Australian Government

Private Health Insurance Ombudsman

Annual Report 2010

Contacts

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(Translating and Interpreting Service)

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

Readers with inquiries about the Ombudsman or this report should contact the Administration Officer at the above address. Information for Senators and Members is available from the Private Health Insurance Ombudsman, at the above telephone and facsimile numbers.

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Australian Government

Private Health Insurance Ombudsman

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

Dear Minister

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

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2009 to 30 June 2010.

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

Yours sincerely

Samantha Gavel

Samantha Gavel
Ombudsman
24 September 2010

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Ombudsman's Overview

Samantha Gavel – Ombudsman

The Private Health Insurance Ombudsman is an Australian Government agency that acts independently in dealing with complaints and reporting in relation to private health insurance.

My role as Private Health Insurance Ombudsman (PHIO) recognises the need for consumers to have access to information about their rights and responsibilities, and to have confidence that their rights are protected.

In undertaking this role, my office provides an independent service for dealing with complaints relating to private health insurance through a system that is accessible, effective, timely, objective and non-judgmental. In addition, PHIO identifies underlying problems in the practices of private health insurers or health providers relevant to the administration of private health insurance and encourages health insurers to continuously improve their own complaints handling processes. PHIO also has an important consumer education role in assisting consumers to understand their private health insurance and their rights and responsibilities in relation to their health insurance.

During the 2009/10 year, we have focussed on improving the range and quality of information available to consumers to assist them to make better informed decisions about private health insurance. We have also worked with insurers in addressing many of the underlying causes of complaints to PHIO to improve their communications and internal complaints handling processes.

The 2009/10 year has been busy and productive for PHIO. Highlights for the year have included:

- A complete refresh and updating of the consumer website www.privatehealth.gov.au to provide better information and resources to consumers about private health insurance;
- 87% of consumers satisfied or very satisfied with PHIO's independent complaint handling service;
- A series of educational workshops to assist industry with improving its internal complaints handling practices in order to address the underlying causes of complaints to the office;
- Updating of PHIO's www.phio.org.au website to simplify the process for consumers to lodge complaints by e-mail and access information about PHIO and private health insurance;
- Development of a set of consumer Fact Sheets about issues of cowncern to consumers, including premium increases, informed financial consent and policy restrictions;

- Organisation of industry consultations in relation to the introduction of new health insurance arrangements for 457 visa holders and acute care certification processes for long stay private patients in public hospitals;
- Resolution of three hospital contract disputes between large insurers and hospital groups through PHIO's mediation process, as well as a number of disputes that required more informal assistance from PHIO.

Owing to their importance, I have detailed further information in relation to these highlights below.

Health Insurance Complaints

An important function of PHIO is our independent complaints handling service. As well as resolving individual complaints, our complaints data is a useful source of information about issues of concern to consumers in relation to private health insurance. Using this data, we are able to identify systemic issues within an insurer, or the industry more broadly. PHIO can address these directly with the individual insurer, the wider industry, or provide advice to government about issues of concern.

PHIO received 2618 complaints during 2009-10, which was an increase of 5% on the 2502 complaints received during the previous year. The increase in overall complaint numbers is within expectations, given the increase during the reporting period in people taking out private health insurance.

The number of higher level complaints investigated by PHIO decreased slightly in 2009-10 to 684, down from 708 in 2008-09. This continues the downward trend in higher level complaints requiring intervention by PHIO over the last five years. PHIO's focus on working with insurers to improve their internal complaints handling practices, improving information and advice to consumers about private health insurance through the consumer website www.privatehealth.gov.au and the introduction of the industry Code of Conduct in 2006 have all contributed to this decline.

Fund Rule Changes

During the year, a number of insurers introduced policy restrictions on some levels of cover. These changes led to an increase in complaints about fund rule changes, from 63 in 2008/09 to 143 in 2009/10. Two funds introduced restrictions on gastric banding services to lower level covers; one fund changed the way its loyalty bonus operated and one fund changed the restrictions for services such as hip replacement, cardiac surgery and obstetrics to exclusions on some of its policies.

Insurers are able to make these types of changes to their policies, in order to manage premium increases, improve services or change features that may be causing difficulties or confusion. It is important, however, that changes such as these are communicated to members in plain and unambiguous language and that advice is provided about options to upgrade or change cover if the member is not happy with the change in their policy.

Where a significant detrimental change is made to a policy, such as removing a benefit for a particular service or treatment, there needs to be follow up communication with members to ensure they are aware of and understand the change to their policy. There also needs to be flexibility to assist members with special circumstances.

During the year, PHIO provided advice to insurers about ways to improve communications with members about rule changes. PHIO also investigated individual complaints from members and assisted members to resolve these with their insurer.

Policy Restrictions and Exclusions

Health insurers offer a range of policies to meet different consumer needs. Some consumers

want a policy that qualifies them for Lifetime Health purposes or to avoid the Medicare Levy Surcharge and are prepared to take a restricted policy for this specific purpose.

It is important, however, for consumers to review their policy every year, to make sure it will continue to meet their needs during the course of the coming year. Funds are required to send a one page "Standard Information Statement" to members each year, which outlines the main features of their policy and any applicable excesses, restrictions or exclusions. This is a useful tool for reminding members about their cover and it can also be used for comparison with other policies they may be interested in purchasing.

PHIO advises consumers to take out the highest level of hospital cover they can afford and choose to take an excess, rather than a policy restriction or exclusion. If consumers choose to take a policy with a restriction or exclusion, it is important that they understand what the restrictions mean.

Restrictions on psychiatric services, cardiac services and plastic and reconstructive services can be problematic, because these services can require immediate treatment and occur in any age group. The waiting period for psychiatric services is two months, however, which provides protection to members who find they need this service and are on an inappropriate level of cover. To assist consumers in understanding how a restriction or exclusion could affect them, PHIO has developed a set of consumer Fact Sheets about restrictions. These are available for downloading from the www.phio.org.au website and copies can also be requested by calling (1800 640 695) or e-mailing PHIO (info@phio.org.au).

Plastic and reconstructive surgery restrictions cause particular problems, because consumers associate plastic surgery with cosmetic procedures. There are, however, many treatments that are classified as plastic and reconstructive surgery that are medically necessary, and these include burns treatment and skin flap repair after cancer surgery.

We received a small number of complaints about restrictions on plastic and reconstructive surgery during the year. Although the number of complaints was small, analysis of these complaints showed that information given to members about plastic and reconstructive surgery restrictions was in some cases confusing and in other cases insufficient.

PHIO has produced a consumer Fact Sheet specifically about restrictions on plastic and reconstructive surgery and is reviewing brochures and other information provided to consumers about this restriction to ensure it is properly explained.

Waiting Periods

PHIO has always received a consistent level of complaints about waiting periods. This is not surprising, because it is an area where people can be understandably aggrieved when they find out they are not covered for treatment due to the application of a waiting period.

The most often complained of waiting period is the twelve-month waiting period for Pre-Existing Conditions (PECs). PHIO received 170 complaints about the PEC waiting period in 2009/10, which was a small increase on the 165 received in the previous year.

All insurers can apply this waiting period under legislation[1] and it is an important protection of the premium contributions of existing members that prevents people from joining a fund and claiming immediate benefits only when they have a condition that may require treatment. It is important, however, that new and upgrading members understand how the waiting period may affect them if they need treatment in their first year of membership or upgrading their cover.

PHIO has done considerable work over many years with insurers to ensure they are applying the PEC rule correctly and that they are applying the PEC Best Practice Guidelines[2] when dealing with new and upgrading members and assessing claims. As a result, in most cases that come to the office, the insurer has applied the PEC rule correctly in assessing the claim. Complaints to the office show, however, that not all insurers are consistently applying the PEC Best Practice Guidelines when advising members about their entitlements and assessing claims.

The PEC Guidelines were developed some years ago to ensure that new and upgrading members are made aware of the PEC waiting period when they join and when they need a hospitalisation in the first twelve months of membership. The Guidelines also provide advice to funds, hospitals and medical practitioners about a number of issues including timeframes for dealing with PEC assessments and ensuring members are able to give Informed Financial Consent to out-of-pocket charges in cases where the waiting period applies to their treatment. PHIO will continue to work with insurers over the coming year to improve compliance in this area.

PHIO provides an important check and balance in relation to the application of the PEC rule. If consumers are unsure about their fund's decision to deny benefits on PEC grounds, they can have the matter independently reviewed by the office.

Working with Insurers to Address Causes of Complaints

In early 2010, PHIO staff members conducted a series of industry workshops designed to assist funds in improving their internal complaint handling processes and ensure that fund staff members understand PHIO's processes and expectations.

The aim of the workshops was to address some of the underlying causes of complaints to PHIO, as well as improve services for consumers and increase the satisfactory resolution of complaints at the fund level, without the need for the member to escalate the matter to the PHIO. This preserves the member's relationship with their fund and results in higher levels of consumer satisfaction overall.

Some of the areas addressed during the workshops included: ways to communicate more clearly with members, particularly in relation to fund rule changes; exclusions and limitations and benefit entitlements; applying the Best Practice Guidelines for the Pre-Existing Condition waiting period; and assisting members to obtain Informed Financial Consent from the fund, as well as medical and hospital providers.

Feedback from the workshops was very positive and PHIO intends to run similar workshops in future. Over time, we expect the workshops to assist in reducing the level of complaints about information and fund rule change issues, as well as PEC waiting periods. In the coming year, PHIO will monitor the level and nature of complaints relating to these issues as a mechanism for measuring the success of the workshops, as well as assessing any required changes to workshop content or emphasis.

Monitoring and Reporting on Fund Performance and Service Delivery

PHIO also has a role in monitoring the performance and service delivery of health insurers and, importantly, making this

[1] Private Health Insurance Act 2007, Division 75

[2] Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars01-02-736_470.htm

information publicly available to consumers. This ensures consumers have ready access to reliable and independent information about private health insurers and health insurance generally. It also encourages insurers to improve their practices and service performance.

The two main areas where we monitor the performance of insurers are through reporting of our complaints statistics (compiled quarterly and annually through PHIO's Annual Report to Parliament) as well as the reporting PHIO undertakes in the annual State of the Health Funds Report. Both of these documents are publicly available through the www.phio.org.au website or by contacting the office (1800 640 695) or e-mailing PHIO (info@phio.org.au).

Consumer Information and Advice

PHIO has an important role in providing consumers with information and advice about private health insurance. In 2009/10, PHIO focussed on a number of initiatives to improve services for consumers in relation to this.

During the year, we undertook a full review of the consumer website (www.privatehealth.gov.au), which originally went live in April 2007.

The review was informed by consumer focus testing, as well as feedback from the survey and "Ask a Question" feature that were both available on the previous version of the website. Based on this information, a full update of the website was undertaken to improve the overall design of the site, improve the location and detail of information, and provide a better comparison tool to enable consumers to search for and compare health insurance policies.

In addition, information was included about average dental charges by State, to help consumers better understand dental charges, make more informed decisions when purchasing dental services and encourage competition between providers.

Pleasingly, visits to the website have continued to increase this year. The website currently receives an average of 25,413 unique visits a month and feedback from consumers continues to be positive.

In March 2009, the "Ask a Question" feature was added to the website to enable consumers to seek speedy responses by e-mail to questions or concerns they may have about private health insurance. The feature is very useful to individuals in having their questions answered, but it is also useful in assisting PHIO gain an insight into issues that are causing confusion or where information is difficult to find. Analysing the types of questions being asked has enabled PHIO to respond by improving or adding information to the website and producing consumer Fact Sheets about issues where consumers are often looking for more information.

PHIO also updated and refreshed its own website www.phio.org.au. The website has improved functionality to make it easier for consumers to lodge complaints via e-mail, subscribe to PHIO's Quarterly Bulletin and access Fact Sheets on issues such as premium increases, policy restrictions and informed financial consent. A set of new consumer Fact Sheets on issues that cause complaints has been developed and are available from the website or by calling PHIO on 1800 640 695.

Each year, PHIO produces a *State of the Health Funds Report*, which provides comparative information about health insurers. This information is useful to consumers who want to assess the performance of their own insurer, or choose an insurer to join. It complements the information available on the www.privatehealth.gov.au website.

The format and content of the *State of the Health Funds Report* will be reviewed in the coming year to make it more consumer friendly. In addition, an interactive web-based version of the report will also be produced.

Introduction of Standard Information Statements - Three Years Later

Standard Information Statements (SISs) were introduced in conjunction with the launch of the www.privatehealth.gov.au website on 1 April 2007. The statements were intended to summarise key policy details into a single-page document, to make it easier for consumers to understand their own health insurance policy and compare it with other policies available for sale.

Since 2007, the statements have been posted to all policy holders in Australia annually, as well as viewed by hundreds of thousands of internet users online. The PHIO has received only rare complaints from consumers in that time about the information provided on the SIS. This low level of complaint, together with research data, survey results and feedback from users of the website indicates that the statements are understood by consumers and that they have find them to be a valuable source of policy information.

The *Ipsos Health Care and Insurance Australia* report released in November 2009 found that there was a high level of awareness among consumers surveyed for the report of receiving their SIS. Almost half of those respondents who recalled receiving their SIS took some positive action upon receiving it, such as reviewing their policy or using the SIS to compare their policy with other policies. Almost half of the remaining respondents filed it away for future reference[3].

I believe that sending an SIS to members annually is an important way of reminding them about important features of their policy, particularly in relation to waiting periods and restrictions or exclusions on the policy.

Many complaints to my office occur because consumers are not aware of restrictions or exclusions on their policies, particularly if a number of years have elapsed between purchasing the policy and needing to claim benefits.

The SIS also promotes competition within the industry, by making it easier for consumers to compare policies and providing greater transparency about what is covered.

Hospital Contracting Issues

During the year, PHIO was required to intervene in several disputes between health insurers and hospitals about renewal of contracting arrangements. In a number of these, PHIO used its mediation process to assist in resolving the dispute.

Under hospital contracting arrangements, health insurers and healthcare providers are able to negotiate a contract for the provision of hospital services at an agreed price. This promotes competition within the market and assists insurers to better manage costs and premium income.

[3] Ipsos Report Health Care & Insurance Australia 2009 pages 465-469

If a member attends a hospital with which their insurer has an agreement, they will have very few, if any, out of pocket costs for their hospitalisation. (They may still incur out of pocket costs for medical services by their treating doctors.)

