total other commitments	**736,449**	947,296
Net commitments by type	**669,499**	861,178
BY MATURITY		
Commitments receivable		
One year or less	**50,224**	41,438
From one to five years	**16,726**	44,680
Total operating lease income	**66,950**	86,118
Commitments payable		
Operating lease commitments		
One year or less	**307,487**	294,247
From one to five years	**183,990**	491,477
Total operating lease commitments	**491,477**	785,724
Other Commitments		
One year or less	**244,972**	161,572
From one to five years	**–**	–
Total other commitments	**244,972**	161,572
Net commitments by maturity	**669,499**	861,178

This schedule should be read in conjunction with the accompanying notes.

Note: Commitments are GST inclusive where relevant.

Operating leases comprise of a lease for office accommodation. Lease payments are subject to a fixed increase of 4.5% per annum as per the lease agreement. The lease will terminate on 31 January 2016.

Other commitments comprise of a contract for maintenance and development of the www.privatehealth.gov.au website. Payments are per the contract agreement. The contract will expire after 31 May 2015.

SCHEDULE OF CONTINGENCIES

As at 30 June 2014

There were no contingent assets and liabilities as at 30 June 2014 (30 June 2013: nil).

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NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 OBJECTIVES OF THE ENTITY

The Private Health Insurance Ombudsman is an Australian Government controlled entity. It is a not-for-profit entity. The objective of the entity is to be an independent body which resolves complaints about private health insurance, and act as the umpire in dispute resolution at all levels within the private health industry.

The entity is structured to meet the following outcome:

Outcome 1: Public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting.

The continued existence of the entity in its present form and with its present programs is dependent on Government policy and on continuing funding by Parliament for the entity's administration and programs.

The Government announced in the May 2014 Budget that a number of Commonwealth Government agencies would be merged or abolished, following the recommendations of the Government's Commission of Audit Report. As part of this process, the Government announced that PHIO will be merged with the Commonwealth Ombudsman from 1 July 2015. The legislation is yet to be considered by Parliament.

Entity activities contributing toward these outcomes are classified as departmental. Departmental activities involve the use of assets, liabilities, income and expenses controlled or incurred by the entity in its own right.

1.2 BASIS OF PREPARATION OF THE FINANCIAL STATEMENTS

The financial statements are general purpose financial statements and are required by section 49 of the *Financial Management and Accountability Act 1997*.

The financial statements have been prepared in accordance with:

a) Finance Minister's Orders (FMOs) for reporting periods ending on or after 1 July 2011; and

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

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities 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 statements are presented in Australian dollars and values are rounded to the nearest dollars unless otherwise specified.

Unless an alternative treatment is specifically required by an accounting standard or the FMOs, assets and liabilities are recognised in the Statement of Financial Position when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under executor contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the Schedule of Commitments or the Schedule of Contingencies.

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

The Australian Government continues to have regard to developments in case law, including the High Court's most recent decision on Commonwealth expenditure in *Williams v Commonwealth (2014) HCA 23*, as they contribute to the larger body of law relevant to the development of Commonwealth programmes. In accordance with its general practice, the government will continue to monitor and assess risk and decide on any appropriate actions to respond to risks of expenditure not being consistent with constitutional or other legal requirements.

1.3 SIGNIFICANT ACCOUNTING JUDGEMENTS AND ESTIMATES

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

1.4 NEW AUSTRALIAN ACCOUNTING STANDARDS

Adoption of New Australian Accounting Standard Requirements

No accounting standard has been adopted earlier than the application date as stated in the standard.

The following revised standards were issued prior to the sign-off date and are applicable to the current reporting period. They did not have a material effect, and are not expected to have a future material effect, on the entity's financial statements.

AASB 13: *Fair Value Measurement*

AASB 119: *Employee Benefits*

Other new standards, revised standards, interpretations and amending standards that were issued prior to the sign-off date and are applicable to the current reporting period did not have a financial impact, and are not expected to have a future financial impact on the Private Health Insurance Ombudsman.

Future Australian Accounting Standard Requirements

AASB 1055: *Budgetary Reporting* was issued prior to the sign-off date and is applicable to future reporting period(s). The standard is not expected to have a future material impact on the entity's financial statements.

Other new standards, revised standards, interpretations and amending standards that were issued prior to the sign-off date and are applicable to the future reporting period are not expected to have a future financial impact on the Private Health Insurance Ombudsman.

1.5 REVENUE

Revenue from the sale of goods is recognised when:

a) the risks and rewards of ownership have been transferred to the buyer;
b) the entity retains no managerial involvement or effective control over the goods;
c) the revenue and transaction costs incurred can be reliably measured; and
d) it is probable that the economic benefits associated with the transaction will flow to the entity.

Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when:

a) the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
b) the probable economic benefits associated with the transaction will flow to the entity.

The stage of completion of contracts at the reporting date is determined by reference to services performed to date as a percentage of total services to be performed.

