Australian Government

Private Health Insurance Ombudsman

Private Health Insurance Ombudsman

2012–13 Annual Report

The Private Health Insurance Ombudsman

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

Contacts

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

Postal address

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

Telephone, fax and e-mail

Enquiries and complaints

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

Website and general enquiries

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

E-mail

info@phio.gov.au

Internet

www.phio.gov.au

Administration

(02) 8235 8777

Facsimile

(02) 8235 8778

Consumers requiring translators

13 14 50 (Translating and Interpreting Service)

Deaf, hearing or speech impaired

1800 555 677 (National Relay Service)

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

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

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Letter of Transmittal

Australian Government
Private Health Insurance Ombudsman

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

Dear Minister

In accordance with Section 253-50 of the *Private Health Insurance Act 2007*, I am pleased to present you with the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2012 to 30 June 2013.

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

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

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

Yours sincerely

Samantha Gavel

Samantha Gavel
Ombudsman
26 September 2013

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Ombudsman's Overview

Introduction

The role of the Private Health Insurance Ombudsman (PHIO) is to protect the interests of private health insurance consumers. PHIO carries out this role in a number of ways, including:

- Assisting members to resolve disputes through its independent complaints handling service;
- Identifying underlying problems in the practices of private health insurers or health care providers in relation to the administration of private health insurance;
- Providing advice to government and industry about issues affecting consumers in relation to private health insurance; and
- Providing advice and recommendations to government and industry about private health insurance, specifically the performance of the sector and the nature of complaints.

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

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

PHIO is funded by a levy collected from private health insurers under the *Private Health Insurance Complaints Levy Act 1995* (Cth), which fully recovers the cost of its funding. The role and functions of PHIO are set out in Part 6-2 of the *Private Health Insurance Act 2007* (Cth). PHIO is prescribed as an agency under the *Financial Management and Accountability Act 1997* (Cth).

Ombudsman Samantha Gavel

2012–13 has proved to be a busy and productive year for PHIO. During the year, overall complaint levels remained at a similar level to last year, but there was a significant decrease in the number

of higher level complaints requiring investigation by PHIO. There were also significant increases in visits to the PrivateHealth.gov.au website and general enquiries from consumers about private health insurance.

PHIO's complaints handling and information and advice services are available to health insurance consumers across Australia. PHIO's dedicated, knowledgeable and experienced team of staff ensures that these services are of a high quality and are provided in a timely manner. This means that the office achieves very good results in its Client Survey and through feedback on the consumer website, PrivateHealth.gov.au.

PHIO works collaboratively with government and industry stakeholders to resolve individual complaints from members, in addition to investigating systemic issues identified through its complaints handling activity, in order to improve complaints handling within individual insurers and the industry as a whole.

The focus of PHIO's complaints handling service is on ensuring the service is independent, objective, accessible, effective and timely. Through PHIO's Client Survey, consumers have advised that they value a complaints handling service that achieves these objectives.

Highlights for the 2012–13 year included:

- A 29% decline in higher level complaints requiring more detailed investigation by PHIO;
- Continued high level of customer satisfaction with PHIO's complaints handling service, with 85% of those surveyed reporting they were satisfied or very satisfied with the service;
- A 41% increase in unique visits to the consumer website PrivateHealth.gov.au;
- Continued positive feedback from consumers in relation to the PrivateHealth.gov.au website, with consistently positive responses on the major criteria. Ninety-two per cent of surveyed clients were happy with the website's visual appeal; 87% rated the website as easy to use; 79% rated information as easy to find; and 78% rated the information as being of very good or satisfactory quality;
- Updates and improvements to the PrivateHealth.gov.au website, resulting from feedback from consumers and modifications required as a result of the introduction of means testing of the Government Rebate;
- PHIO's biannual industry seminar held in September 2012, focusing on issues presented to the office by consumers. Speakers at the Seminar addressed these issues and other current topics relevant to the industry; and
- Working with insurers to improve their internal processes to reduce complaints about particular issues causing complaints from members. During the reporting period, PHIO focused on ways to reduce complaints about specific issues including Hospital Exclusions and Restrictions, Customer Service Issues, and the Pre-Existing Condition Waiting Period, either within a particular insurer receiving a higher level of complaint about these issues, or across the industry more broadly.