If an insurer and hospital are not able to reach agreement about a new contract, and the contract is terminated, members attending that hospital will have substantial out of pocket costs. PHIO has produced a set of "Termination and Communication Protocols" for health insurers and hospitals to ensure adequate transitional arrangements in the event of a contract termination. These were updated, in consultation with stakeholders, during the year.

Because contract disputes can have a significant detrimental impact on consumers' entitlements under their health insurance, PHIO has legislative powers to require a health insurer and hospital to attend mediation with an independent mediator, to assist in resolving the dispute.[4] PHIO organised for independent mediation on three occasions during the year and a satisfactory outcome was achieved in all of these disputes.

Overseas Visitor Cover

In 2009, the Government introduced a number of changes to immigration requirements for 457 visa holders. Included in these changes was the introduction of a minimum health insurance requirement from 1 September 2009 to ensure that 457 visa holders and their families would be adequately covered by health insurance for the duration of their stay in Australia.

The office assisted the Department of Immigration and Citizenship to develop the minimum health insurance requirement and with its industry consultation in relation to this issue.

To date, the new arrangements appear to be working well, with a broad range of policies available from registered health insurers and general insurers that meet the minimum standard.

I have noted my concern in previous reports[5] about some of the health insurance policies available to overseas visitors. Overseas visitors, unless covered by the reciprocal arrangements, are completely reliant on health insurance or their own resources to cover their health costs while in Australia. Complaints to this office have revealed that some basic levels of Overseas Visitor cover do not provide sufficient cover.

Setting a minimum health insurance requirement, as has been done with the minimum requirement for health insurance for 457 visa holders, would be an option for addressing this issue.

Industry Developments

From 1 July 2010, new legislative provisions mean that people who have held a hospital policy for ten years will be eligible to have their Lifetime Health Cover penalty loading removed from their policy. [6]PHIO will be working with insurers to assist consumers with any problems that arise, particularly in regard to the recognition of previous health insurance memberships.

During the year, a number of insurers introduced broader health initiatives, to give their members access to chronic disease management, health prevention and hospital substitution programs. It is pleasing to note

[4] Private Health Insurance Act 2007, Division 247
[5] PHIO State of the Health Funds Report 2009 p 11
[6] Private Health Insurance Act 2007, Division 34-10

some very positive innovation occurring in the broader health area, which will greatly benefit members. It is hoped that more insurers will consider the introduction of similar programs over the coming year.

PHIO is also currently consulting with insurers, State Health Departments and public hospitals in relation to arrangements for the certification of long stay patients in public hospitals who are treated as private patients. The aim of the consultation is to improve processes to ensure they are transparent, fair and administratively efficient for insurers and hospitals.

Corporate Governance

PHIO is a prescribed statutory agency under the *Financial Management and Accountability Act 1997* (FMA Act) and works through its Audit Committee to ensure compliance with the requirements of the FMA Act.

PHIO became subject to the FMA Act from 1 July 2007. As 2010 marked three years since the transition to the FMA Act, an independent review of PHIO's compliance with the FMA Act was undertaken in late June 2010. The review found that the processes, procedures and controls PHIO has in place comply with the Act.

PHIO staff members are employed under the provisions of the *Public Service Act 1999* and are required to adhere to the Australian Public Service Values and Code of Conduct. PHIO provides a flexible working environment to its staff and training and development through its Performance Development Program.

PHIO reviewed its accommodation needs during the year and resulting from this, has acquired a five-year lease and will re-locate its offices in early July 2010. The new premises will better meet PHIO's requirements for space, security, accessibility and energy efficiency in future years.

During the year, PHIO improved its corporate planning processes and is in the process of updating the corporate plan for the coming year. Pleasingly, the goals of this year's plan were met, including the updating of our two websites, the industry education seminars and the development of a new series of consumer fact sheets.

The Year Ahead

PHIO has a number of priorities for the coming year, including:

- On-going monitoring and review of the consumer website www.privatehealth.gov.au to ensure it continues to meet consumers' needs for independent information about private health insurance;
- Review and updating of the format of the State of the Health Funds report to make it more accessible and consumer friendly;
- A consumer awareness campaign to focus attention on the updated www.privatehealth.gov.au website;
- Finalising the industry consultation on Acute Care Certification issues;
- Focusing on continuous improvement to our complaints handling service through staff development and training and initiatives to reduce the number of complaints that are open after 90 days;
- Monitoring any issues arising out of the removal of the Lifetime Health penalty loading from members who have held hospital insurance for ten years.

Samantha Gavel
Private Health Insurance Ombudsman

Role and Function

Introduction

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

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 problems about private health insurance, and acts as the umpire in dispute resolution at all levels within the private health industry.

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

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

Damien Maynard, Alison Leung, Kate Hocknull, Samantha Gavel, Ursula Schappi, Jim Robertson, Kaylie Blyton, Rosie Edwards, Hilary Bassingthwaighte, Richard Van Der Male, David McGregor.

Who Can Make a Complaint?

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

Persons Against Whom a Complaint May Be Made

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

What Can the Ombudsman Do with a Complaint?

The Ombudsman is able to deal with complaints by:

- 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?

The Ombudsman is able to recommend that:

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

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

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

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

How the Ombudsman's Staff Resolve Complaints

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

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

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

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

Performance

The 2009/10 Portfolio Statement for the Health and Ageing Portfolio outlines the Ombudsman's program to promote public confidence in private health insurance. The program's Key Strategic Directions are:

- To ensure the protection of the interests of insured persons;
- To further improve the quality and accessibility of information available to consumers on private health insurance products; and
- To provide private health insurance consumers with an efficient and effective complaints handling service.

The following is a summary of performance outcomes against the program's formal performance indicators in 2009/10:

Qualitative deliverable	Output	2009/10 Result
Protecting the interests of private health consumers.	Quality information to better understand their private health insurance and choose an insurance policy that better meets their individual needs. Measured by utilisation of PHIO's consumer brochures and the consumer website.	Consumer brochures were sent directly to consumers and also distributed by health funds, hospitals and providers, with over 94,000 brochures distributed throughout the year. The consumer website received 264,692 unique visits throughout the year, an increase of 35% from the previous year.

Quantitative deliverable	2009/10 Budget Target	2009/10 Result
Number of high quality and timely advisory services, policy advice, and submissions and reports, measured by stakeholder feedback.	≥12	14

Key Performance Indicators

Quantitative deliverable	2009/10 Budget Target	2009/10 Result
Protecting the interests of health insurance consumers		
Percentage of recommendations that have resulted in changes to insurer or industry practices.	75%	100%
Contribute to consumer empowerment		
Level of customer satisfaction	85%	87%
Percentage of information products useful or very useful for consumers	75%	95%
Complaints handling service		
Percentage of complaints finalised during the year	90%	98%
Percentage of complaints finalised within one month of receipt and a reduction in the average time taken to finalise level 3 disputes	80%	77.6% finalised, increase in average time taken to finalise level 3 disputes

Complaints

The Ombudsman received 2618 complaints during 2009/10. This was an increase of 116 complaints (5%) on the previous year.

Of those complaints, 684 were classified as Level 3 Disputes, a 3% decrease on the previous year. Level 3 complaints are those where the Ombudsman's staff acts on behalf of a complainant by requesting a report from a health fund or other object of complaint. The report is then reviewed and either closed as a satisfactory response or investigated further.

Figure 1 shows the distribution of complaints over the four quarters of the 2009/10 financial year.

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.

Consumer Enquiries

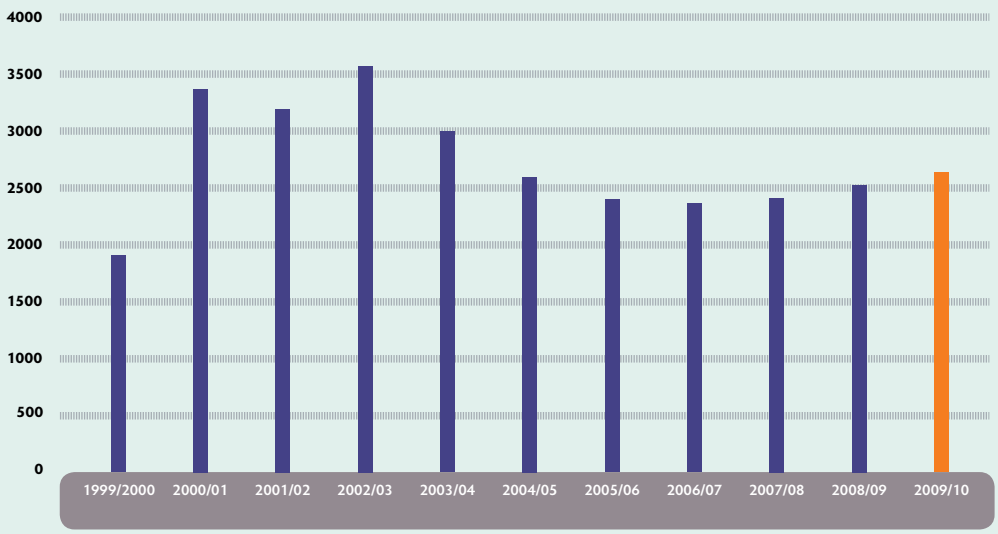
Enquiries are instances where the Ombudsman's staff provided advice or information, where the matter does not meet the definition of a complaint. In 2009/10, 1757 consumer enquiries were recorded. This was a 290% increase on last year's figure of 605 enquiries.

The majority of enquiries (1520 enquiries, or 87%) are received via the Ombudsman's consumer website www.privatehealth.gov.au. The large increase in enquiries is due to the addition of the 'Ask A Question' feature on the website in March 2009, which allows consumers to contact the Ombudsman by filling out a form, and due to the increased visibility and awareness of the website in general. (See: *Consumer Website* section for more information.)

Figure 1 **Total Complaints Received per Quarter**

Figure 2 shows the total number of complaints received per year for the last 10 years. The increase in the number of complaints in the 2000/01 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.

Figure 2 **Total Complaints Received per Year**



Recording and Categorisation of Complaints

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

Complaints 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 who 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 2009/10, 80% of Level 1 complaints were resolved as "Assisted Referrals," where the Dispute Resolution Officer referred a complaint directly to the insurer or service provider on behalf of the complainant. 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.

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

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

Level 2 complaints are dealt with by staff 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 respondent and not have been resolved. The Ombudsman attempts resolution through conciliation by telephone or in writing. Common complaints in this category include pre-existing ailments, lack of informed financial consent, benefits available on transfer of membership, benefits not in accordance with brochure descriptions and contribution errors.

Figure 3 shows the ratio of complaints by level: 1560 complaints were classified as Level 1, 374 as Level 2, and 684 as Level 3. There was a significant increase in the number of Level 1 complaints from the previous year, and reductions in the number of Level 2 and 3 complaints.

Figure 3 Complaints Received per Year by Category

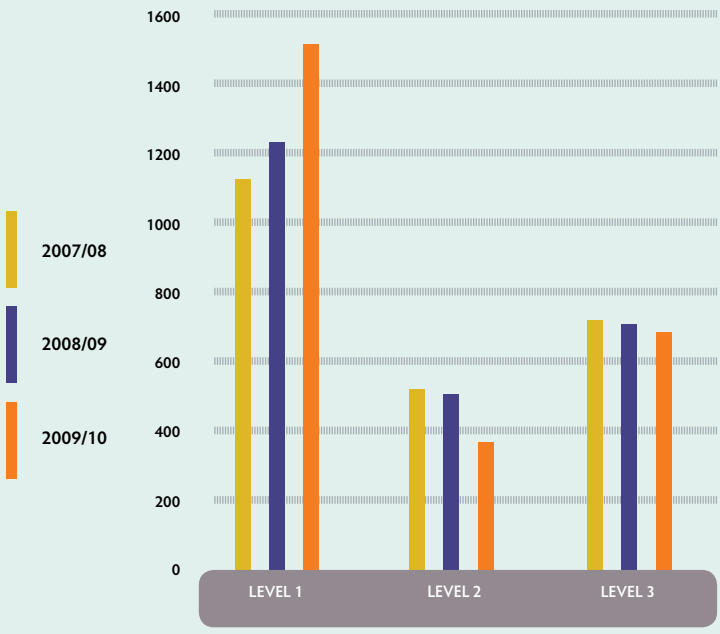
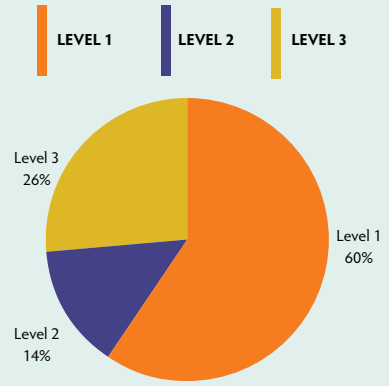


Figure 4 Complaints by Category 2009/10



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 fund's initial response or if further investigation of the matter was required.

A complaint's categorisation may be changed from Level 1 to 3 in audit. All 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.

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

Figure 5 Steps In Handling Approaches To The Ombudsman

LEVEL 3 [DISPUTE]

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

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

Outcomes
Explanation of health fund or provider's action; mediated resolution including payment of benefits; or formal recommendation by Ombudsman.

LEVEL 2 [GRIEVANCE]

Timeframe
Usually within 24 hours

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

Outcomes
Detailed information provided which appropriately resolves the issue.

LEVEL 1 [PROBLEM]

Timeframe
Immediate

Action
If complainant has made insufficient effort to resolve the matter with fund or provider, refer complaint to fund on behalf of complaint or empower the complainant to take the matter up directly.

Outcomes
Referral to health fund or provider. Complainant may also contact PHIO and request a review; these matters may then be upgraded to a Level 3 Dispute.

David McGregor (Director Policy & Client Services)

- Hospitals (generally about inadequate information to enable informed financial consent);
- Doctors (almost always about lack of informed financial consent or the gap between charges and benefits paid through Medicare and the fund); or
- Other practitioners (generally about the gap between the charges and the benefit paid 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 surrounding selective contracting and difficulties in arriving at a satisfactory conclusion to a contract or arrangement constitute the majority of complaints from this group.