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any impairment allowance account. Collectability of debts is reviewed at end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

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

Revenue from Government

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

1.6 GAINS

Resources Received Free of Charge

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

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

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

1.7 TRANSACTIONS WITH THE GOVERNMENT AS OWNER

Equity Injections

Amounts appropriated which are designated as 'equity injections' for a year (less any formal reductions) and Departmental Capital Budgets (DCBs) are recognised directly in contributed equity.

Restructuring of Administrative Arrangements

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

Other Distributions to Owners

The FMOs require that distributions to owners be debited to contributed equity unless it is in the nature of a dividend.

1.8 EMPLOYEE BENEFITS

Liabilities for 'short-term employee benefits' (as defined in AASB 119 *Employee Benefits*) and termination benefits due within twelve months of the end of reporting period are measured at their nominal amounts.

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

Other long-term employee benefits are measured as net total of the present value of the defined benefit obligation at the end of the reporting period minus the fair value at the end of the reporting period of plan assets (if any) out of which the obligations are to be settled directly.

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 entity is estimated to be less than the annual entitlement for sick leave.

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

Separation and Redundancy

Provision is made for separation and redundancy benefit payments. The entity recognises a provision for termination when it has developed a detailed formal plan for the terminations and has informed those employees affected that it will carry out the terminations.

Superannuation

The entity's staff are members of the Public Sector Superannuation Scheme (PSS) or the PSS accumulation plan (PSSap).

The PSS is a defined benefit scheme for the Australian Government. The PSSap is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported in the Department of Finance's administered schedules and notes.

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

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

1.9 LEASES

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

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

The entity has no finance leases.

1.10 FAIR VALUE MEASUREMENT

The entity deems transfers between levels of the fair value hierarchy to have occurred at the date of the event or change in circumstances that caused the transfer.

1.11 CASH

Cash is recognised at its nominal amount. Cash and cash equivalents includes:

a) cash on hand; and
b) demand deposits in bank accounts with an original maturity of 3 months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value.

1.12 FINANCIAL ASSETS

The entitiy classifies its financial assets as 'loans and receivables' which comprises trade receivables, loans and other receivables that have fixed or determinable payments that are not quoted in an active market. Loans and receivables are measured at amortised cost using the effective interest method less impairment. Interest is recognised by applying the effective interest rate. The agency has no loans.

Effective Interest Method

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or, where appropriate, a shorter period.

Income is recognised on an effective interest rate basis except for financial assets that are recognised at fair value through profit or loss.

1.13 FINANCIAL LIABILITIES

The entity classifies financial liabilities as Other, including supplier and other payables which are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

1.14 CONTINGENT LIABILITIES AND CONTINGENT ASSETS

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

1.15 ACQUISITION OF ASSETS

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

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

1.16 PROPERTY, PLANT AND EQUIPMENT

Asset Recognition Threshold

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

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in office premises taken up by the entity where there exists an obligation to restore the premises to its original state. These costs are included in the value of the entity's Leasehold Improvements asset with a corresponding provision for the 'make good' recognised.

Revaluations

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

Revaluation adjustments were made on a class basis. Any revaluation increment was credited to equity under the heading of asset revaluation reserve except to the extent that it reversed a previous revaluation decrement of the same asset class that was previously recognised in the surplus/deficit. Revaluation decrements for a class of assets were recognised directly in the surplus/deficit except to the extent that they reversed a previous revaluation increment for that class.

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

Depreciation

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

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

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

Class	2014	2013
Leasehold improvements	Lease term	Lease term
Property, plant and equipment	4 to 10 years	4 to 10 years

Impairment

All assets were assessed for impairment at 30 June 2014. 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 entity were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

1.17 INTANGIBLES

The entity's intangibles comprise purchased software for internal use. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the entity's software are 5 to 7 years (2012–13: 5 to 7 years).

All software assets were assessed for indications of impairment as at 30 June 2014.

1.18 TAXATION

The entity is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses, assets and liabilities are recognised net of GST except:

a) where the amount of GST incurred is not recoverable from the Australian Taxation Office; and

b) for receivables and payables.

NOTE 2: EVENTS AFTER THE REPORTING PERIOD

1. An amount of $1,762,722 relating to *Appropriation Acts 2007–2008* and 2008–2009 lapsed on 1 July 2013 when the *Statute Stocktake (Appropriations) Act 2013* became effective. The PHIO wrote to the Minister of Finance during 2013–2014 and the amount of $763,000 was approved to be made available to the PHIO through *Appropriation Act 2014–2015*.

NOTE 3: EXPENSES

NOTE 3A: EMPLOYEE BENEFITS	2014 ($)	2013 ($)
Wages and salaries	**1,216,295**	1,054,496
Superannuation:		
Defined contribution plans	**58,640**	59,885
Defined benefit plans	**131,929**	97,295
Leave expense and other entitlements*	**(29,413)**	39,865
Other employee expenses	**6,775**	10,353
Total employee benefits	**1,384,226**	1,261,893

* The decrease in leave expense and other entitlements is due to the over provision of long service leave in 2012–13, which has been adjusted in 2013–14.