Pleasingly, consumer satisfaction with PHIO and its services remained high during the reporting period and the office met or exceeded all of its Key Performance Indicators. More information about PHIO's performance during the year is available on page 14 of this Report

Health Insurance Complaints

There were 2955 complaints to PHIO in 2012–13, which was similar to the 2995 complaints received in the previous year. Complaints have remained at a similar level since 2010–11, when there was a 17% increase in complaints to the office.

Pleasingly, there has been a 29% decrease in higher level complaints requiring investigation by PHIO in 2012–13, with 450 higher level complaints in 2012–13, compared with 630 in 2011–12.

These figures reflect PHIO's work with insurers to address the underlying systemic issues that lead to complaints, as well as the industry's own commitment to improving its internal complaints handling. They also reflect an increased awareness among consumers of the advice and education services provided by PHIO, including the PrivateHealth.gov.au consumer website. These resources assist consumers to be better informed about their rights and responsibilities in relation to their private health insurance.

Complaint Issues

PHIO categorises its complaints by issue and sub-issue, which allows for detailed analysis of complaint data and the identification of issues that are problematic within an insurer or the industry more broadly. PHIO has 10 major complaint issue categories, which are further broken down into three or more sub-issues. More information about PHIO's complaints categorisation is available on pages 19–22 of this Report.

Historically, the largest complaint issue has been the category of 'Benefit.' This relates to complaints about the level of benefit received by the member from their insurer. The sub-issues within this category include delays in payment of benefits, amount of benefits, restricted and excluded benefits, and medical and hospital gaps.

The sub-issues recording the highest number of complaints in 2012–13 were:

- Information—Oral Advice (289 complaints, compared with 261 the previous year);
- Waiting Period—Pre-Existing Conditions (207 complaints, compared with 207 the previous year);
- Membership Cancellation (192 complaints, compared with 148 the previous year);
- Benefit—Hospital Exclusion/Restriction (180, compared with 215 the previous year); and
- Delay in Payment (157, compared with 172 the previous year).

Although there was an increase in complaints in the category of Oral Advice in 2012–13, there was a decline in complaints about Hospital Exclusions and Restrictions, while the number of complaints about the Pre-Existing Condition Waiting Period was the same as last year. PHIO has focused on all three of these complaint areas with insurers and will continue to do so this year, in order to assist insurers to reduce complaints about these issues.

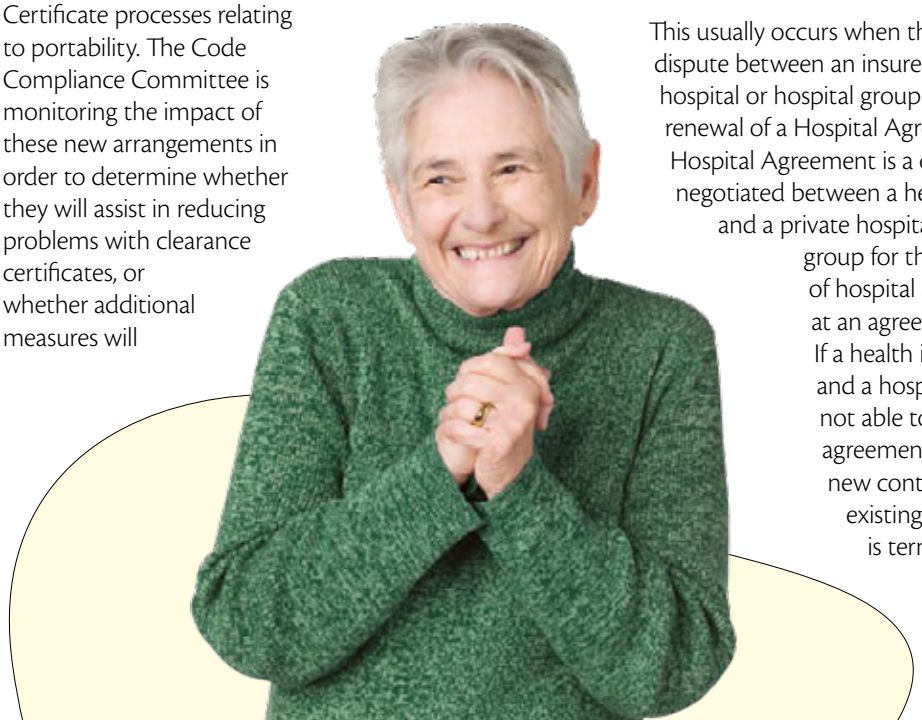
29%

The decrease in higher level complaints requiring investigation in 2012–13.