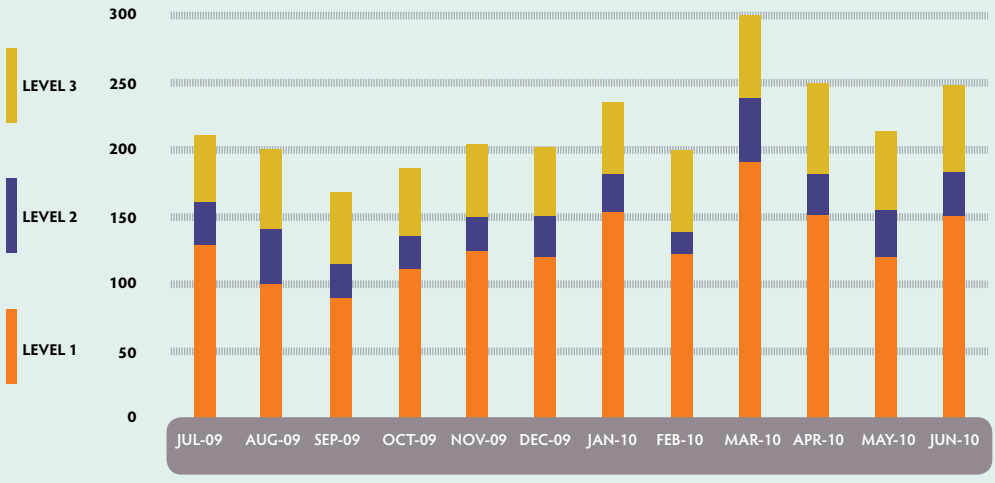
Workload

The office received 2618 complaints (Level 1, 2 and 3) in 2009/10, an average of 218 per month compared to 209 per month in the previous year.

The office finalised 2634 complaints during the year, an average of 220 per month compared to 205 in the previous year.

Of the finalised complaints, 694 were Level 3 complaints, compared to 679 in the previous year.

Figure 6 **Total Complaints Received by Month**



The Ombudsman recorded 1757 consumer enquiries this year, compared to 605 in the previous year.

Figure 6 shows the number of complaints by month and by level. The office tends to receive high numbers of contacts during March to July each year, due to the annual premium adjustments for all health insurers.

Time Taken to Resolve Complaints

Figures 7 and 8 provide information on the time taken to resolve complaints this year compared to last year. There has been a small increase in the time taken to handle complaints, with 82.1% of complaints handled within one month, compared to 83% the previous year and 87% the year before that.

Figure 7 Time Taken to Finalise Complaints

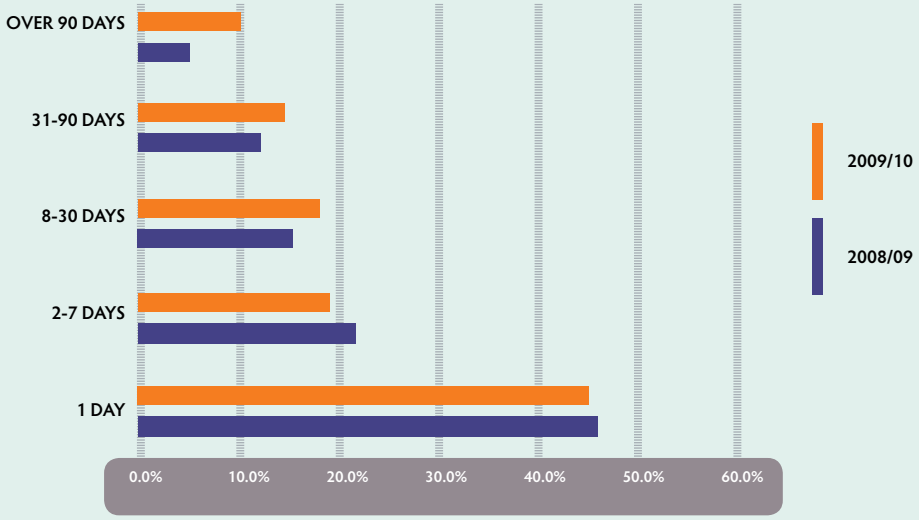


Figure 8 Complaints Finalised Since Day of Lodgement

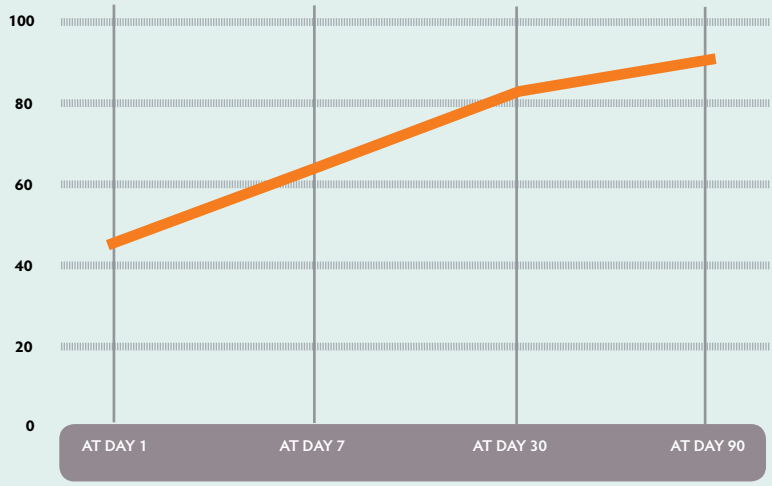


Figure 9 **Objects of Complaint 2009/10**

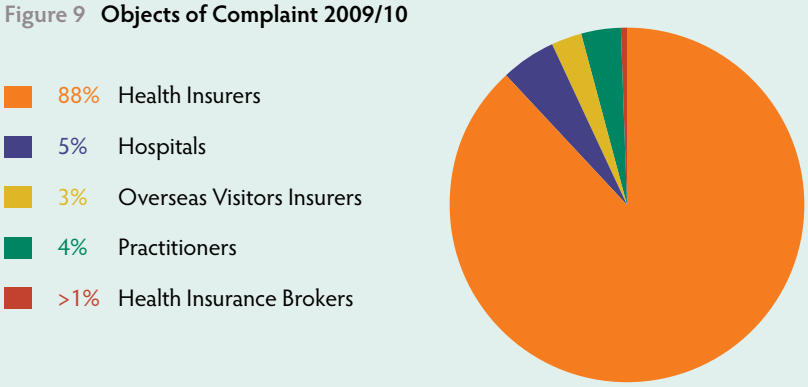


Figure 10

	2008/09	2009/10
Health Insurers	2325	2376
Hospitals	134	138
Overseas Visitors Insurers	92	71
Practitioners	72	104
Health Insurance Brokers	19	8

Who Was Complained About

Most complaints were made about registered health insurers, followed by hospitals, practitioners, overseas visitor policies, and health insurance brokers.

As some complaints concerned one or more health insurers, or a health insurer as well as a health care provider, the total number of organisations or people that were complained about (2697) adds up to more than the total number of individual complainants contacting the Ombudsman (2618).

Complaints about Registered Health Insurers

Figure 11 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. 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 disputes resolution process for complex issues within the insurer.

Complaints about Hospitals

The Ombudsman received 138 complaints about hospitals, steady from 134 complaints 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

Amelia Messner (Dispute Resolution Officer)

Figure 11 **Complaints by Health Insurer Market Share (01 July 2009 - 30 June 2010)**

NAME OF INSURER	COMPLAINTS	PERCENTAGE OF COMPLAINTS	DISPUTES	PERCENTAGE OF COMPLAINTS	MARKET SHARE
AHM	83	3.5%	24	3.9%	3.0%
AU	101	4.3%	26	4.3%	3.1%
BUPA	248	10.4%	62	10.2%	9.8%
CBHS	18	0.8%	4	0.7%	1.2%
Cessnock	0	0.0%	0	0.0%	0.1%
CUA	5	0.2%	1	0.2%	0.4%
Defence	17	0.7%	4	0.7%	1.5%
Doctors	1	0.0%	0	0.0%	0.1%
GMHBA	33	1.4%	12	2.0%	1.6%
GU	11	0.5%	0	0.0%	0.3%
HBF	72	3.0%	13	2.1%	7.7%
HCI	0	0.0%	0	0.0%	0.1%
HIF	10	0.4%	3	0.5%	0.5%
HealthGuard	5	0.2%	1	0.2%	0.5%
Health-Partners	9	0.4%	1	0.2%	0.7%
HCF	151	6.4%	29	4.8%	8.9%
Latrobe	27	1.1%	6	1.0%	0.6%
MU	93	3.9%	32	5.2%	1.4%
MBF Alliances	95	4.0%	23	3.8%	1.9%
MBF	498	21.0%	144	23.6%	15.7%
Medibank	556	23.4%	127	20.8%	28.6%
Mildura	1	0.0%	1	0.2%	0.3%
Onemedifund	0	0.0%	0	0.0%	0.1%
Navy	3	0.1%	1	0.2%	0.3%
NIB	215	9.0%	66	10.8%	7.1%
Peoplecare	4	0.2%	0	0.0%	0.4%
Phoenix	0	0.0%	0	0.0%	0.1%
QCH	3	0.1%	0	0.0%	0.2%
Reserve	0	0.0%	0	0.0%	0.0%
RT	24	1.0%	1	0.2%	0.4%
Police	6	0.3%	2	0.3%	0.3%
St Lukes	7	0.3%	5	0.8%	0.4%
Teachers Fed	55	2.3%	16	2.6%	1.8%
Teachers Union	8	0.3%	2	0.3%	0.4%
Westfund	17	0.7%	4	0.7%	0.8%
TOTAL for health insurers	**2376**	**100%**	**610**	**100%**	**100%**

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.

The reasons why people are faced with hospital gap charges varies. Most gaps occurred because people held policies with restrictions on certain treatments, or because patients were within 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.

Complaints about Practitioners

Most complaints about doctors and practitioners concerned medical gap issues and/or a lack of informed financial consent (IFC). During 2009/10, a new issue for IFC complaints was added to the reporting database to allow for greater accuracy in identifying complaints about specific types of IFC issues.

Possibly as a result of the change in reporting methods, the office registered 104 complaints against practitioners (including doctors, dentists, and other practitioners) compared to 72 in the previous year. In total, the office registered 130 complaints about either doctors'

Figure 12 **Outcome of Finalised Complaints**

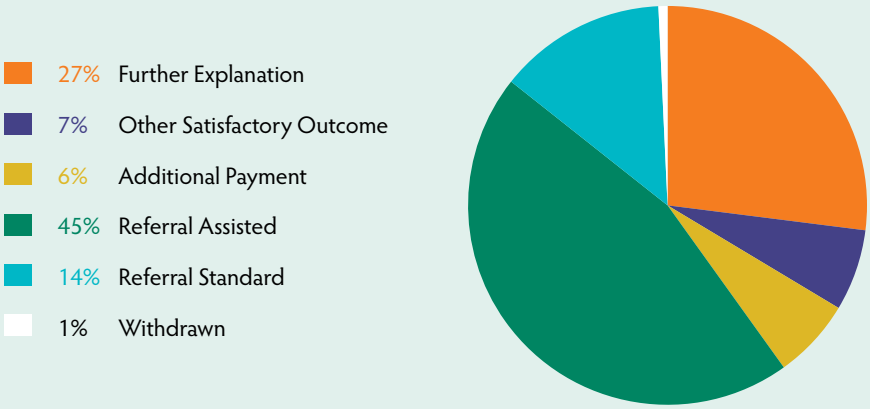
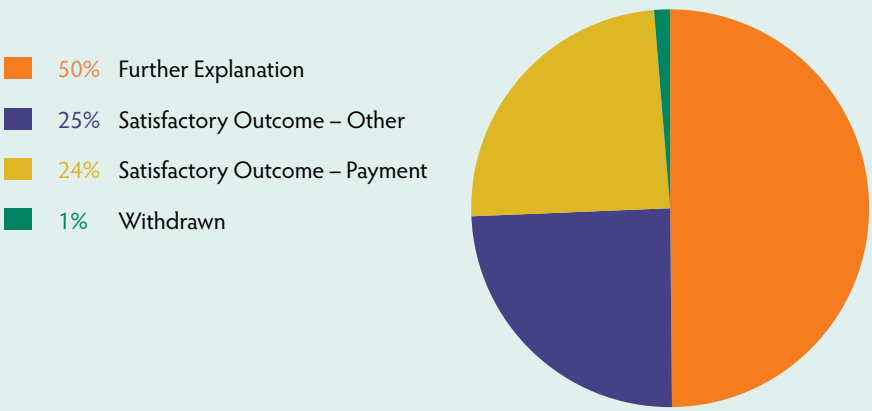


Figure 13 **Outcome of Finalised Level 3 Complaints**



IFC or medical gap issues, compared to 84 complaints about medical gap issues the previous year. The Ombudsman will continue to monitor and investigate complaints about this issue for trends in the industry.

Complaints about Brokers

Most complaints about brokers concerned issues relating to the information provided on joining and the level of cover chosen. There were 8 complaints about brokers in 2009/10, down from 19 in 2008/09.

Resolving Complaints

Twenty-seven percent of complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint.

Forty-five percent of 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.

Fourteen percent of complaints were resolved by the complainant obtaining advice from the Ombudsman's office and then referring their complaint to the appropriate body themselves. Six percent of complaints were resolved by a payment by the health insurer, and seven percent by another satisfactory outcome.

Resolving Level 3 Complaints

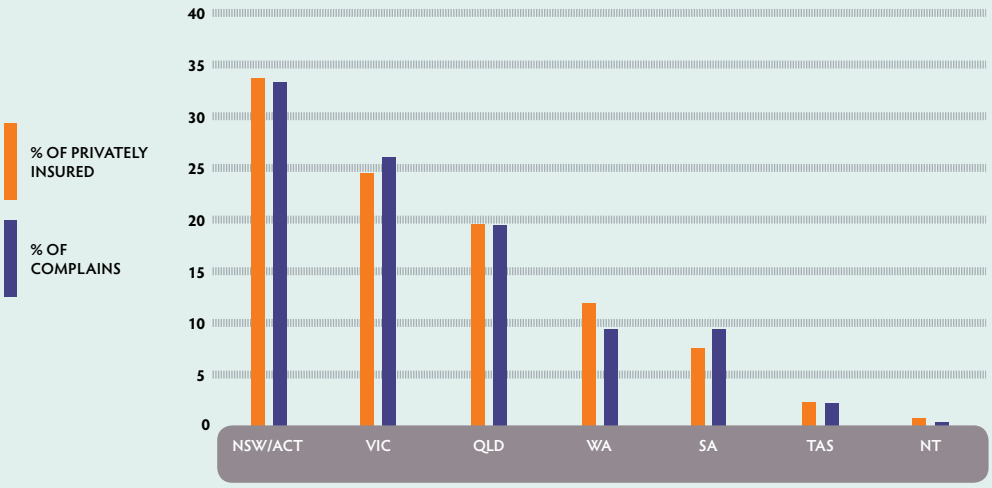
In relation to higher Level 3 complaints investigated by the Ombudsman, fifty percent were resolved by giving a more detailed explanation to the member; one percent was withdrawn by the complainant and the remaining forty nine percent were resolved by a payment or other satisfactory outcome.