NOTE 3B: SUPPLIERS		
Goods and services		
Accounting and audit	**31,853**	47,119
Brochures and printing	**58,315**	55,038
Consultants	**1,403**	1,320
Insurance	**8,514**	9,478
Legal	**–**	6,525
Campaign advertising	**–**	135,969
Media and non campaign advertising	**41,148**	33,354
Mediation	**3,500**	12,928
Recruitment	**4,545**	3,559
Stationery	**–**	1,581
Staff development	**21,688**	39,948
Travel and accommodation	**48,359**	41,418
Website	**139,183**	141,875
Other	**131,330**	182,320
Total goods and services	**489,838**	712,432
Goods and services are made up of:		
Rendering of services – external parties	**489,838**	712,432
Total goods and services	**489,838**	712,432
Other supplier expenses		
Operating lease rentals – external parties:		
Minimum lease payments	**269,269**	258,350
Workers compensation expenses	**7,830**	9,348
Total other supplier expenses	**277,099**	267,698
Total supplier expenses	**766,937**	980,130

NOTE 3C: DEPRECIATION AND AMORTISATION	2014 ($)	2013 ($)
Depreciation:		
Property, plant and equipment	17,407	23,480
Leasehold improvements	31,924	36,237
Total depreciation	49,331	59,717
Amortisation:		
Web development	235,934	314,763
Intangibles	7,524	7,526
Total amortisation	243,458	322,289
Total depreciation and amortisation	292,789	382,006

NOTE 3D: FINANCE COSTS		
Unwinding of discount	1,644	418
Total finance costs	1,644	418

NOTE 4: OWN-SOURCE INCOME

OWN-SOURCE REVENUE NOTE 4A: SALE OF GOODS AND RENDERING OF SERVICES	2014 ($)	2013 ($)
Rendering of services—external parties	–	31,916
Total sale of goods and rendering of services	–	31,916

NOTE 4B: OTHER REVENUE		
MoU for website improvements	–	136,000
Other income	1,882	20,612
Total other revenue	1,882	156,612

NOTE 4C: OTHER GAINS		
Resources received free of charge	17,800	16,000
Total other gains	17,800	16,000

REVENUE FROM GOVERNMENT NOTE 4D: REVENUE FROM GOVERNMENT		
Appropriations:		
Departmental appropriation	2,203,000	2,052,000
Total revenue from Government	2,203,000	2,052,000

NOTE 5: FAIR VALUE MEASUREMENTS

The following table provide an analysis of assets and liabilities that are measured at fair value.

The different levels of the fair value hierarchy are defined below.

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.

Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset and liability, either directly or indirectly.

Level 3: Unobservable inputs for the asset or liability.

NOTE 5A: FAIR VALUE MEASUREMENTS

Fair value measurements at the end of the reporting period by hierarchy for assets and liabilities in 2014.

	Fair value ($)	Fair value measurements at the end of the reporting period using		
		Level 1 inputs ($)	Level 2 inputs ($)	Level 3 inputs ($)
Non-financial assets				
Leasehold improvements	94,755	–	–	94,755
Property, plant and equipment	43,241	–	–	43,241
Total non-financial assets	137,996	–	–	137,996
Total fair value measurements of assets in the statement of financial position	137,996	–	–	137,996

NOTE 5B: LEVEL 1 AND LEVEL 2 TRANSFERS FOR RECURRING FAIR VALUE MEASUREMENTS

No recurring fair value measurements were transferred between Level 1 and Level 2 for assets and liabilities during 2013–14.

NOTE 5C: VALUATION TECHNIQUE AND INPUTS FOR LEVEL 2 AND LEVEL 3 FAIR VALUE MEASUREMENTS

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

	Category (Level 2 or Level 3)	Fair value ($)	Valuation technique	Inputs used	Range (weighted average)
Non-financial assets					
Leasehold improvements	Level 3	94,755	Depreciated replacement cost	Total useful life and remaininng useful life	$110 per sqm
Property, plant and equipment	Level 3	43,241	Market approach	Market observables	2%–5%

Level 3 fair value measurements—valuation processes

The entitiy engages an external valuer to analyse changes in fair value measurements every 3 to 5 years. The last valuation was performed by the Australian Valuation Office at 30 June 2011, as the valuation is primarily based on depreciated replacement cost and market approach.