In relation to complaints about the Pre-Existing Condition Waiting Period, which applies to all new members who take out a hospital policy, PHIO is currently working with the Department of Health and Ageing to update the Pre-Existing Condition *Best Practice Guidelines* for insurers and hospitals, which were originally developed in 2000. PHIO is also planning to update and publicise the Pre-Existing Condition Guidelines for Medical Practitioners, to assist medical practitioners to better understand and advise their patients about how the waiting period may affect them. PHIO expects the updated material to be available by late-2013.

During the reporting period, complaints about portability issues increased. The number of complaints about Membership Cancellation increased from 148 to 192, and the number of complaints about Clearance Certificates increased from 89 to 152. PHIO's data shows that complaints about these issues were higher in the September 2012 and June 2013 quarters. The increases in the June 2013 quarter coincided with larger numbers of consumers switching their health insurance during the One Big Switch campaign aimed at encouraging a large group of members to switch to a new insurer, which commenced in March 2013.

Insurers introduced new initiatives in late-2012 under the auspices of the industry Code of Conduct, to streamline Clearance Certificate processes relating to portability. The Code Compliance Committee is monitoring the impact of these new arrangements in order to determine whether they will assist in reducing problems with clearance certificates, or whether additional measures will be needed. PHIO is supportive of these new arrangements and believes they will reduce complaints over time. PHIO will also continue to monitor complaints to the office about this issue over the coming year.



Complaints in most other complaint categories decreased during the year, or recorded only very small increases. (See table on page 32 to view detailed information about complaints to PHIO during 2012–13.)

Industry Issues and Developments

The Australian Government introduced income testing of the Government Rebate for private health insurance and increases to the Medicare Levy Surcharge for higher income earners who did not hold a hospital policy from 1 July 2012.

This change resulted in significant numbers of enquiries to PHIO, but there were very few complaints about this issue during the reporting period, with 13 complaints recorded for 2012–13.

PHIO has legislative power under the *Private Health Insurance Act 2007* (Cth) to settle complaints by mediation. PHIO was given the mediation power primarily to resolve disputes between health insurers and health care providers that may adversely affect consumers' entitlements under their health insurance.

This usually occurs when there is a dispute between an insurer and a hospital or hospital group about the renewal of a Hospital Agreement. (A Hospital Agreement is a contract negotiated between a health insurer and a private hospital or hospital group for the provision of hospital services at an agreed price.) If a health insurer and a hospital are not able to reach agreement about a new contract and the existing contract is terminated,

From left to right: Rosie Edwards, Joanna Wong, Tracey Salkeld, Alison Leung, Jim Robertson, Samantha Gavel, Kate Hocknull, Jaye Nang, Emma Howes, Kaylie Blyton, David McGregor and Henny Oentojo.

members of the health insurer attending that hospital will not be fully covered and may incur substantial out-of-pocket costs.

In order to protect consumers who may be adversely affected by an out-of-contract situation, PHIO is able to use its mediation power to help the parties to resolve the dispute. The aim of such mediation is to assist the parties to reach a position where direct negotiation between them is likely to resolve the matter. It does not involve PHIO ruling on the relative merits of the parties' negotiating positions or the prices they are seeking to pay or receive, which would not be considered an appropriate role for an Ombudsman.

During 2012–13, PHIO organised for formal mediation by an independent mediator of two disputes between health insurers and healthcare providers, in relation to the renewal of their Hospital Agreements. Following mediation, both disputes were resolved.

PHIO also has recommendatory powers under the *Private Health Insurance Act 2007* (Cth). These enable the Ombudsman to make a formal recommendation to an insurer, broker or healthcare provider to take a specific course of action in relation to a complaint, following an investigation by PHIO.

PHIO works collaboratively with its industry stakeholders and aims to resolve the majority of complaints and disputes without the need for a formal recommendation. In the majority of cases where PHIO has investigated and formed a view about how a complaint should be resolved, the insurer, broker or healthcare provider has agreed to resolve the matter in the way PHIO has suggested. During 2012–13, there were no matters that required PHIO to make a formal recommendation to an insurer, broker or health care provider.