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* allows private health insurance members, health care

Figure 14 **Complaints by Population Covered by State & Territory**



providers, health insurance brokers or persons acting on their behalf to lodge complaints. Overwhelmingly, 96% of complaints were made by health insurance members (2515). 38 complaints were made by practitioners, and 13 by hospitals.

How Complaints Were Made

Sixty-nine percent of complaints were made initially by telephone, 25% were lodged through the internet or by email, 5% by letter, and less than 1% by fax, personal visit to the Ombudsman's office in Sydney or by parliamentary representation.

Complaints by State/Territory

Figure 14 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 Victorians and South Australians had a greater tendency to have a health insurance complaint, while Western Australians had a lower level of complaints compared to the population covered by private health insurance.

Investigations

From 1 July 2009 to 30 June 2010 there were no investigations under section 244 of the *Private Health Insurance Act 2007* (or under the preceding Act).

Complaint Issues

Introduction

Complaints to the Ombudsman must first meet the requirements of section 241-10 of the Private Health Insurance Act 2007, 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. The most significant type of complaints concern benefits, followed by service issues, information, membership issues and waiting periods. Figures 15 and 16 illustrate the proportion of complaints corresponding to each issue type.

Benefit Amounts and Issues

The most significant area of complaint to the Ombudsman's office was benefits, with a total of 971 complaints for the 2009/10 year.

The number of complaints was similar to the previous year, though within the broad category of benefit complaints some sub-issues increased on the previous year and other areas decreased.

The main areas of concern for consumers were inadequate levels of cover, delays in payment, inadequate benefit amounts and hospital and medical gaps.

Service and Payment Related Issues

The next significant area of complaint was service and payment administration with 432 complaints, a 10% reduction on the previous year. Of these, 252 were general service related problems and 180 were premium payment problems associated with direct debit systems.

Figure 15 **Percentage of Complaint Issues 2008/09**

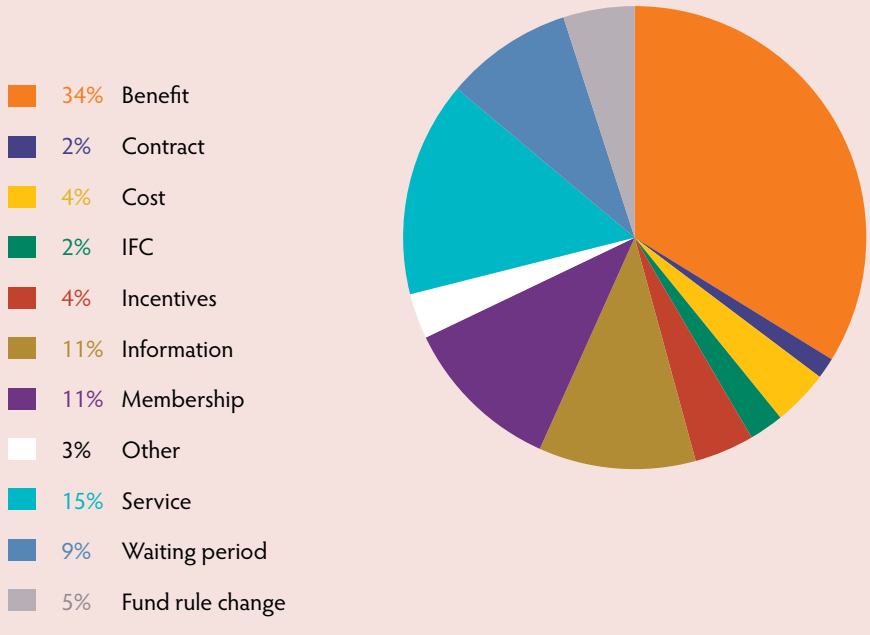
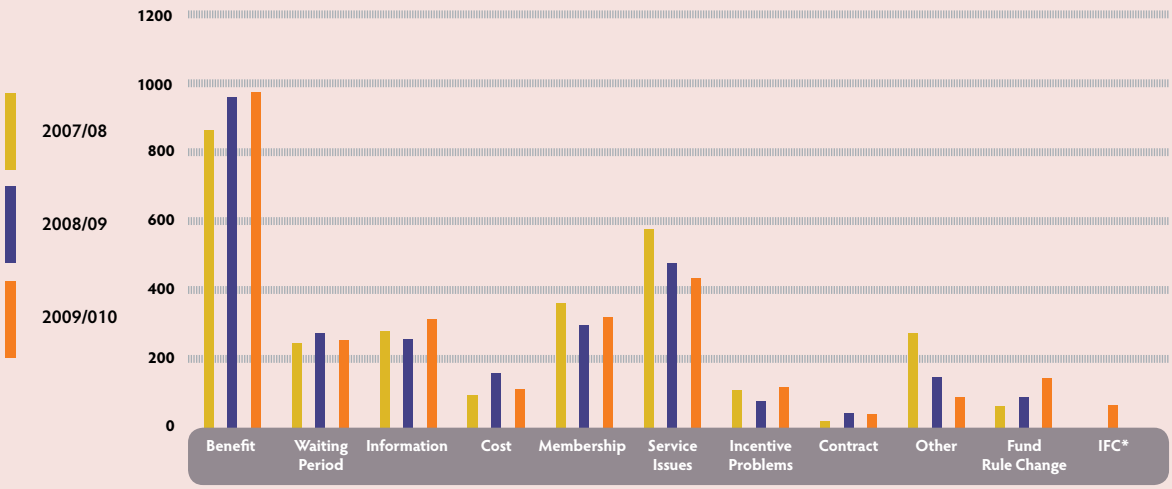


Figure 16 **Complaint Issues 2007/08 to 2009/10**



*** IFC is a new category, introduced mid-year in 2009/10**

Policy Administration (membership) Issues

Issues with policy (membership) administration increased by 8% on the previous year with a total of 321 complaints. Most complaints (71%) were related to problems experienced by people when cancelling, transferring or suspending their health insurance policy. The other significant cause of complaints was issues with policies falling into arrears due to premium payment problems.

Information Issues

Complaints about information 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.

The number of information complaints increased by 22% on the previous year, with a total of 315 complaints received. Of these over half (53%) related to oral advice provided by customer service staff at health insurers, 30% related to consumers believing they weren't advised of a change to their policy, usually because a letter wasn't received. The number of complaints about brochures and other written materials was relatively low, with only 8% of complaints about health insurance brochures and only of 7% complaints about other written material from insurers.

Health Insurer Premium Increases

The Ombudsman has received a relatively low number of premium increase complaints for a number of years. This can be attributed to two developments in recent years. Average premium increases for individual policy holders have been lower, and there has been greater

Leonie Hull (Principal Policy Officer)

transparency by funds in communicating to members about the reasons for health insurance premium increases.

During the year, the Ombudsman received only 75 (3%) complaints about premium increases, which was a reduction from the 89 received the previous year.

Hospital Contracts

During 2009/10, the office recorded 25 complaints relating to hospital contracts, a decrease from the 35 complaints received the year before. However, the overall figures do not necessarily reflect the scale of the problems. Four of the complaints about hospital contracts were disputes between health funds and private hospitals about contractual arrangements which required intensive investigation and mediation by the Ombudsman.

A private hospital is said to be an 'agreement hospital' with a particular health fund when a contract exists between the two parties. Known as Hospital Provider Purchaser Agreements, the contracts set down agreed hospital charges and ensure that the fund's members are be covered with no or minimal out-of-pocket expenses. The contracts are periodically re-negotiated to adjust for increases in hospital costs, changes in claiming patterns and demand on hospital resources.

In the four cases which required the Ombudsman's intervention, negotiations between the fund and the hospital had stalled, leaving fund members at risk of being left with potentially very large hospital gap fees. The mediation processes implemented by the Ombudsman to resolve these disputes required significant allocation of PHIO staff resources. Mediation typically included several face-to-face meetings and on several occasions, mediation sessions with an independent mediator appointed by the Ombudsman. All contract disputes that required mediation by the Ombudsman were resolved during 2009/10 through this process.

Overseas Visitors Health Cover

The Ombudsman assisted 71 consumers with complaints about overseas visitors cover (for visitors to Australia); this is a decrease on the 92 complaints received in 2008/09 but still higher than the 55 complaints received in 2007/08.

Overseas visitor covers are not "complying health insurance policies" under the Act and these complaints are therefore not included in figure 11, which lists complaints by each health insurer.

The 71 complaints were registered across a small number of insurers who offer these policies. As market share information for overseas visitor cover was unavailable at the time of publishing, the number of complaints against each insurer has not been listed, because it would not allow a fair comparison of complaint numbers against the number of policies held.

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

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

Some OVHC policies provide similar cover to that available to Australian residents, while others can be very different. Benefits, 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.

The most common complaints investigated by the office in relation to OVHC concern waiting periods and other restrictions on the policy. Complaints about the application of the pre-existing waiting period tend to be complicated, because information about a person's medical history before coming to Australia is held overseas. Sometimes fund members are not aware that they are not covered for pre-existing ailments for periods of up to 12 months or more, and with some funds not at all.

Changes for 457 Visa Holders

In 2009/10, the Ombudsman contributed to the Department of Immigration & Citizenship's review of Subclass 457 temporary business visa requirements. The 457 visa is the most commonly used program for employers to sponsor overseas workers to work in Australia on a temporary basis.

As a result of the review, new visa requirements for 457 applicants came into effect on 14 September 2009. People applying for the visa from that date are required to make arrangements for a minimum level of health insurance and to maintain that insurance for the duration of their stay in Australia. The new requirements should ensure that that 457 visa holders have an adequate level of health insurance to meet their needs while in Australia.

Kaylie Blyton (Senior Dispute Resolution Officer) and Alison Leung (Senior Project & Policy Officer)

Figure 17 Complaint Sub-issues

		2008/09	2009/10
Benefit	Accident and Emergency	3	8
Benefit	Accrued	16	6
Benefit	Ambulance	44	33
Benefit	Amount	131	116
Benefit	Community Rating	1	0
Benefit	Delay in Payment	94	135
Benefit	Excess	56	45
Benefit	Gap - Hospital	68	59
Benefit	Gap - Medical	84	97
Benefit	Level of Cover	262	236
Benefit	Limit Reached	20	45
Benefit	New Baby	6	13
Benefit	Non Acute Care	2	2
Benefit	Non Health Insurance	6	5
Benefit	Non Recognised Other Practitioner	32	42
Benefit	Non-Recognised Podiatry	24	26
Benefit	Other Compensation	8	6
Benefit	Out of Pocket NEC	34	29
Benefit	Out of Time	15	22
Benefit	Preferred Provider Schemes	35	27
Benefit	Prostheses	10	18
Benefit	Workers Compensation	1	1
Contract	2nd Tier Default Benefit	2	3
Contract	Doctors & Dentists	6	14
Contract	Hospitals	35	25
Cost	Dual Charging	4	3
Cost	Fees / Informed Financial Consent	66	34
Cost	Premiums	89	75
IFC	Doctors	n/a	33
IFC	Hospitals	n/a	34
IFC	Other	n/a	2
Incentives	Problems (LHC 30% rebate Medicare levy)	76	120
Information	Lack of Notification	63	96
Information	Oral	156	167
Information	Printed	25	26
Information	Radio / Television	2	5
Information	Written	12	21
Membership	Arrears	75	62
Membership	Cancellation / Suspension	103	141
Membership	Non-Contributor	7	12
Membership	Rate & Benefit Protection	4	5
Membership	Transfer / Continuity	88	90
Membership	Young People	17	11
Service	General Service Issues	305	252
Service	Premium Payment Problems	168	180
Waiting Period	Benefit Limitation Period	4	2
Waiting Period	General	39	18
Waiting Period	Obstetric	49	52
Waiting Period	Other	11	14
Waiting Period	Pre Existing Ailment	165	170
Other	Access	4	10
Other	Acute Care Certificates	2	3
Other	Complaint NEC	30	51
Other	Confidentiality & privacy	12	18
Other	Demutualisation/Sale Health Insurers	125	3
Other	Discrimination	0	2
Other	Fund Rule Change	63	143
Other	NESB	0	2
Other	Private Patient Election	1	2

Case Studies 

The following case studies highlight some of the common types of complaints received by the Private Health Insurance Ombudsman (PHIO). They illustrate the lessons that can be learned from complaints by both health insurers and consumers. The names and some details have been changed to protect confidentiality.

1. Premium Payment Problems

This case concerns a health fund's premium deduction system. PHIO received 180 premium payment problem complaints during the year, mostly to do with payments not occurring and memberships falling into arrears, or with larger than expected payments being taken out of a member's account. In most cases, the fund is able to investigate a complaint and correct any problem with the payment. In this case, correcting the mistake in payments wasn't so easy.

Mr and Mrs Blue were long-term members of their health fund and had regularly kept their membership paid up to date since 1962. Membership payments had been made through deductions from Mr Blue's salary until recently, when Mr Blue retired and started paying the membership manually every six months.

At that time, the Blues started to receive some confusing letters from their health fund. These letters requested payments be made, even though the membership had been paid regularly and was always paid up to date. When Mr Blue rang his fund to discuss these letters, he was told that this was a computer problem and that he should ignore any letters requesting payments to his membership.

Mr and Mrs Blue learned to ignore the reminder letters, but then a problem developed with their membership cards which meant they were unable to lodge direct claims at dental surgeries and with other providers. Although they could pay the accounts themselves and claim them back from the fund, the inability to access automated claiming was inconvenient.

Then Mrs Blue tried to make a claim and was advised that not only was she unable to make a claim, but that the membership had been cancelled due to lack of payments. She contacted the health fund and was told that this was a computer system problem and that the way to resolve the problem would be to start a new policy, with a new membership number and cards.

After receiving their new cards, however, the Blues received another overdue payment reminder. When they again contacted the fund, they were advised that their last payment could not be found on the computer system. At this point, Mr and Mrs Blue requested assistance from PHIO to find a permanent solution to the ongoing problems with their membership.

PHIO's investigation of the matter revealed that the fund's computer system was having difficulty accepting payments for the Blues membership, which resulted in the need to send the information to the fund's finance department for correction.

In order to solve the problem, the fund decided to start the Blues on a new membership with a new membership number. Unfortunately, the new membership inherited some of the previous problems, so that the Blues continued to experience problems.