NOTE 5D: RECONCILIATION FOR RECURRING LEVEL 3 FAIR VALUE MEASUREMENTS

	Leasehold improvements 2014 ($)	Property, plant and equipment 2014 ($)	Total 2014 ($)
Opening balance	126,679	54,885	181,564
Purchases	–	5,763	5,763
Depreciation/amortisation	(31,924)	(17,407)	(49,331)
Closing balance	94,755	43,241	137,996

NOTE 6: FINANCIAL ASSETS

	2014 ($)	2013 ($)
NOTE 6A: CASH AND CASH EQUIVALENTS		
Cash on hand or on deposit	90,023	79,016
Total cash and cash equivalents	90,023	79,016
NOTE 6B: TRADE AND OTHER RECEIVABLES		
Goods and Services:		
Goods and services—external	138	646
Total goods and services	138	646
Appropriations receivable:		
For existing programs	30,000	1,762,722
Total appropriations receivable	30,000	1,762,722
Other receivables:		
GST receivable from the Australian Taxation Office	25,023	41,798
Total other receivables	25,023	41,798
Total trade and other receivables (net)	55,161	1,805,166
Receivables are expected to be recovered in:		
No more than 12 months	30,138	42,444
More than 12 months	25,023	1,762,722
Total trade and other receivables (net)	55,161	1,805,166
Receivables are aged as follows:		
Not overdue	55,161	1,805,166
Total receivables (gross)	55,161	1,805,166

NOTE 7: NON-FINANCIAL ASSETS

NOTE 7A: LEASEHOLD IMPROVEMENTS

	2014 ($)	2013 ($)
Leasehold improvements:		
Fair value	207,041	207,041
Accumulated depreciation	(112,286)	(80,362)
Total leasehold improvements	94,755	126,679

No indicators of impairment were found for leasehold improvements.

No leasehold improvements are expected to be sold or disposed of within the next 12 months.

NOTE 7B: PROPERTY, PLANT AND EQUIPMENT

	2014 ($)	2013 ($)
Property, plant and equipment:		
Fair value	83,094	123,248
Accumulated depreciation	(39,853)	(68,363)
Total property, plant and equipment	43,241	54,885

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

No property, plant and equipment is expected to be sold or disposed of within the next 12 months.

Revaluations of non-financial assets

All revaluations were conducted in accordance with the revaluation policy stated at Note 5. The last revaluation was conducted on 30 June 2011 by the Australian Valuation Office.

NOTE 7C: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT (2013–14)

	Leasehold Improvements ($)	Property, Plant & Equipment ($)	Total ($)
As at 1 July 2013			
Gross book value	207,041	123,248	330,289
Accumulated depreciation and impairment	(80,362)	(68,363)	(148,725)
Net book value 1 July 2013	126,679	54,885	181,564
Additions	–	5,763	5,763
Depreciation expense	(31,924)	(17,407)	(49,331)
Net book value 30 June 2014	94,755	43,241	137,996
Net book value as of 30 June 2014 represented by:			
Gross book value	207,041	83,094	290,135
Accumulated depreciation and impairment	(112,286)	(39,853)	(152,139)
	94,755	43,241	137,996

NOTE 7C (CONT'D):
RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT (2012–13)

	Leasehold Improvements ($)	Property, Plant & Equipment ($)	Total ($)
As at 1 July 2012			
Gross book value	205,071	110,747	315,818
Accumulated depreciation and impairment	(43,421)	(45,587)	(89,008)
Net book value 1 July 2012	161,650	65,160	226,810
Additions	1,970	12,501	14,471
Depreciation expense	(36,941)	(22,776)	(59,717)
Net book value 30 June 2013	126,679	54,885	181,564
Net book value as of 30 June 2013 represented by:			
Gross book value	207,041	123,248	330,289
Accumulated depreciation and impairment	(80,362)	(68,363)	(148,725)
	126,679	54,885	181,564

NOTE 7D: INTANGIBLES

	2014 ($)	2013 ($)
Computer software:		
Purchased	**1,048,771**	1,989,547
Accumulated amortisation	**(582,471)**	(1,389,923)
Total computer software	**466,300**	599,624
Other intangibles:		
Purchased	**75,262**	75,262
Accumulated amortisation	**(31,672)**	(24,148)
Total other intangibles	**43,590**	51,114
Total intangibles	**509,890**	650,738

No indicators of impairment were found for intangible assets.

No intangibles are expected to be sold or disposed of within the next 12 months.

	Computer software purchased ($)	Other intangibles purchased ($)	Total ($)
NOTE 7E: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF INTANGIBLES (2013–14)			
As at 1 July 2013			
Gross book value	1,989,547	75,262	2,064,809
Accumulated amortisation	(1,389,923)	(24,148)	(1,414,071)
Net book value 1 July 2013	599,624	51,114	650,738
Additions	102,610	–	102,610
Amortisation	(235,934)	(7,524)	(243,458)
Net book value 30 June 2014	466,300	43,590	509,890
Net book value as of 30 June 2014 represented by:			
Gross book value	1,048,771	75,262	1,124,033
Accumulated amortisation	(582,471)	(31,672)	(614,143)
	466,300	43,590	509,890

	Computer software purchased ($)	Other intangibles purchased ($)	Total ($)
NOTE 7E (CONT'D): RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF INTANGIBLES (2012–13)			
As at 1 July 2012			
Gross book value	1,815,797	75,262	1,891,059
Accumulated amortisation	(1,075,160)	(16,622)	(1,091,782)
Net book value 1 July 2012	740,637	58,640	799,277
Additions	173,750	–	173,750
Amortisation	(314,763)	(7,526)	(322,289)
Net book value 30 June 2013	599,624	51,114	650,738
Net book value as of 30 June 2013 represented by:			
Gross book value	1,989,547	75,262	2,064,809
Accumulated amortisation	(1,389,923)	(24,148)	(1,414,071)
	599,624	51,114	650,738

	2014 ($)	2013 ($)
NOTE 7F: OTHER NON-FINANCIAL ASSETS		
Prepayments	26,486	36,518
Total other non-financial assets	26,486	36,518
Total other non-financial assets—are expected to be recovered in:		
No more than 12 months	26,486	36,518
Total other non-financial assets	26,486	36,518

No indicators of impairment were found for other non-financial assets.