Consumer Information and Advice

In recent years, PHIO's consumer information and advice role has become increasingly important. PHIO fulfils this role through its management of the consumer website PrivateHealth.gov.au, the publication of the consumer e-bulletin *Health Insurance Insider, Quarterly Bulletin*, and consumer brochures and factsheets, as well as its e-mail and telephone advice services. Enquiries through these channels are approaching similar numbers to PHIO's complaint handling services.

The consumer website PrivateHealth.gov.au is a significant resource for consumers, which was developed and is managed by PHIO. The website, which is Australia's leading source of independent information about private health insurance, has now been in operation since April 2007. During that time, there has been steady growth in visits to the site each year, as increasing numbers of consumers become aware of this important resource. The increase in visits to the site is attributable to PHIO initiatives to promote the site, the Department of Health and Ageing's annual Lifetime Health Cover mailings, and the site becoming better known through internet searches. More information about website visits can be found on page 44 of this Report.

An ongoing challenge for the office is ensuring that consumer awareness of the site and its resources continues to improve. PHIO has met this challenge through its own consumer awareness campaign, as well as strategic linking to other websites that assist in generating traffic to the site, such as the Australian Tax Office and Health Insite. The annual information campaigns in May–June each year, which inform people turning 31 and new migrants about Lifetime Health Cover, encourage a significant increase in visitors to the site and greatly assist in raising consumer awareness of its resources.

In May and June 2013, the Department of Health and Ageing provided funding to PHIO to conduct a consumer awareness initiative, to assist in raising awareness of the PrivateHealth.gov.au website. The initiative coincided with the Lifetime Health Cover mailing, a period when historically consumers are actively looking to take out a private health insurance policy.

The initiative was based around internet advertising across the country, including digital display, Facebook and search to target consumers actively searching for information about private health insurance.

PHIO's website data shows that the initiative was successful in increasing visits to the site. In addition, the initiative will allow PHIO to analyse the success of the various channels, which will be useful for undertaking further initiatives in the future. The PrivateHealth.gov.au website received 621,865 unique visitors throughout the year, an increase of 41% on the previous year.

Consumers who visit the PrivateHealth.gov.au website can provide feedback about their experience of using the site via the website survey feature. Consumer feedback from the survey continues to be very positive. In late-2013, PHIO will be conducting a tender process to seek a new contract for the maintenance and hosting of the website from 1 June 2014, when the current contract expires. It is expected that the new contract will include provision for the refresh and updating of the current site, to ensure it continues to meet consumers' needs in future years.

During 2012–13, PHIO has continued to produce its consumer e-bulletin *Health Insurance Insider*. The newsletter covers current topics and issues of interest to consumers. It complements the office's *Quarterly Bulletin*, which focuses on providing statistical information to industry and government stakeholders.

Corporate Governance

In January 2013, the Minister for Health and Ageing provided PHIO with a 'Statement of Expectations', which formally outlined how PHIO should operate in order to achieve the office's key objectives.

In response to the Statement of Expectations, PHIO provided a 'Statement of Intent' to the Minister, outlining the measures PHIO will put in place in 2013 to achieve the objectives set out in the Statement of Expectations.

Both documents are available for viewing at the office website www.phio.gov.au.

The Year Ahead

In the coming year, PHIO will continue to focus on ensuring that its complaint handling and information services meet consumers' needs for accessible, informative and useful services. This will include the introduction of a social media channel for consumers who choose to interact with the office through social media platforms.

PHIO will continue to monitor consumer feedback and satisfaction with the consumer website PrivateHealth.gov.au, which will inform updates and improvements to the site. It is important to ensure the site continues to meet consumers' needs as Australia's leading independent source of reliable and engaging information about private health insurance. This will include the conduct of a tender process to seek a new contract for the hosting and maintenance of the website from June 2014.

PHIO will continue to work with insurers to reduce complaints about the issues that have caused problems for members in 2012–13. This will include the office's regular workshops to assist insurers to improve their internal complaints handling services and focus on measures to reduce complaints from members.

Role and Function

Introduction

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

The role of the Ombudsman is to protect the interests of consumers in relation to private health insurance.