The fund was in a difficult position because it couldn't assure Mrs Blue that the computer system wouldn't make another mistake. Fortunately, however, the fund had already made a decision to replace its computer system, due to problems it was causing for

members like Mr and Mrs Blue.

The fund advised the Blues that the system was soon to be replaced and that they would assist them with any problems that arose in the meantime. The fund also credited Mr and Mrs Blue's membership with an ex-gratia payment in recognition of the difficulties they had experienced with the fund's payment system.

Since the fund switched the Blues to the new computer system some months ago, they have not experienced any problems with their membership payments.

2. Pre-Existing Condition Waiting Period and Best Practice Guidelines

Health insurers are able to apply a twelve-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" available at www.phio.org.au or by phoning our office.

PHIO received 170 complaints about the PEC waiting period during the year. PHIO's role in investigating complaints about this waiting period is to ensure that the fund has applied the waiting period correctly and that the fund and hospital have complied with the Best Practice Guidelines.

A copy of the best practice guidelines for the industry is available from the PHIO office at info@phio.org.au or by telephoning 1800 640 695.

Mr Green joined a hospital cover and two days later he visited his doctor due to concerns about pain and inflammation on his left side. Mr Green explained to his doctor that he had been aware of the pain for some weeks and that it was getting worse. Mr Green's doctor ordered some tests and referred him to a specialist, who diagnosed his condition as bowel cancer.

Mr Green's surgeon suggested he undergo surgery in a private hospital and advised him to contact his health insurer to find out how much, if anything, he would need to pay. Mr Green phoned his insurer on the Monday of the week in which he was going to hospital. The fund staff member advised him that he was within the twelve month waiting period for Pre-Existing Conditions (PECs) but added that "as long as you were diagnosed after your join date, which is 8 July 2009, then you will be covered."

This advice was incorrect, because application of the PEC waiting period relies on the presence of signs or symptoms of the condition needing treatment and not on diagnosis. The inflammation and pain that Mr Green experienced before joining the fund were signs and symptoms of bowel cancer, which meant that the fund could deny benefits for any treatment relating to this condition on grounds of the PEC waiting period.

Accordingly, when it received Mr Green's hospital claim, the fund declined payment due to the PEC rule. In deciding to reject the claim, the fund cited the medical certificates completed by Mr Green's medical practitioners which showed an onset of symptoms of several months prior to visiting a doctor two days after taking out hospital cover.

Mr Green couldn't understand why his claim was refused because he wasn't aware he had bowel cancer until after he took out hospital cover. When he contacted PHIO for assistance, we reviewed the information provided by the fund about the way it had handled the matter.

The investigation concluded that the fund had not complied with the Best Practice Guidelines in two respects. Firstly, in the

Ursula Schappi (Dispute Resolution Officer)

phone conversation before he was admitted to hospital, the fund incorrectly advised Mr Green that the PEC depends upon when a condition is diagnosed. Secondly, the fund did not take sufficient notice that Mr Green was phoning about a hospital admission within five days. There was insufficient time for forms to be completed to assess whether his condition was a PEC or not. The Best Practice Guidelines recommend that funds take special care when advising members who are within waiting periods and need hospital treatment about their benefit entitlements. The Guidelines state that the following warning should be given to the member:

"If patient proceeds with the admission before PEC (pre-existing condition) assessment is finalised and the condition is subsequently determined to be pre-existing, health fund benefits under the current hospital table will NOT be payable".

PHIO concluded that the health fund had not followed best practice with Mr Green and this had contributed to him incurring a hospital bill for which benefits were not payable. After double checking to ensure that the hospital or surgeon hadn't corrected the insurer's advice before he was admitted to hospital, PHIO requested the fund to pay Mr Green's hospital account, which they agreed to do.

3. Policy Changes

Mr and Mrs Red were busily preparing for Mrs Red to give birth at a local private hospital. They had provided their health insurance details to the hospital a few weeks ahead of the expected delivery date. As they had held obstetrics cover for over ten years, they were not expecting to have any problems with their level of cover for the admission.

On admission to the hospital, they paid a $250 excess and signed a document in which the hospital indicated that their membership had been verified and the only other charges would be items such as pharmacy, pathology and other small items.

A few weeks after Mrs Red and the baby were discharged, they received an account for $2200 for the hospital stay. They assumed that a mistake had been made, but when they contacted their fund to query the account, they were advised that their cover had been altered, by the insurer, some six months before the hospital admission. There had been a number of changes made to their policy, the most important of which was that the policy no longer covered benefits for obstetrics services.

The insurer said that they had warned all members on this level of hospital cover of the policy changes by sending a letter before the changes took effect. The letter explained that obstetrics would no longer be covered and people who wanted to maintain cover for obstetrics needed to upgrade to a new policy before a certain date.

As it was well past the cut-off date, the fund advised that unfortunately it couldn't assist Mrs Red. Her only option was to pay for the hospital charges herself. Dissatisfied with the insurer's response, Mrs Red requested PHIO to investigate the matter.

There were two areas that PHIO needed to investigate with this case. Firstly, why hadn't the hospital advised Mrs Red that she was not covered for obstetrics and obtained Informed Financial Consent from her for the cost of the admission? Secondly, were the Reds sufficiently notified by the insurer of the removal

Jim Robertson (Dispute Resolution Officer)

of obstetric benefits from their policy prior to the deadline? As Mrs Red was already pregnant when her hospital cover was downgraded, it seemed unusual that she would choose to stay on the cover if she had received advice that it would no longer cover obstetrics services.

The hospital checked its records and ascertained that an admissions staff member had overlooked a warning provided by the fund's electronic membership verification system. Based on this error, the hospital was prepared to write off 50% of the outstanding account, but they requested that PHIO ask the insurer to pay the other 50%. This was because it did not appear that the Reds had been adequately advised by the fund of the change to their cover.

The fund explained that it had notified policy holders of the removal of obstetric benefits months ahead of the change. PHIO had previously reviewed that letter when investigating other complaints and considered that while it included the information about the removal of obstetric benefits, there was not sufficient prominence given to this important information. The fund had offered to phone affected members to double check that they understood that they were no longer covered for obstetrics and to allow them to upgrade cover without waiting periods.

On reviewing the records, however, it seemed that Mr and Mrs Red had been overlooked in the outbound phone campaign. The fund also accepted that it would be unlikely that the Reds would have remained on a cover that excluded obstetrics if they had been aware of the change to their cover. The fund therefore agreed to pay the remaining 50% of the hospital account and allow the Reds to upgrade their cover to include obstetrics without waiting periods.

4. Policy Restrictions (Plastic and Reconstructive Surgery)

This case concerned a health insurer's policy restriction on plastic and reconstructive surgery. This type of restriction usually occurs in lower level policies which restrict a number of services that a young and healthy person might feel they are less likely to use. The problem with this restriction is that it consumers can confuse it with cosmetic surgery. The term "plastic and reconstructive surgery", however, includes many medically necessary procedures such as skin grafts following burns, skin flap repair after removal of tumours, breast reconstructions following cancer and other services such as those discussed in this case study.

Ms Pink joined a mid-level hospital policy some years ago. Earlier this year, she was admitted to hospital for surgery to her jaw. She received an account from the hospital some weeks later and sent it to her health insurer to pay. The insurer only paid a small amount, leaving Ms Pink with a bill of more than $2000.

Ms Pink called her health fund and was advised by the customer service officer that she was not fully covered for plastic and reconstructive surgery in a private hospital. Ms Pink did not understand why her jaw surgery was considered plastic surgery because the surgery had a Medicare item number and was considered medically necessary. It was not performed for cosmetic reasons.

Ms Pink's surgeon wrote to her health fund to clarify that the surgery was on her jaw and was clearly not cosmetic, but the fund still refused to pay the claim.

Ms Pink contacted PHIO for assistance. The Ombudsman's staff member arranged with the hospital to hold off any demands for payment while the matter was investigated and asked Ms Pink a number of questions about the advice she received before going to hospital.

PHIO asked the fund to explain how the restriction to her policy had been explained to her both when she joined and before her hospitalisation. The fund's response was that there had been no phone call or other communication with Ms Pink before her hospitalisation, so there had been no

opportunity to warn her that benefits for the surgery would be restricted under her cover. The fund had, however, provided information about the restriction in the policy documents it had sent to Ms Pink when she took out the policy and in reminder letters over a number of years.

PHIO reviewed the insurer's policy documents to see how the restriction had been explained. In PHIO's opinion, the insurer's descriptions of the restriction were too brief and therefore increased the likelihood of a consumer mistakenly thinking the restriction only applied to cosmetic surgery.

Kate Hocknull (Dispute Resolution Officer)

PHIO also believed that the hospital had some responsibility for Ms Pink's account, because it had not sought sufficient informed financial consent from Ms Pink to incurring the out-of-pocket charges on admission. PHIO also believed that as Ms Pink had chosen a mid-level policy which restricted a number of items, she had some responsibility for not checking her entitlements with her fund prior to her hospitalisation. PHIO concluded that the hospital account should be settled by a three-way split between the fund, hospital and Ms Pink. All parties agreed to this resolution of the complaint.

PHIO also requested the fund to include more detailed information about the plastic and reconstructive surgery restriction in its policy documents so that members would have a better understanding of what types of surgery would be restricted under this cover.

PHIO will be reviewing the information provided to members about plastic and reconstructive surgery over the coming year. Consumer fact sheets about policy restrictions and the plastic and reconstructive surgery restriction have also been added to the www.phio.org.au website and can also be obtained by contacting the office.

5. Telephone Advice from Health Funds

The challenge in investigating an oral advice complaint is obtaining a sufficient record of the conversation, which may have taken place several months or years ago. Fortunately, many health insurers record phone conversations and PHIO supports this practice, as it protects consumers and makes these types of complaint easier to resolve.

Ms Yellow decided to change her health insurance policy to remove her hospital excess of $450 because she was due to give birth later on this year. She shopped around and decided on a policy with a zero excess from a new health insurer. When she phoned for a quote and details of the policy, Ms Yellow was assured by her new health insurer that no waiting periods would apply.

Ms Yellow contacted the hospital to make arrangements for her stay. The hospital advised her that although she was sure she was covered, it was best for Ms Yellow to phone her health fund to double check her level of cover. When she did so, Ms Yellow's fund advised her that there was a $500 excess on her policy, because she was within a waiting period. The waiting period meant that she was not entitled to the new zero excess on her new cover and would have to pay the level of excess on her previous cover. Because her new insurer did not have a policy with a $450 excess, they would "round it up" to a $500 excess she would need to pay.

Clearly, this advice was different from what Ms Yellow was advised on joining the fund. She also realised that she had received no policy documentation from her new fund to explain the features of her new policy. She phoned the

fund to complain, but was advised that the fund had no choice but to charge the $500 excess.

Ms Yellow was dissatisfied with the fund's response and contacted PHIO for assistance. Our staff reviewed the fund's call recordings and noted that fund staff did not check what excess Ms Yellow had with her previous fund when she asked for a no excess policy. There was also no record of a letter being sent to confirm Ms Yellow's policy details after she had taken out the policy over the telephone.

PHIO took the view that if the fund staff member had asked Ms Yellow what her excess was on her previous cover, the waiting period could have been identified and explained to Ms Yellow prior to her agreeing to join the new fund.

PHIO also concluded that applying a $500 excess as the nearest equivalent to Ms Yellow's $450 excess policy was not consistent with the way continuity is determined by the Private Health Insurance Act 2007. The fact that the new fund had no exactly equivalent policy cannot be taken into account, as the maximum excess that the fund could apply to a transferring member would be the $450 excess applicable to the previous policy. If a fund is going to apply a "nearest equivalent" excess to a transferring member, it can only choose a lower excess, not a higher one.

The Ombudsman was able to negotiate a satisfactory resolution of the complaint with the insurer.

Hilary Bassingthwaighte (Director Programmes & Education) and Damien Maynard (Dispute Resolution Officer)

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, email or by post.

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

People who are non-English speakers can contact the office through the Translating and Interpreting Service by telephoning 13 14 50.

To raise public awareness of the services provided by the Ombudsman, the following strategies were employed during 2008/09:

- Details of the Ombudsman's services were referenced in various government publications and in publications produced by other agencies and consumer bodies.
- Health insurers provide information about the availability of the Ombudsman's services and contact details in brochures, publications and in some correspondence to their members.

These details are also included on health insurers' websites.

- The Ombudsman also contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites.
- The Ombudsman publishes a regular quarterly report which is distributed in both printed format and on the PHIO website.
- The Ombudsman hosts an internet site where consumers can access a range of brochures, Quarterly Bulletins, annual reports and fact sheets. The site enables consumers to make enquiries, lodge complaints, and requests printed copies of brochures. Website users can subscribe to updates via an email newsletter or through RSS feeds. The website also links to other useful sites. The website is located at http://www.phio.org.au/.
- The Ombudsman conducted a number of media interviews and spoke at a number of health industry conferences during the year.

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.

The Ombudsman produces a Quarterly Bulletin containing general information about current issues and health insurance complaint statistics that is sent in printed form to members of Federal Parliament, health insurers, hospitals and others who specifically request the printed version. The Bulletin is released simultaneously in electronic form on the Ombudsman's website at www.phio.org.au.

In 2009/10 the Ombudsman's website added a series of factsheets about topics which are regularly raised by consumers, such as why and how health premiums are assessed, and how to plan to be covered for pregnancy and obstetrics services. More factsheets will be progressively added through the next year.

The Ombudsman also produces a "State of the Health Funds" report each year, to assist consumers to compare funds and make decisions about their health insurance.

The Ombudsman has a Website Reference Group comprised of representatives of health insurers and the Consumers' Health Forum which meets quarterly. The Reference Group provides advice to the Ombudsman about issues relating to the consumer website www.privatehealth.gov.au.

The Ombudsman held a series of industry workshops in 2009/10, aimed at improving the internal complaint handling practices of insurers. The workshops were held with small groups of industry contacts and dispute resolution staff who communicate with the Ombudsman's staff in resolving consumer disputes. The workshops aimed to raise awareness of the Ombudsman's complaint handling processes, the challenges faced by the office in resolving disputes, and how health funds could more effectively resolve complaints and prevent problems from arising.

Client Survey

About the Survey

In June 2010, the Ombudsman carried out a postal survey of 360 randomly selected complainants. The office received 105 responses (29%), a reasonable participation rate for a postal survey.

The aim of the survey was to gauge how well PHIO was meeting its clients' needs and to identify areas where improvements could be made.