NOTE 8: PAYABLES

NOTE 8A: SUPPLIERS

	2014 ($)	2013 ($)
Trade creditors and accruals	106,078	65,415
Total supplier payables	106,078	65,415
Supplier payables expected to be settled within 12 months:		
External parties	106,078	65,415
Total	106,078	65,415
Total supplier payables	106,078	65,415

Settlement is usually made within 30 days.

NOTE 8B: OTHER PAYABLES

	2014 ($)	2013 ($)
GST payable to Australian Taxation Office	(36)	236
Lease liabilities	30,361	49,536
Other	22,369	23,628
Total other payables	52,694	73,400

NOTE 9: PROVISIONS

NOTE 9A: EMPLOYEE PROVISIONS

	2014 ($)	2013 ($)
Leave	358,944	388,357
Total employee provisions	358,944	388,357
Employee provisions are expected to be settled in:		
No more than 12 months	221,580	253,329
More than 12 months	137,364	135,028
Total employee provisions	358,944	388,357

NOTE 9B: OTHER PROVISIONS

Provision for restoration obligations	41,632	39,988
Total other provisions	41,632	39,988
Other provisions are expected to be settled in:		
More than 12 months	41,632	39,988
Total other provisions	41,632	39,988

NOTE 9B: OTHER PROVISIONS (CONT'D)

	Provision for restoration ($)	Total ($)
Carrying amount 1 July 2013	39,988	39,988
Unwinding of discount	1,644	1,644
Closing balance 2014	41,632	41,632

The entity currently has one agreement for the leasing of premises which have provisions requiring the entity to restore the premises to their original condition at the conclusion of the lease. The entity has made a provision to reflect the present value of this obligation.

NOTE 10: CASH FLOW RECONCILIATION

	2014 ($)	2013 ($)
Reconciliation of cash and cash equivalents as per Statement of Financial Position to Cash Flow Statement		
Cash and cash equivalents as per:		
Cash flow statement	90,023	79,016
Statement of financial position	90,023	79,016
Difference	–	–
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	(2,425,914)	(2,419,919)
Add revenue from Government	2,203,000	2,052,000
Adjustments for non-cash items		
Depreciation / amortisation	292,789	382,006
Net write down of non-financial assets	–	–
Finance cost	1,644	418
Changes in assets / liabilities		
Decrease in net receivables	17,283	99,881
(Increase) / decrease in prepayments	10,032	(30,933)
Increase / (decrease) in employee provisions	(29,413)	59,871
Increase in supplier payables	40,547	11,366
(Decrease) in other payables	(20,588)	(38,904)
Net cash from operating activities	89,380	115,786

NOTE 11: SENIOR EXECUTIVE REMUNERATION

	2014 ($)	2013 ($)
NOTE 11A: SENIOR EXECUTIVE REMUNERATION EXPENSES FOR THE REPORTING PERIOD		
Short-term employee benefits:		
Salary	**252,408**	230,196
Total short-term employee benefits	**252,408**	230,196
Post-employment benefits:		
Superannuation	**34,503**	32,831
Total post-employment benefits	**34,503**	32,831
Other long-term employee benefits:		
Annual leave accrued	**19,227**	18,775
Long-service leave	**8,652**	8,449
Total other long-term employee benefits	**27,879**	27,224
Total senior executive remuneration expenses	**314,790**	290,251

1. Note 11A is prepared on an accrual basis.
2. Note 11A excludes acting arrangements and part-year service where total remuneration expensed as a senior executive was less than $195,000.

NOTE 11B: AVERAGE ANNUAL REPORTABLE REMUNERATION PAID TO SUBSTANTIVE SENIOR EXECUTIVES DURING THE REPORTING PERIOD

Average annual reportable remuneration paid to substantive senior executives in 2014

Average annual reportable remuneration[1]	Substantive senior executives (No.)	Reportable salary[2] ($)	Contributed superannuation[3] ($)	Reportable allowances[4] ($)	Bonus paid[5] ($)	Total reportable remuneration ($)
Total reportable remuneration (including part-time arrangements):						
$225,000 to $254,999	1	212,594	34,503	–	–	247,097
Total number of substantive senior executives	1					

Average annual reportable remuneration paid to substantive senior executives in 2013