Functions

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

The functions of the Ombudsman, as outlined in section 238-5 of the *Private Health Insurance Act 2007* (Cth), are to:

- Deal with complaints and conduct investigations;
- Publish aggregate data about complaints;
- Publish the *State of the Health Funds Report*;
- Make recommendations to the Minister or Department of Health 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; and
- Undertake any other functions that are incidental to the performance of any of the preceding functions.

Who Can Make a Complaint?

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

Objects of Complaint

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

What Can the Ombudsman Do With a Complaint?

The 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* (Cth) provides various grounds for the Ombudsman to decide not to deal with a complaint. These include:

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

How the Ombudsman's Staff Resolve Complaints

The Ombudsman deals with most complaints by telephone, 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 refer the complaint themselves in order to provide a faster and more convenient service to the complainant.

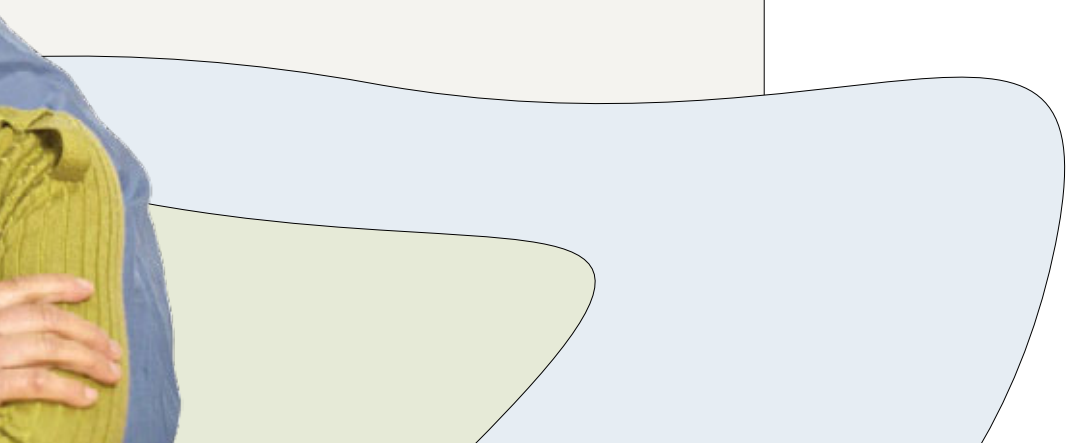
Where complaints are complex, or where formal contact with the health insurer has been unable to resolve the problem, the Ombudsman will write to the insurer or provider seeking further information.

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.

89.1%

Percentage of complaints finalised within 30 days—an improvement on the 83.8% in the previous year.



Performance

Performance Indicators

The 2012–13 Portfolio Budget Statements (PBS) indicate that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 9, Private Health: Improved choice in health services by supporting affordable quality private health care, including through private health insurance rebates and a regulatory framework.

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

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

The following is a summary of performance outcomes against the program's formal performance indicators in 2012–13:

Deliverables

Protect the interests of health insurance consumers

Qualitative Deliverable	2012–13 Reference Point or Target	2012–13 Result
Investigate the practices and procedures of health insurers	Investigation and mediation of complaints as required	PHIO staff worked closely with industry stakeholders to identify and address systemic issues causing complaints within a specific insurer or the industry as a whole; PHIO staff members were also involved in mediating complaints between health insurers and health care providers.

Improve the quality and accessibility of private health insurance information

Qualitative Deliverable	2012–13 Reference Point or Target	2012–13 Result
Publish the annual *State of the Health Funds Report*	The *State of the Health Funds Report* is published by PHIO by 31 March 2013	Report published on 28 March 2013.
Provide consumers with accurate and up-to-date information	Regular and timely updates of the private health consumer website (PrivateHealth.gov.au) and production of private health insurance factsheets	Website regularly updated in response to industry changes and issues of concern to consumers. Private health insurance factsheets produced and updated.