Overall, 87% of clients were satisfied or very satisfied with the overall handling of their complaint. This was steady from the 88%

satisfaction of the previous year, and higher than the result of 78% in the year before. This year there was also a marked improvement in the satisfaction of Level 1 and 2 complainants – 97% per cent of Level 1 and 2 clients were satisfied or very satisfied with the overall handling of their complaint, compared to 90% in the year before.

an outcome to their complaint that was satisfactory from their perspective. The length of time it takes to respond to complaints is an area in which satisfaction dropped and this is an area the office will be focusing on in the upcoming year.

A summary of the survey responses is shown below.

PHIO Client Satisfaction Results	2007/08	2008/09	2009/10
Overall Satisfaction	78%	88%	87%
Agreed that staff listened adequately	87%	98%	96%
Satisfied with Staff Manner	75%	89%	86%
Resolved complaint or provided adequate explanation	65%	87%	89%
Thought PHIO acted independently	80%	87%	85%
Would recommend PHIO to others	76%	91%	87%
Happy with time taken to resolve complaint	74%	83%	77%

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 99%. This indicates that complainants correlate the service that the office provides directly with the outcome that the office is able to achieve, regardless of whether they are satisfied with the way the Ombudsman's staff deal with their complaint.

The challenge for the Ombudsman's office is to improve satisfaction levels for the complainants who indicated they weren't satisfied with the Ombudsman's office, who did not receive

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;
- Submission to the Productivity Commission Study of the Performance of Public and Private Hospitals;
- Assistance to the Department of Immigration and Citizenship in setting a minimum standard of health insurance for 457 visa holders and in consulting with industry about this issue;
- 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.

Consumer Website

www.privatehealth.gov.au

The consumer website www.privatehealth.gov.au was established in 2007 to provide independent information to consumers about health insurance. The website allows consumers to view a standard information statement for their own policy and compare it with other policies available for purchase. The website has been reviewed regularly since its establishment in response to feedback from consumers and to take account of industry changes.

Usage

The website recorded 264,692 unique visitors during the year, an increase of 35% on the previous year. Analysis of the available data suggests that growth of the site's usage can be attributed to the site becoming better known via recommendations and search results, as well as regular reminders of the site's existence in annual mailings of standard information statements and lifetime health cover letters.

Survey Results

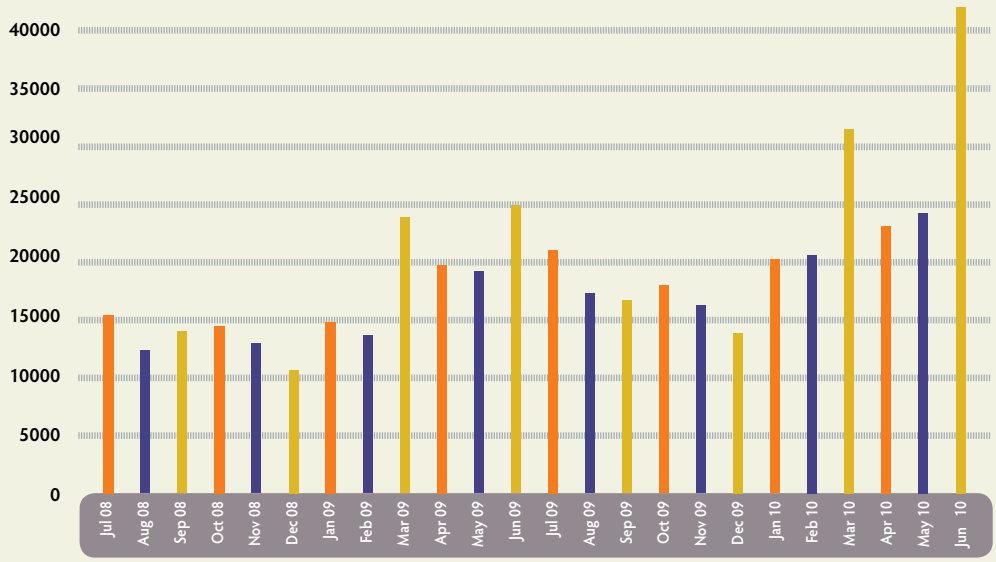
During the year, 525 users completed a survey about the website. The survey was one of a number of sources of feedback from consumers which was used to inform improvements to the website. In particular, survey respondents highlighted the difficulties they had in locating particular information they were looking for on the website. 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.

The key ratings for the site are summarised in Figure 20.

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

Figure 18 **Unique Visitors to www.privatehealth.gov.au**



on the enquiries line 1300 737 299. The feature is used by consumers who have been unable to obtain answers to general health insurance questions elsewhere on the website or by contacting individual health insurers.

The office responded to 1520 consumer enquiries through the website in 2009/10, making up 87% of the total number of enquiries received by the office.

The most frequently raised questions are about the following topics:

- Lifetime Health Cover, especially about how this affects new migrants to Australia and Australians returning from overseas. The Lifetime Health Cove 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.
- Waiting periods for people who are currently uninsured.
- How to use the website and locate information.
- How to choose a health insurance policy.
- Overseas visitors health cover, especially for subclass 457 visa holders.

Website Refresh

During 2009/10, a full review of the website was undertaken with a view to relaunching the website in mid 2010 with a fresh look and new features, to allow consumers to easily find the information that they need about health insurance and to compare a range of policies. During the redesign and reorganisation process, PHIO consulted with consumer, industry and government stakeholders to ensure the new website will most effectively meet consumer needs. The Ombudsman will be monitoring site usage and feedback throughout the upcoming year.

The new website features include:

- **Compare Policies:** the new search engine and policies comparison feature allows users to search for database of health insurance

policies more effectively and then compare them side-by-side.

- **Average Dental Charges:** the website now publishes information about the average cost of the most common dental services by state, so consumers can compare how their policies' benefits compare to costs.
- **New look and feel:** the appearance of the site has been refreshed to make it more user-friendly and visually appealing, including a restructure and streamlining of the structure of the site to remove duplicated information and make it easier to locate information.
- **New Google search feature:** improved search engine allows users to find the information they need more quickly.

Figure 19 **Consumer Enquiries about www.privatehealth.gov.au**

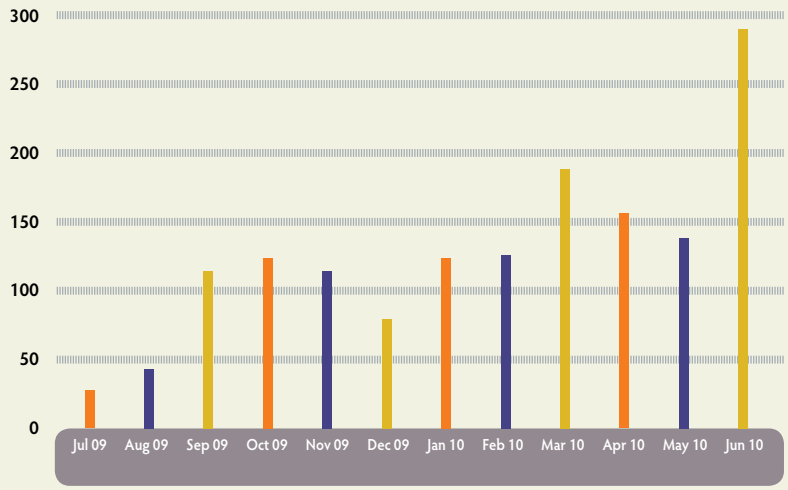
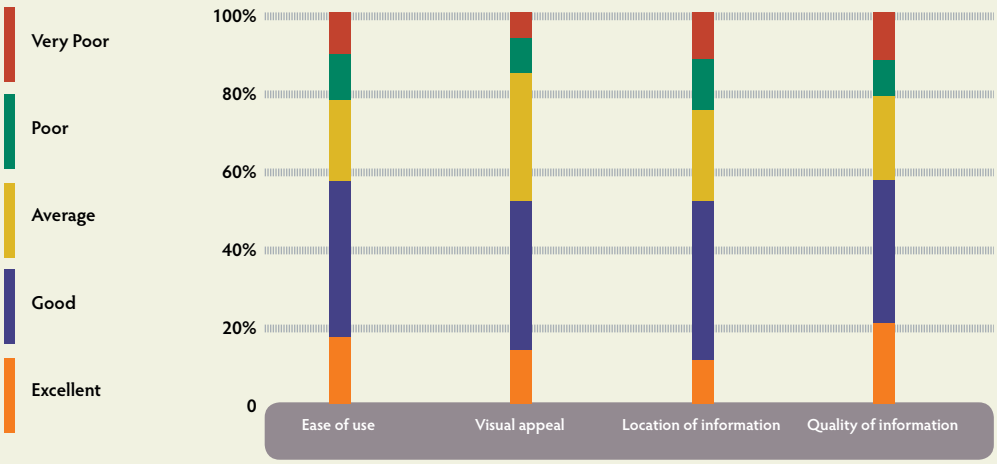


Figure 20 **Website Survey Ratings for www.privatehealth.gov.au**



Appendices

Statutory Reporting Information

Corporate Governance

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

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

Management of Human Resources

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

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

Organisational Structure

As at 30 June 2010, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman (SES 2)	1	-
Director, Policy & Client Services (EL 2)	-	1
Director, Programmes & Education (EL 2)	1	-
Principal Project Officer (EL 1)	1	-
Senior Dispute Resolution Officer (APS 6)	1	-
Senior Project & Policy Officer (APS 6)	1	-
Financial Officer (APS 6)	1	-
Dispute Resolution Officers (APS 5)	3	2
Administration & Desktop Support Officer (APS 4)	-	1

Statutory Positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

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

Staff Development and Training

During the 2009/10 financial year, $53,497 was spent directly on PHIO 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 is an important priority for the office, to ensure 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.

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, other than Senior Executive Service staff, are covered under an Enterprise Agreement in accordance with the *Fair Work Act 2009*.

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 to balance their work and family responsibilities effectively. The following table shows the numbers and status of staff who were employed on 30 June 2009.

Occupational Group	Women	Men	Total Staff	NESB1
SES	1	0	1	0
Other	9	4	13	3
Total	**10**	**4**	**14***	**3**

SES Senior Executive Service, Ombudsman

Other All other staff – temporary and permanent

NESB1 Non-English speaking background, 1st generation

* Includes part-time employees and those on maternity leave. Actual EFT = 11.3

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.

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.

Accounting

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 Act 1997*.

Outcomes and Outputs

The 2009/10 Portfolio Budget Statement (PBS) indicates that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 9, Private Health.

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

The Private Health Insurance Ombudsman's agency outcome is specified as *Public confidence in private health insurance, including through consumer and provider*

complaint and enquiry investigations, and performance monitoring and reporting. The Ombudsman reports on achievements towards this outcome and a set of performance indicators (see the Performance section of this report for more information).

Consultancy Services

Complete GST Solutions provided financial, accounting and reporting assistance to the office during the financial year.

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

Human Solutions continued to maintain and develop the consumer website (privatehealth.gov.au) under the contract awarded in 2006.

Payroll Services

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

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 agency's fraud data to the Australian Institute of Criminology in accordance with the Commonwealth Fraud Control Guidelines.

Consultancy Services let during 2009-10, of $10,000 or more				
Consultant Name	Description	Contract Price	Selection Process	Justification
The Hon Neil Anthony Brown QC	Mediation services	$10,250.00	Direct sourcing	B - need for specialised or professional skills
LAETA Pty Ltd	Independent advice in resolving contract disputes	$21,000.00	Direct sourcing	C - need for independent research or assessment

Information Systems

The Ombudsman's information system is based on a Windows 2008 Network Server and the Microsoft Office suite. Accounting software used is *Mind Your Own Business (MYOB) Accounting and Asset Manager.* In addition, the Ombudsman has a purpose-built *Complaints Management and Reporting* system on-site. PHIO's Internet service is supplied by IINET (Naked DSL).

Service Charter

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

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

Occupational Health and Safety

The Ombudsman has a staff member who is designated as the Ombudsman's First Aid and Occupational Health and Safety Officer.

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

No reportable incidents occurred during the year.

Equal Employment Opportunity

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

Advertising and Market Research

The Ombudsman did not conduct any advertising or market research in 2009/10 that meets the reporting requirements under Section 311A of the *Commonwealth Electoral Act 1918.*

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.* 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 Stars under the National Australian Built Environment Rating: Water and 2.5 Stars under the National Environment Building Rating: Energy, and is committed to purchasing 25% of base building energy from government accredited GreenPower renewable energy resources.

Grant Programs

The Ombudsman did not administer any grant programs during the 2009/10 financial year.

Rosie Edwards (Accounts Manager) and Richard Van Der Male (Administration & Desktop Support)

Freedom of Information Statement

This statement is published to meet the requirements of *Section 8 of the Freedom of Information Act 1982* (FOI Act). It is correct as at 30 June 2010.

Establishment

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

Public Information

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

Requests

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

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

Documents Held by the Ombudsman

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

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

Documents Available Free of Charge

The following brochures are available free of charge upon request:

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

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

Access to documents

People may obtain documents:

- from the office of the Ombudsman located at Suite 2, Level 22, 580 George Street, Sydney NSW 2000
- by telephoning (02) 8235 8777 or 1800 640 695 (Free-call)

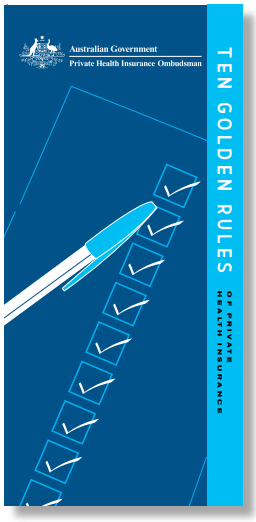
- by fax on (02) 8235 8778
- by e-mail to info@phio.org.au
- from the web site http://www.phio.org.au

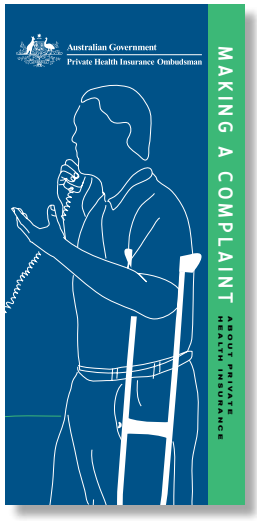
Information and Procedures for Freedom of Information Act Requests

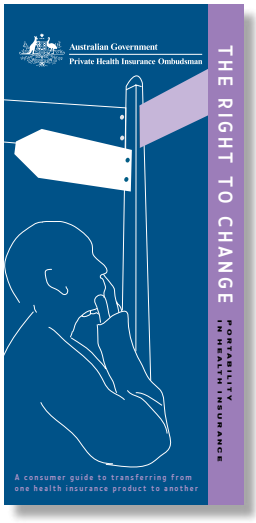
Informal requests for access to information held by the Ombudsman's office can be made by telephone, email, personal visit or by letter. People can make the request either via the dispute resolution officer allocated to their case or that person's supervisor.