Average annual reportable remuneration[1]	Substantive senior executives (No.)	Reportable salary[2] ($)	Contributed superannuation[3] ($)	Reportable allowances[4] ($)	Bonus paid[5] ($)	Total reportable remuneration ($)
Total reportable remuneration (including part-time arrangements):						
$225,000 to $254,999	1	209,338	32,831	–	–	242,169
Total number of substantive senior executives	1					

Notes:

1. This table reports substantive senior executives who received remuneration during the reporting period. Each row is an averaged figure based on headcount for individuals in the band.
2. 'Reportable salary' includes the following:
   a) gross payments (less any bonuses paid, which are separated out and disclosed in the 'bonus paid' column);
   b) reportable fringe benefits (at the net amount prior to 'grossing up' for tax purposes);
   c) reportable employer superannuation contributions; and
   d) exempt foreign employment income.
3. The 'contributed superannuation' amount is the average cost to the entity for the provision of superannuation benefits to substantive senior executives in that reportable remuneration band during the reporting period.
4. 'Reportable allowances' are the average actual allowances paid as per the 'total allowances' line on individuals' payment summaries.
5. 'Bonus paid' represents average actual bonuses paid during the reporting period in that reportable remuneration band. The 'bonus paid' within a particular band may vary between financial years due to various factors such as individuals commencing with or leaving the entity during the financial year.

NOTE 12: REMUNERATION OF AUDITORS

Financial statement audit services were provided free of charge to the Private Health Insurance Ombudsman.

	2014 ($)	2013 ($)
Fair value of the services provided:		
Revenue received free of charge	17,800	16,000
Total	17,800	16,000

No other services were provided by the auditors of the financial statements.

NOTE 13: FINANCIAL INSTRUMENTS

NOTE 13A: CATEGORIES OF FINANCIAL INSTRUMENTS

	2014 ($)	2013 ($)
Financial Assets		
Cash and cash equivalents	90,023	79,016
Trade and other receivables	138	646
Total	90,161	79,662
Carrying amount of financial assets	90,161	79,662
Financial Liabilities		
Trade creditors	106,078	65,415
Total	106,078	65,415
Carrying amount of financial liabilities	106,078	65,415

NOTE 13B: FAIR VALUE OF FINANCIAL INSTRUMENTS

	Carrying amount 2014 ($)	Fair value 2014 ($)	Carrying amount 2013 ($)	Fair value 2013 ($)
Financial Assets				
Cash and cash equivalent	90,161	90,161	79,663	79,663
Total	90,161	90,161	79,663	79,663
Financial Liabilities				
Trade creditors	106,078	106,078	65,415	65,415
Total	106,078	106,078	65,415	65,415

NOTE 13C: CREDIT RISK

The Private Health Insurance Ombudsman's maximum exposure to credit risk was the risk that arises from potential default of a debtor.

NOTE 13D: LIQUIDITY RISK

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

NOTE 13E: MARKET RISK

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

The Ombudsman is not exposed to currency risk or other price risk.

NOTE 14: APPROPRIATIONS

TABLE A: ANNUAL APPROPRIATIONS ('RECOVERABLE GST EXCLUSIVE')

	2014 Appropriations			Appropriation applied in 2014 (current and prior years) ($)	Variance ($)
	Appropriation Act	*FMA Act*	Total appropriation ($)		
	Annual Appropriation ($)	Section 31 ($)			
DEPARTMENTAL					
Ordinary annual services	2,263,000	1,882	2,264,882	2,142,977	121,905
Total departmental	2,263,000	1,882	2,264,882	2,142,977	121,905

	2013 Appropriations			Appropriation applied in 2013 (current and prior years) ($)	Variance ($)
	Appropriation Act	*FMA Act*	Total appropriation ($)		
	Annual Appropriation ($)	Section 31 ($)			
DEPARTMENTAL					
Ordinary annual services	2,119,000	188,528	2,307,528	2,244,435	63,093
Total departmental	2,119,000	188,528	2,307,528	2,244,435	63,093

TABLE B: DEPARTMENTAL AND ADMINISTERED CAPITAL BUDGETS ('RECOVERABLE GST EXCLUSIVE')

	2014 Capital Budget Appropriations		Capital Budget Appropriations applied in 2014 (current and prior years)		Variance ($)
	Appropriation Act Annual Capital Budget ($)	Total Capital Budget Appropriations ($)	Payments for non-financial assets[2] ($)	Total payments ($)	
DEPARTMENTAL					
Ordinary annual services — Departmental Capital Budget[1]	60,000	60,000	30,000	30,000	30,000

	2013 Capital Budget Appropriations		Capital Budget Appropriations applied in 2013 (current and prior years)		Variance ($)
	Appropriation Act Annual Capital Budget ($)	Total Capital Budget Appropriations ($)	Payments for non-financial assets[2] ($)	Total payments ($)	
DEPARTMENTAL					
Ordinary annual services — Departmental Capital Budget[1]	60,000	60,000	60,000	60,000	–

Notes:

1. Departmental Capital Budgets are appropriated through Appropriation Acts (No.1,3,5). They form part of ordinary annual services, and are not separately identified in the Appropriation Acts. For more information on ordinary annual services appropriations, please see Table A: Annual appropriations.
2. Payments made on non-financial assets include purchases of assets, expenditure on assets which has been capitalised, costs incurred to make good an asset to its original condition, and the capital repayment component of finance leases.