Protect the interests of health insurance consumers

Quantitative Deliverable	2012–13 Budget Target	2012–13 Result
Number of high-quality and timely advisory services, policy advice, and submissions and reports, measured by stakeholder feedback	>12	12

Key Performance Indicators

Protect the interests of health insurance consumers

Qualitative Indicator	2012–13 Reference Point or Target	2012–13 Result
Production of high-quality and timely advisory services, policy advice, submissions and reports	Positive stakeholder feedback on information products	Consumer brochures were sent directly to consumers, accessed online, and also distributed by health insurers, hospitals and providers, with over 139,000 brochures distributed throughout the year. The consumer website received 621,865 unique visitors throughout the year, an increase of 41% on the previous year.

Improve the quality and accessibility of private health insurance information

Qualitative Indicator	2012–13 Reference Point or Target	2012–13 Result
Provide independent and reliable information to consumers via the private health insurance consumer website (PrivateHealth.gov.au)	Measured by website survey and consumer focus testing which indicates that information provided is viewed as independent and reliable	79% of surveyed website clients rated information as easy to find and 78% rated the information as being of very good or satisfactory quality.

Protect the interests of private health insurance consumers

Quantitative Indicator	2012–13 Budget Target	2012–13 Result
Percentage of recommendations that have resulted in changes to insurer or industry practices	75%	Not applicable: no formal recommendations necessary.

Deliver a consumer complaints handling service

Quantitative Indicator	2012–13 Budget Target	2012–13 Result
Percentage of clients satisfied with complaint handling service	84%	85%

Complaints

The Ombudsman received 2955 complaints during 2012–13, a similar figure to the 2995 complaints received in 2011–12. Complaint levels have remained steady in this range for three years.

Of those complaints, 450 were classified as Level 3 Disputes, a decrease from the previous year's figure of 630. Level 3 complaints are those where an Ombudsman's dispute resolution staff member acts on behalf of a complainant by requesting a detailed report from a health insurer or other object of a complaint. The report is then reviewed and a decision is made as to whether the initial response was satisfactory or whether a further investigation is warranted.

FIGURE 1 shows the distribution of complaints over the four quarters of the 2012–13 financial year.

FIGURE 2 shows the total number of complaints received per year since 1999–2000. The increase

FIGURE 1: Complaints by Quarter

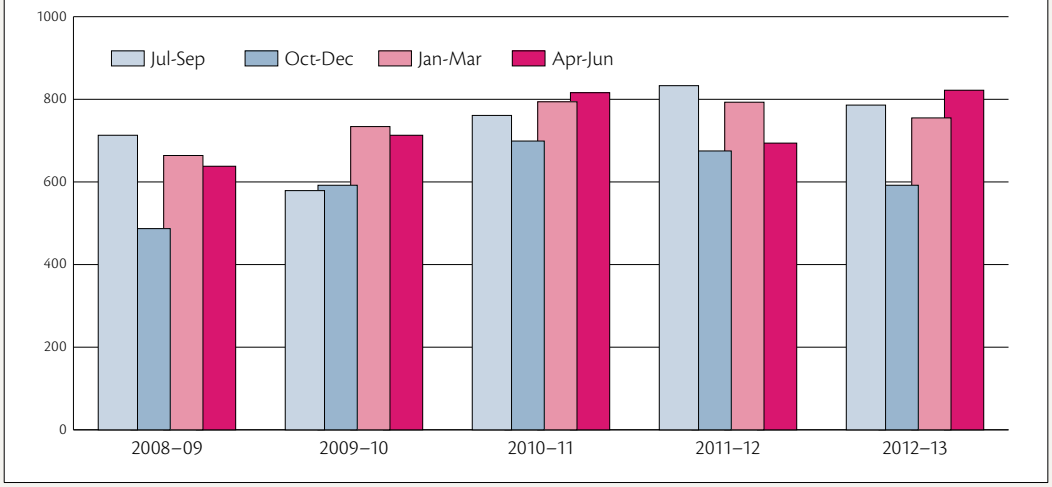
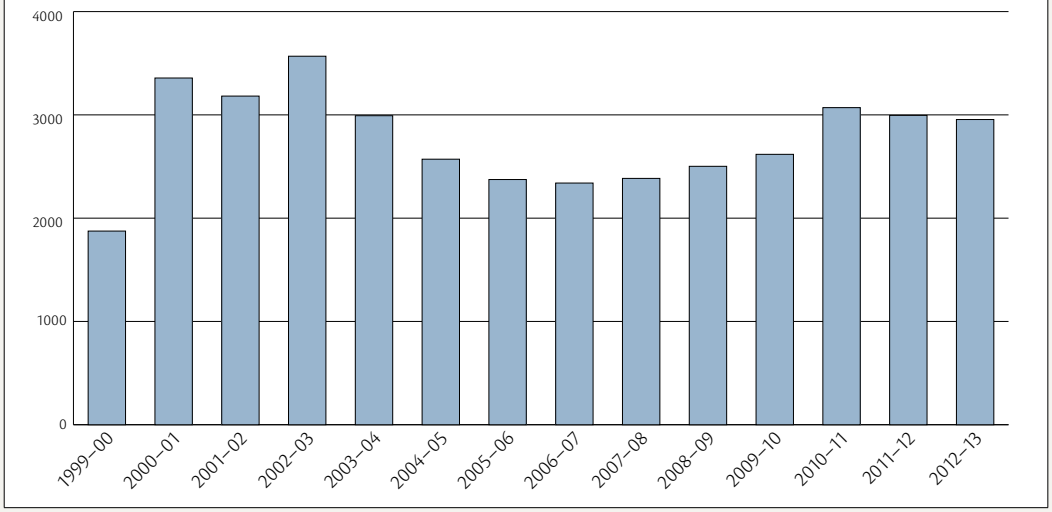