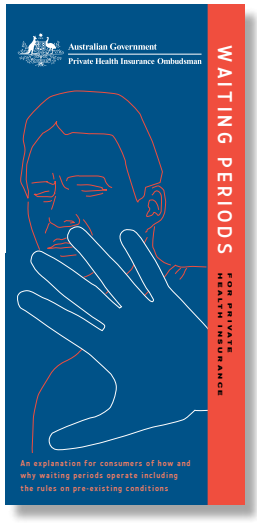
If a person wishes to make a formal request under the FOI Act, requests can be made in writing and directed to:

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









External Review and Scrutiny

The office subjects itself to regular review of its performance by conducting a survey of complainants. Detail of the review for this year is provided in the body of this report.

Courts

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

Commonwealth Ombudsman

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

Other

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

Service Charter

In line with requirements for all Australian Government agencies, the Ombudsman has a Service Charter which was last reviewed during 2009/10.

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

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

Financial Information

Australian National
Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Ageing

Scope

I have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2010, which comprise: a Statement by the Ombudsman and Chief Financial Officer; Statement of Comprehensive Income; Balance Sheet; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments; Schedule of Contingencies; Schedule of Asset Additions; and Notes to and forming part of the Financial Statements, including a Summary of Significant Accounting Policies.

The Responsibility of the Private Health Insurance Ombudsman for the Financial Statements

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

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on 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 whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Private Health Insurance Ombudsman's preparation and fair presentation of the financial statements 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 accounting policies used and the reasonableness of accounting estimates made by the Ombudsman, as well as evaluating the overall presentation of the financial statements.

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

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

Independence

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

Auditor's Opinion

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

(a) have been prepared in accordance with the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997,* including 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 2010 and its financial performance and cash flows for the year then ended.

Australian National Audit Office

Graham Johnson
Senior Director
Delegate of the Auditor-General

Sydney

20 August 2010

Private Health Insurance Ombudsman

STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2010 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, as amended.

Signed .....Samantha Gavel.....

Samantha Gavel

Ombudsman (Chief Executive Officer/Chief Financial Officer)

20 August 2010

Statement of Comprehensive Income

FOR THE PERIOD ENDED 30 JUNE 2010

	Notes	2010 $	2009 $
EXPENSES			
Employee benefits	2A	1,016,342	842,260
Supplier expenses	2B	673,504	694,135
Depreciation and amortisation	2C	255,585	201,391
Write-down and impairment of assets	2D	53,196	350
Total expenses		1,998,627	1,738,136
LESS:			
OWN-SOURCE INCOME			
Own-source revenue			
Sale of goods and rendering of services	3A	100,000	12,433
Other	3B	16,080	41,910
Total own-source revenue		116,080	54,343
Net cost of (contribution by) services		1,882,547	1,683,793
Revenue from Government	3C	1,964,000	1,962,000
Surplus		81,453	278,207
OTHER COMPREHENSIVE INCOME			
Changes in asset revaluation reserves		-	-
Total other comprehensive income		-	-
Total comprehensive income		81,453	278,207

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

Balance Sheet

AS AT 30 JUNE 2010

	Notes	2010 $	2009 $
ASSETS			
Financial Assets			
Cash and cash equivalents	4A	54,193	65,857
Trade and other receivables	4B	2,355,722	2,252,932
Total financial assets		2,409,915	2,318,789
Non-Financial Assets			
Leasehold improvements	5A	37,000	87,145
Property, plant and equipment	5B,C	59,625	77,824
Intangibles	5D,E	837,078	713,442
Other	5F	13,200	1,960
Total non-financial assets		946,903	880,371
Total Assets		3,356,818	3,199,160
LIABILITIES			
Payables			
Suppliers	6A	145,957	131,788
Total payables		145,957	131,788
Provisions			
Employee provisions	7A	256,628	194,592
Total provisions		256,628	194,592
Total Liabilities		402,585	326,380
Net Assets		2,954,233	2,872,780
EQUITY			
Contributed equity		2,110,041	2,110,041
Retained surplus		844,192	762,739
Total Equity		2,954,233	2,872,780

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

Private Health Insurance Ombudsman Statement of Changes in Equity

FOR THE PERIOD ENDED 30 JUNE 2010

	RETAINED EARNINGS		CONTRIBUTED EQUITY/CAPITAL		TOTAL EQUITY	
	2010 $	2009 $	2010 $	2009 $	2010 $	2009 $
OPENING BALANCE						
Balance carried forward from previous period	762,739	484,532	2,110,041	2,110,041	2,872,780	2,594,573
Opening balance	762,739	484,532	2,110,041	2,110,041	2,872,780	2,594,573
COMPREHENSIVE INCOME						
Other comprehensive income	-	-	-	-	-	-
Surplus for the period	81,453	278,207			81,453	278,207
Total comprehensive income	81,453	278,207	-	-	81,453	278,207
of which: Attributable to the Australian Government	81,453	278,207	-	-	81,453	278,207
CLOSING BALANCE AT 30 JUNE	844,192	762,739	2,110,041	2,110,041	2,954,233	2,872,780
CLOSING BALANCE ATTRIBUTABLE TO THE AUSTRALIAN GOVERNMENT	844,192	762,739	2,110,041	2,110,041	2,954,233	2,872,780

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

Cash Flow Statement

FOR THE PERIOD ENDED 30 JUNE 2010

	Notes	2010 $	2009 $
OPERATING ACTIVITIES			
Cash received			
Goods and services		100,000	-
Appropriations		1,845,000	1,692,000
Net GST received		-	20,564
Other		16,600	41,143
Total cash received		1,961,600	1,753,707
Cash used			
Employees		954,307	803,597
Suppliers		654,884	589,604
Total cash used		1,609,191	1,393,201
Net cash from operating activities	8	352,409	360,506
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		18,401	125,877
Purchase of intangibles		345,672	223,732
Total cash used		364,073	349,609
Net cash used by investing activities		(364,073)	(349,609)
Net decrease in cash held		(11,664)	10,897
Cash and cash equivalents at the beginning of the reporting period		65,857	54,960
Cash and cash equivalents at the end of the reporting period	4A	54,193	65,857

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

Schedule of Commitments

AS AT 30 JUNE 2010

	2010 $	2009 $
BY TYPE		
Commitments receivable		
GST recoverable on commitments	21,335	41,501
Total commitments receivable	21,335	41,501
Other commitments		
Operating leases	73,115	156,455
Other	161,571	300,061
Total other commitments	234,686	456,516
Net commitments by type	213,351	415,015
BY MATURITY		
Commitments receivable		
Other commitments receivable		
One year or less	21,335	19,562
From one to five years	-	21,939
Total other commitments receivable	21,335	41,501
Commitments payable		
Operating lease commitments		
One year or less	73,115	76,694
From one to five years	-	79,761
Total operating lease commitments	73,115	156,455
Other Commitments		
One year or less	161,571	138,490
From one to five years	-	161,571
Total other commitments	161,571	300,061
Net commitments by maturity	213,351	415,015

NB: Commitments are GST inclusive where relevant.

Operating leases comprise of a lease for office accommodation. Lease payments are subject to increase 4% per annum as per the lease agreement. The lease term is three years.

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 is over five years.

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

Private Health Insurance Ombudsman Schedule of Contingencies

AS AT 30 JUNE 2010

There were no contingent losses or gains as at 30 June 2010.

Private Health Insurance Ombudsman Schedule of Asset Additions

FOR THE PERIOD ENDED 30 JUNE 2010

The following non-financial non-current assets were added in 2009-10:

	LEASEHOLD IMPROVEMENTS	INFRASTRUCTURE, PLANT & EQUIPMENT	INTANGIBLES	TOTAL
	$	$	$	$
By purchase - appropriation ordinary annual services	-	18,401	345,672	364,073
Total additions	-	18,401	345,672	364,073

The following non-financial non-current assets were added in 2008-09:

	Leasehold improvements	Infrastructure, plant & equipment	Intangibles	Total
	$	$	$	$
By purchase - appropriation ordinary annual services	87,487	38,390	223,732	349,609
Total additions	87,487	38,390	223,732	349,609

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Objectives of The Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman is an Australian Government controlled entity. The objective of the Private Health Insurance Ombudsman is to be an independent body which resolves complaints about private health insurance, and act as the umpire in dispute resolution at all levels within the private health industry.

The Agency is structured to meet one 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 Agency in its present form and with its present programs is dependent on Government policy and on continuing appropriations by Parliament for the Agency's administration and programs.

Agency activities contributing toward these outcomes are classified as either departmental or administered. Departmental activities involve the use of assets, liabilities, income and expenses controlled or incurred by the Agency in its own right. Administered activities involve the management or oversight by the Agency, on behalf of the Government, of items controlled or incurred by the Government.

The Agency conducts no administered activities.

1.2 Basis of Preparation of the Financial Statements

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

The Financial Statements have been prepared in accordance with:

- Finance Minister's Orders (or FMO) for reporting periods ending on or after 1 July 2009; and
- Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and 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 dollar unless otherwise specified.

Unless an alternative treatment is specifically required by an accounting standard or the FMO, assets and liabilities are recognised in the balance sheet when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under Agreements Equally Proportionately Unperformed are not recognised unless required by an accounting standard. Liabilities and assets that are 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.

1.3 Significant Accounting Judgements and Estimates

No accounting assumptions or estimates have been identified that have a significant risk

of causing a material adjustment to carrying amounts of assets and liabilities within the next accounting period.

1.4 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.

Other new standards, revised standards, interpretations, or amending standards that were issued prior to the signing of the statement by the Ombudsman 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 entity.

Future Australian Accounting Standard Requirements

No new standards, revised standards, interpretations, or amending standards were issued by the Australian Accounting Standards Board prior to the signing of the statement by the Ombudsman, which are expected to have a financial impact on the entity for future reporting periods.

The following standard issued prior to the signing of the statement by the Ombudsman has not been adopted by the Department of Finance and Deregulation, but if adopted will have an impact on future presentation of the financial statements.

AASB 1053: Application of Tiers of Australian Accounting Standards – June 2010

1.5 Revenue

Revenue from Government

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

Appropriations receivable are recognised at their nominal amounts.

Resources Received Free of Charge

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

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

Other Types of Revenue

Revenue from the sale of goods is recognised when:

- the risks and rewards of ownership have been transferred to the buyer;
- the agency retains no managerial involvement or effective control over the goods;
- the revenue and transaction costs incurred can be reliably measured; and
- 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:

- the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- 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 reporting period. Allowances are made when collectability of the debt is no longer probable.

1.6 Transactions with the Government as Owner

Equity Injections

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

Restructuring of Administrative Arrangements

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

1.7 Employee Benefits

Liabilities for 'short-term employee benefits' (as defined in AASB 119 *Employee Benefits*) and termination benefits due within twelve months of 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 Agency 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 apply at the time the leave is taken, including the Agency's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long service leave has been determined by reference to the work of an actuary as at 30 June 2010. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Superannuation

Staff of the Private Health Insurance Ombudsman are members of the Public Sector Superannuation Scheme (PSS) or the PSS accumulation plan (PSSap).

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

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

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

1.8 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 Agency has no finance leases.

1.9 Cash

Cash and cash equivalents includes cash on hand, cash held with outsiders, 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. Cash is recognised at its nominal amount.

1.10 Financial Liabilities

Supplier and other payables

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

1.11 Contingent Liabilities and Contingent Assets

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

1.12 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 agency's accounts immediately prior to the restructuring.

1.13 Property, Plant and Equipment

Asset Recognition Threshold

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

Revaluations

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

Asset Class	Fair value measured at
Leasehold improvements	Depreciated replacement cost
Infrastructure, plant and equipment	Market selling price

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

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

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

Depreciation

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

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

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

	2010	2009
Leasehold improvements	10 years	10 years
Plant and Equipment	4 to 10 years	4 to 10 years

Impairment

All assets were assessed for impairment at 30 June 2010. 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 Private Health Insurance Ombudsman 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.

1.14 Intangibles

The Private Health Insurance Ombudsman's intangibles comprise internally developed 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 Private Health Insurance Ombudsman's software is 5 years (2008-09: 5 years).

All software assets were assessed for indications of impairment as at 30 June 2010.