TABLE C: UNSPENT DEPARTMENTAL ANNUAL APPROPRIATIONS ('RECOVERABLE GST EXCLUSIVE')

Authority	2014 ($)	2013 ($)
2007–2008 Appropriation Act 1	–	1,692,722
2008–2009 Appropriation Act 1	–	70,000
2012–2013 Appropriation Act 1	–	7,000
2013–2014 Appropriation Act 1 — DCB	30,000	–
Cash on hand or on deposit	90,023	79,016
Total	120,023	1,848,738

NOTE 15: COMPENSATION AND DEBT RELIEF

	2014 ($)	2013 ($)
Compensation and Debt Relief—Departmental		
No 'Act of Grace payments' were expensed during the reporting period (2013: nil)	–	–
The estimated amount outstanding in relation to payments being made on a periodic basis as at 30 June 2014 was $0 ($0 at 30 June 2013).	–	–
No waivers of amounts owing to the Australian Government were made pursuant to subsection 34(1) of the *Financial Management and Accountability Act 1997* (2013: No waivers).	–	–
No payments were provided under the Compensation for Detriment caused by Defective Administration (CDDA) Scheme during the reporting period (2013: No payments).	–	–
No ex-gratia payments were provided for during the reporting period (2013: No payments).	–	–
No payments were provided in special circumstances relating to APS employment pursuant to section 73 of the *Public Service Act 1999* (PS Act) during the reporting period (2013: No payments).	–	–

NOTE 16: REPORTING OF OUTCOMES

The Private Health Insurance Ombudsman is structured to meet one outcome, namely public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting.

	Outcome 1	
	2014 ($)	2013 ($)
NET COST OF OUTCOME DELIVERY		
Expenses		
Departmental	**2,445,596**	2,624,447
Total	**2,445,596**	2,624,447
Other own-source income		
Departmental	**19,682**	204,528
Total	**19,682**	204,528
Net cost/(contribution) of outcome delivery	**2,425,914**	2,419,919

NOTE 17: NET CASH APPROPRIATION ARRANGEMENTS

	2014 ($)	2013 ($)
Total comprehensive income (loss) less depreciation/amortisation expenses previously funded through revenue appropriations[1]	69,875	14,087
Plus: depreciation/amortisation expenses previously funded through revenue appropriation	(292,789)	(382,006)
Total comprehensive loss—as per the Statement of Comprehensive Income	(222,914)	(367,919)

1. From 2010–11, the Government introduced net cash appropriation arrangements, where revenue appropriations for depreciation/amortisation expenses ceased. Entities now receive a separate capital budget provided through equity appropriations. Capital budgets are to be appropriated in the period when cash payment for capital expenditure is required.

NOTE 18: CONTINGENCIES

There were no quantifiable, unquantifiable or remote contingencies in 2013–14 (2012–13: nil).

Glossary

Agreement hospital: Private hospital or day surgery contracted with a health insurer to provide services at low or no out-of-pocket costs.

Broker: A person or organisation which sells private health insurance on behalf of a health insurer.

Combined policy: Health insurance that covers both hospital and general treatment services. See General treatment policy and Hospital policy.

Exclusions: Conditions or services which are not covered by a hospital insurance policy.

Health fund: see Health insurer.

Health insurer: Organisation which provides private health insurance, also known as a 'health fund'.

Department of Health: The Commonwealth Government department responsible for policy development and maintaining the regulatory framework for private health insurance.

Gap fee: The amount you pay out of your own pocket for medical treatment in hospital, over and above what you get back from Medicare or your private health insurer. Health insurers have gap cover arrangements to insure against some or all of these additional payments.

General treatment policy: Health insurance to cover non-hospital medical services that are not covered by Medicare, such as dental, optical, and ambulance. Also known as 'extras' or 'ancillary' cover.

Hospital policy: Health insurance to cover your costs as a private patient in hospital.

Hospital Agreement: The contract between a health insurer and a private hospital to provide services at low or no out-of-pocket costs.

Informed Financial Consent: The provision of cost information to patients; including notification of likely out-of-pocket expenses (gap fees) by all relevant service providers, preferably in writing, prior to admission to hospital.

Lifetime Health Cover: A government initiative introduced from 1 July 2000 that determines how much you pay for private hospital insurance, primarily based on your age.

Medicare: Australia's universal public health care system.

Medicare Benefits Schedule: The schedule of fees set by the government for standard medical services.

Medicare Levy Surcharge: An income tax levy that applies to Australian taxpayers who earn above a certain income and do not have private hospital cover.

Overseas Student Health Cover: A type of health cover designed for overseas student visa holders which can be purchased from some Australian private health insurers.