FIGURE 2: Complaints by Year



in the number of complaints in the 2000–01 year was associated with a large increase in the number of Australians covered by private health insurance following the introduction of the 30% Health Insurance Rebate and Lifetime Health Cover.

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

Consumer Enquiries: the Ombudsman's Consumer Education Function

Enquiries are instances where the Ombudsman's staff provide advice or information, where the matter does not meet the definition of a complaint. In 2012–13, 2175 consumer enquiries were recorded, increasing from the 1500 consumer enquiries recorded in the previous year.

The majority of enquiries (1480 enquiries, or 68%) were received via the Ombudsman's consumer website PrivateHealth.gov.au. Using the 'Ask a Question' feature on the website, consumers can contact the Ombudsman by filling out a form, and generally receive a response within one to two working days.

A significant percentage of enquiries occurred in May and June 2013 as changes to the Australian Government Private Health Insurance Rebate and the commencement of the Department of Health and Ageing's annual Lifetime Health Cover mailing caused heightened consumer awareness of private health insurance. (See the Consumer Website section on page 42 for more information.)

Recording and Categorisation of Complaints

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

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

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

Currently complaints are categorised as follows:

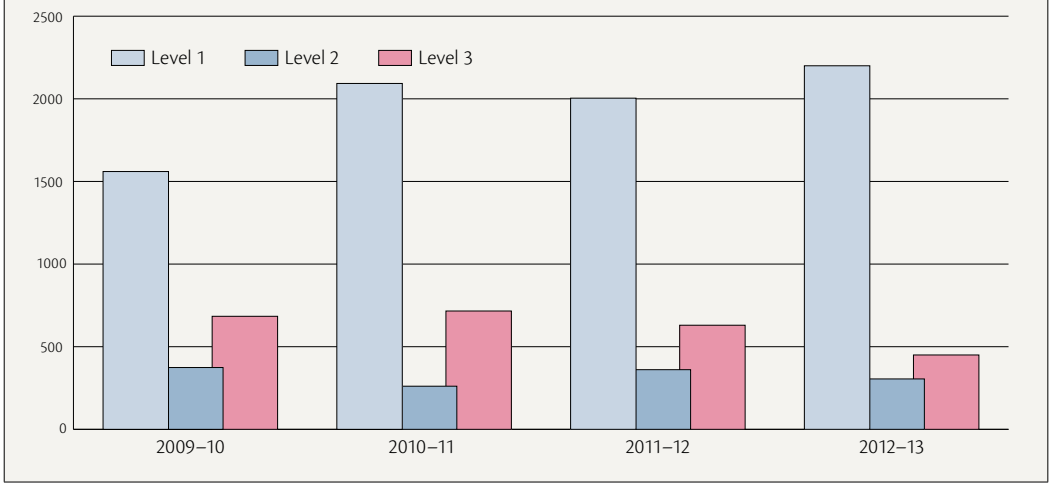
Complaint Level 1 (Problems): Moderate level of complaint

Level 1 complaints are dealt with by referring the complainant back to the health insurer, health care provider or health insurance broker which is the object of complaint. This occurs where, in the view of the Ombudsman, the complainant has not made an adequate attempt to resolve the problem or the Ombudsman is able to suggest to the complainant other ways of approaching the problem. Issues within this category may fall anywhere across the whole complaint range including product description, benefits paid, informed financial consent, pre-existing ailments and service quality.