1.15 Taxation

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

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

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

NOTE 2: EXPENSES

	2010	2009
	$	$
NOTE 2A: EMPLOYEE BENEFITS		
Wages and salaries	826,257	704,042
Superannuation:		
Defined contribution plans	38,249	24,910
Defined benefit plans	83,640	67,202
Leave and other entitlements	62,036	41,836
Other employee expenses	6,160	4,270
Total employee benefits	1,016,342	842,260
NOTE 2B: SUPPLIERS		
Goods and services		
Consultants	16,329	13,169
Mediation	37,986	10,000
Insurance	15,095	15,766
Stationery	1,699	3,037
Recruitment	2,004	2,825
Legal	8,682	20,228
Website	147,748	210,744
Other	368,137	340,274
Total goods and services	597,680	616,043
Goods and services are made up of:		
Provision of goods – external parties	64,672	69,074
Rendering of services – related entities	59,851	-
Rendering of services – external parties	473,157	546,969
Total goods and services	597,680	616,043
Other supplier expenses		
Operating lease rentals – external parties:		
Minimum lease payments	70,835	74,132
Workers compensation expenses	4,989	3,960
Total other supplier expenses	75,824	78,092
Total supplier expenses	673,504	694,135

	2010	2009
	$	$
NOTE 2C: DEPRECIATION AND AMORTISATION		
Depreciation:		
Infrastructure, plant and equipment	24,373	25,917
Leasehold improvements	9,176	3,334
Total depreciation	33,549	29,251
Amortisation:		
Intangibles:		
Computer Software	222,036	172,140
Total amortisation	222,036	172,140
Total depreciation and amortisation	255,585	201,391
NOTE 2D: WRITE-DOWN AND IMPAIRMENT OF ASSETS		
Asset write-downs and impairments from:		
Revaluation decrement - Leasehold improvements	40,969	-
Revaluation decrement - Infrastructure, plant & equipment	9,982	-
Disposal of assets	2,245	350
Total write-down and impairment of assets	53,196	350

NOTE 3: INCOME

	2010	2009
REVENUE	$	$

NOTE 3A: SALE OF GOODS AND RENDERING OF SERVICES

Rendering of services - related entities	100,000	-
Rendering of services - external parties	-	12,433
Total sale of goods and rendering of services	100,000	12,433

NOTE 3B: OTHER REVENUE

Resources received free of charge:		
Audit services	15,690	13,200
Other income	390	28,710
Total other revenue	16,080	41,910

REVENUE FROM GOVERNMENT

NOTE 3C: REVENUE FROM GOVERNMENT

Appropriations:		
Departmental outputs	1,964,000	1,962,000
Total revenue from Government	1,964,000	1,962,000

NOTE 4: FINANCIAL ASSETS

	2010	2009
	$	$
NOTE 4A: CASH AND CASH EQUIVALENTS		
Cash on hand or on deposit	54,193	65,857
Total cash and cash equivalents	54,193	65,857
NOTE 4B: TRADE AND OTHER RECEIVABLES		
Appropriations receivable:		
For existing outputs	2,355,722	2,236,722
Total appropriations receivable	2,355,722	2,236,722
Other receivables:		
GST receivable from the Australian Taxation Office	-	16,210
Total other receivables	-	16,210
Total trade and other receivables (net)	2,355,722	2,252,932
Receivables are expected to be recovered in:		
No more than 12 months	2,355,722	2,252,932
Total trade and other receivables (net)	2,355,722	2,252,932
Receivables are aged as follows:		
Not overdue	2,355,722	2,252,932
Total receivables (gross)	2,355,722	2,252,932

NOTE 5: NON-FINANCIAL ASSETS

	2010	2009
	$	$
NOTE 5A: LEASEHOLD IMPROVEMENTS		
Leasehold improvements:		
Fair value	37,000	90,986
Accumulated depreciation	-	(3,841)
Total leasehold improvements	37,000	87,145

No indicators of impairment were found for leasehold improvements.

NOTE 5B: INFRASTRUCTURE, PLANT AND EQUIPMENT		
Infrastructure, plant and equipment:		
Fair value	69,052	120,197
Accumulated depreciation	(9,427)	(42,374)
Total infrastructure, plant and equipment	59,625	77,824

Plant and equipment under finance leases were subject to revaluation. The carrying amount is included in the valuation figures above.

All revaluations were conducted in accordance with the revaluation policy stated at Note 1. On 30 June 2010, an independent valuer conducted the revaluations.

Revaluation decrement of $40,969 for leasehold improvements and $9,982 for plant and equipment were credited to the asset revaluation reserve by asset class and included in the equity section of the balance sheet; no decrements were expensed.

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

NOTE 5C: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PROPERTY, PLANT AND EQUIPMENT (2009-2010)

	LEASEHOLD IMPROVEMENTS	INFRASTRUCTURE, PLANT & EQUIPMENT	TOTAL
	$	$	$
As at 1 July 2009			
Gross book value	90,986	120,197	211,183
Accumulated depreciation and impairment	(3,841)	(42,374)	(46,215)
Net book value 1 July 2009	87,145	77,824	164,968
Additions:			
By purchase	-	18,401	18,401
Revaluations recognised in the operating result	(40,969)	(9,981)	(50,950)
Depreciation expense	(9,176)	(24,373)	(33,549)
Other movements	-	-	-
Disposals:			
Other	-	(2,245)	(2,245)
Net book value 30 June 2010	37,000	59,626	96,625
Net book value as of 30 June 2010 represented by:			
Gross book value	37,000	69,052	106,052
Accumulated depreciation	-	(9,427)	(9,427)
	37,000	59,625	96,625

NOTE 5C (CONT'D): RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PROPERTY, PLANT AND EQUIPMENT (2008-2009)

	LEASEHOLD IMPROVEMENTS	INFRASTRUCTURE, PLANT & EQUIPMENT	TOTAL
	$	$	$
As at 1 July 2008			
Gross book value	3,499	82,307	85,806
Accumulated depreciation and impairment	(507)	(16,607)	(17,114)
Net book value 1 July 2008	2,992	65,700	68,692
Additions:			
By purchase	87,487	38,390	125,877
Depreciation expense	(3,334)	(25,917)	(29,251)
Disposals:			
Other	-	(350)	(350)
Net book value 30 June 2009	87,145	77,824	164,968
Net book value as of 30 June 2009 represented by:			
Gross book value	90,986	120,197	211,183
Accumulated depreciation	(3,841)	(42,374)	(46,215)
	87,145	77,824	164,968

	2010	2009
	$	$
NOTE 5D: INTANGIBLES		
Computer software:		
Purchased	1,344,656	1,043,386
Total computer software (gross)	1,344,656	1,043,386
Accumulated amortisation	(548,990)	(329,944)
Total computer software (net)	795,666	713,442
Other intangibles:		
Purchased	44,402	-
Total other intangibles (gross)	44,402	-
Accumulated amortisation	(2,990)	-
Total other intangibles (net)	41,412	-
Total intangibles	837,078	713,442

No indicators of impairment were found for intangible assets.

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

NOTE 5E: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF INTANGIBLES (2009-2010)

	COMPUTER SOFTWARE PURCHASED	OTHER INTANGIBLES PURCHASED	TOTAL
	$	$	$
As at 1 July 2009			
Gross book value	1,043,386	-	1,043,386
Accumulated amortisation and impairment	(329,944)	-	(329,944)
Net book value 1 July 2009	713,442	-	713,442
Additions:			
By purchase	301,270	44,402	345,672
Amortisation	(219,046)	(2,990)	(222,036)
Net book value 30 June 2010	795,666	41,412	837,078
Net book value as of 30 June 2010 represented by:			
Gross book value	1,344,656	44,402	1,389,058
Accumulated amortisation and impairment	(548,990)	(2,990)	(551,980)
	795,666	41,412	837,078
As at 1 July 2008			
Gross book value	819,653	-	819,653
Accumulated amortisation and impairment	(157,803)	-	(157,803)
Net book value 1 July 2008	661,850	-	661,850
Additions:			
By purchase	223,732	-	223,732
Amortisation	(172,140)	-	(172,140)
Net book value 30 June 2009	713,442	-	713,442
Net book value as of 30 June 2009 represented by:			
Gross book value	1,043,385	-	1,043,385
Accumulated amortisation and impairment	(329,943)	-	(329,943)
	713,442	-	713,442

	2010	2009
	$	$
NOTE 5F: OTHER NON-FINANCIAL ASSETS		
Prepayments	13,200	1,960
Total other non-financial assets	13,200	1,960

All other non-financial assets were current assets.

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

NOTE 6: PAYABLES

NOTE 6A: SUPPLIERS		
Trade creditors and accruals	145,957	131,788
Total supplier payables	145,957	131,788
Supplier payables expected to be settled within 12 months:		
External parties	145,957	131,788
Total	145,957	131,788
Total supplier payables	145,957	131,788

Settlement is usually made within 30 days.

NOTE 7: PROVISIONS

NOTE 7A: EMPLOYEE PROVISIONS		
Leave	256,628	194,592
Total employee provisions	256,628	194,592
Employee provisions are expected to be settled in:		
No more than 12 months	214,738	135,381
More than 12 months	41,890	59,211
Total employee provisions	256,628	194,592

NOTE 8: CASH FLOW RECONCILIATION

	2010	2009
	$	$
Reconciliation of cash and cash equivalents as per Balance Sheet to Cash Flow Statement		
Cash and cash equivalents as per:		
Cash flow statement	54,193	65,857
Balance sheet	54,193	65,857
Difference	-	-
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	1,882,547	1,683,793
Add revenue from Government	1,964,000	1,962,000
Adjustments for non-cash items		
Depreciation / amortisation	255,585	201,391
Net write down of non-financial assets	53,196	350
Changes in assets / liabilities		
(Increase) / decrease in net receivables	(102,709)	(249,436)
(Increase) / decrease in prepayments	(11,240)	(1,960)
Increase / (decrease) in employee provisions	62,036	41,836
Increase / (decrease) in supplier payables	14,169	90,118
Net cash from (used by) operating activities	352,490	360,506

NOTE 9: SENIOR EXECUTIVE REMUNERATION

NOTE 9A: ACTUAL REMUNERATION PAID TO SENIOR EXECUTIVES

Executive Remuneration

	2010	2009
The number of senior executives who received:		
$220,000 to $234,999	-	1
$235,000 to $349,999	1	
Total	1	1

Total expense recognised in relation to Senior Executive employment

	$	$
Short-term employee benefits:		
Salary (including annual leave taken)	225,507	203,748
Changes in annual leave provisions	15,088	14,649
Total Short-term employee benefits	240,595	218,397
Other long-term benefits	4,526	4,395
Total	245,121	222,792

NOTE 9B: SALARY PACKAGES FOR SENIOR EXECUTIVES

Average annualised remuneration packages for substantive Senior Executives

	As at 30 June 2010			As at 30 June 2009		
	NO. SES	BASE SALARY (INCLUDING ANNUAL LEAVE)	TOTAL REMUNERATION PACKAGE	NO. SES	BASE SALARY (INCLUDING ANNUAL LEAVE)	TOTAL REMUNERATION PACKAGE
Total remuneration:						
$220,000 to $234,999	-	-	-	1	$201,267	$222,792
$235,000 to $349,999	1	$218,014	$245,121	-	-	-
Total	1			1		

NOTE 10: REMUNERATION OF AUDITORS

	2010	2009
	$	$
Financial statement audit services were provided free of charge to the Agency.		
The fair value of the services provided was:		
Revenue received free of charge	15,690	13,200
	15,690	13,200

No other services were provided by the Auditor-General.

NOTE 11: FINANCIAL INSTRUMENTS

	2010	2009
	$	$
NOTE 11A: CATEGORIES OF FINANCIAL INSTRUMENTS		
Financial Assets		
Cash and cash equivalents	54,193	65,857
Total	54,193	65,857
Carrying amount of financial assets	54,193	65,857
Financial Liabilities		
Trade Creditors	145,957	131,788
Total	145,957	131,788
Carrying amount of financial liabilities	145,957	131,788

NOTE 11B: CREDIT RISK

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

The Ombudsman has no significant concentration of credit risk.

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

NOTE 11C: 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 11D: MARKET RISK

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

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

NOTE 12: APPROPRIATIONS

TABLE A1: ACQUITTAL OF AUTHORITY TO DRAW CASH FROM THE CONSOLIDATED REVENUE FUND FOR ORDINARY ANNUAL SERVICES APPROPRIATIONS

Particulars	Departmental outputs	
	2010	2009
	$	$
Balance brought forward from previous period *(Appropriation Acts)*	**2,302,579**	2,021,682
Appropriation Act:		
Appropriation Act (No. 1, 3&5) 2009-2010 as passed	**1,964,000**	1,962,000
FMA Act:		
*Appropriations to take account of recoverable GST (*FMA Act* section 30A)[1]	**-**	16,340
Relevant agency receipts *(FMA Act s 31)*	**100,390**	41,143
Total appropriation available for payments	**4,366,969**	4,041,165
Cash payments made during the year (GST inclusive)	**1,957,054**	1,738,586
Balance of authority to draw cash from the Consolidated Revenue Fund for ordinary annual services appropriations and as represented by:	**2,409,915**	2,302,579
Cash at bank and on hand	**54,193**	65,857
*Departmental appropriations receivable	**2,355,722**	2,236,722
*Net GST payable (to)/from ATO	**-**	-
Total as at 30 June	**2,409,915**	2,302,579

[1] The amounts in this line item are calculated on an accrual basis to the extent that an expense may have been incurred that includes GST but has not been paid by year end.

NOTE 13: SPECIAL ACCOUNTS

The Private Health Insurance Ombudsman has a Special Account established with the name Services for Other Entities and Trust Moneys Special Account (Departmental). This account was established under section 20 of the *Financial Management and Accountability Act 1997* (FMA Act).

For the year ended 30 June 2010 the account had nil balances and there were no transactions debited or credited to it. The account has not been used in the current and prior period.

The purposes of the account are to:

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

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

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

NOTE 14: COMPENSATION AND DEBT RELIEF

	2010	2009
	$	$
Departmental		
No 'Act of Grace' expenses were incurred during the reporting period (2009: No expenses).	-	-
The estimated amount outstanding in relation to payments being made on a periodic basis as at 30 June 2010 was $0 ($0 at 30 June 2009).		
No waivers of amounts owing to the Australian Government were made pursuant to subsection 34(1) of the *Financial Management and Accountability Act 1997.* (2009: No waivers)	-	-
No payments were provided under the Compensation for Detriment caused by Defective Administration (CDDA) Scheme during the reporting period. (2009: No payments)	-	-
No ex-gratia payments were provided for during the reporting period. (2009: 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. (2009: No payments)	-	-

NOTE 15: 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.

NOTE 15A: NET COST OF OUTCOME DELIVERY

	Outcome 1	
	2010	2009
	$	$
Expenses		
Departmental	1,998,627	1,738,136
Total	1,998,627	1,738,136
Income from non-government sector		
Departmental		
Activities subject to cost recovery	116,080	54,343
Total departmental	116,080	54,343
Total	116,080	54,343
Net cost/(contribution) of outcome delivery	1,882,547	1,683,793

Glossary

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

Benefit: The amount paid by the insurer for a specific service.

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

Health care provider: a provider of medical services or treatment. May refer to a hospital, doctor, dentist, or other practitioner.

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

Department of Health & Ageing: The federal department is responsible for policies relating to private health insurance.

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

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

Hospital cover: Health insurance to cover your costs as a private patient in hospital, including hospital accommodation and medical treatment.

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

Medicare: an Australian Government agency that delivers universal public healthcare to the Australian community.

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

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

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.

Overseas Student Health Cover: A type of health cover designed for overseas students which can be purchased from some Australian private health insurers. It is a requirement to hold this type of insurance under certain visas.

Overseas Visitors Health Cover: A type of health cover designed for people without Medicare benefits which can be purchased from some Australian private health insurers, and some international or general insurers.

Private Health Insurance Administration Council: An independent Statutory Authority that regulates the private health insurance industry.

Rebate: A federal government subsidy of between 30 and 40% of the cost of private health insurance.

Waiting period: How long you need to be a member of a policy before you are eligible for benefits. The Government has set maximum waiting periods for benefits for hospital services, but insurers can set their own waiting periods for general treatment cover.

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Australian Government

Private Health Insurance Ombudsman

Protecting the interests of people covered by private health insurance