Overseas Visitors Health Cover: A type of health cover designed for people without Medicare benefits or with only reciprocal (partial) Medicare benefits.

Pharmaceutical Benefits Scheme: A government subsidy which reduces the price of some prescription medicines. The Scheme is available to all Australian residents who hold a current Medicare card.

PHIO: Private Health Insurance Ombudsman.

Private Health Insurance Administration Council: An independent Statutory Authority which is responsible for the prudential regulation of private health insurers.

Private Health Insurance Rebate: Most Australians with private health insurance currently receive a Rebate from the government to help cover the cost of their premiums. The Rebate is income tested and varies depending on your age.

Restrictions: Treatment or services which a hospital insurance policy covers to a limited extent and which are eligible for only reduced benefits on hospital admissions. Where a policy has a restriction, the benefit paid is only sufficient to cover the cost of admission as a private patient in a shared room in a public hospital; it is not sufficient to cover the cost of a private room in a public hospital or any room in a private hospital.

Waiting period: How long you need to be a member of a policy before you are eligible for benefits.

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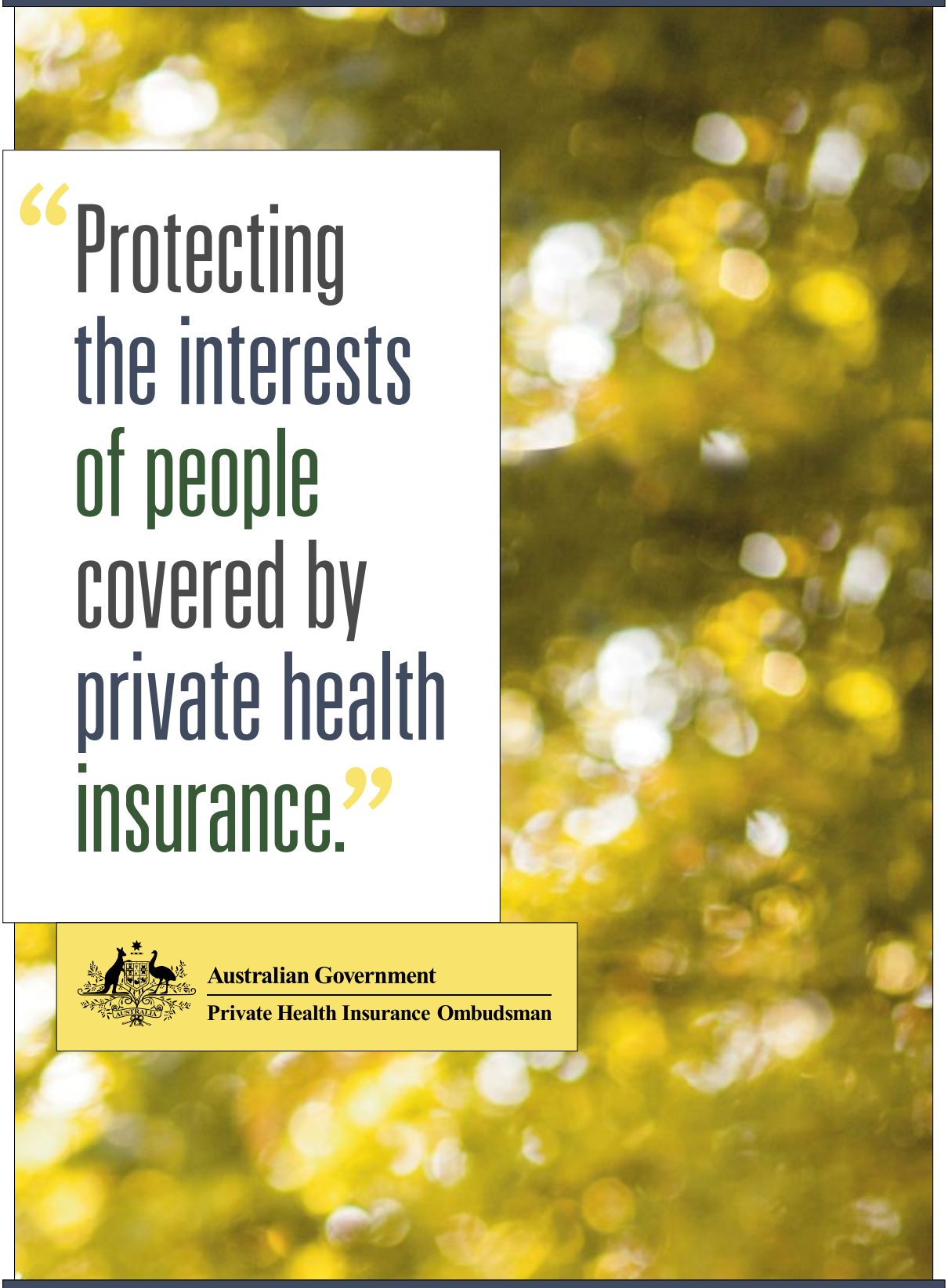

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