In 2012–13, 75% of Level 1 complaints were resolved as 'Assisted Referrals,' where the Dispute Resolution Officer referred a complaint directly to a specifically arranged representative in the insurer or service provider on behalf of the complainant. When this occurs, the officer will counsel the complainant, advise them of the complaint process and timeframes, ensure the complaint is responded to by the other party, and offer to investigate the complaint at a later date if the matter is not resolved.

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

FIGURE 3: Complaints by Level



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

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

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

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

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

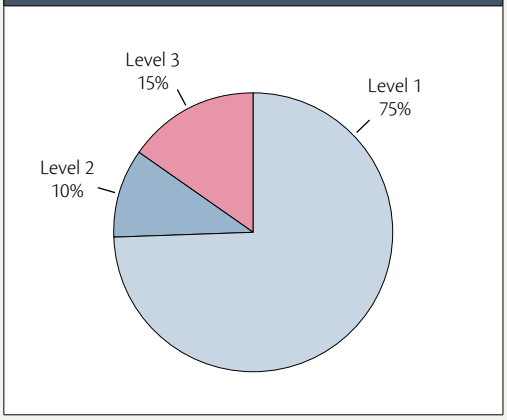
Level 3 complaints are dealt with by Ombudsman staff contacting the health insurer, health care provider or health insurance broker about the matter and requesting a formal report. Issues in this category will have previously been the subject of dispute between the complainant and the insurer or service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

FIGURE 3 and **FIGURE 4** shows the ratio of complaints by level. This year, 2200 complaints were classified as Level 1, 305 as Level 2, and 450 as Level 3. The volume of Level 1 complaints remained generally steady from 2011–12. Level 3 complaint levels have steadily decreased in recent years, as most cases are resolved by direct referral to the fund.

Complaint Audit and Escalation

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

FIGURE 4: Complaints by Level, 2012–13



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

Complaints Handling Procedures

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

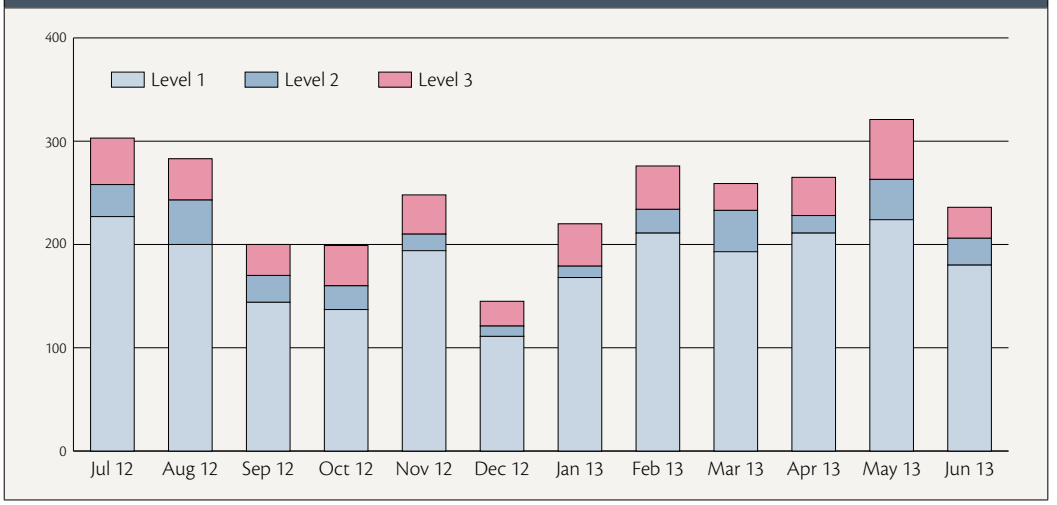
Health insurer members can also lodge complaints about health care providers, including:

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

FIGURE 5: Steps in Handling Approaches to the Ombudsman

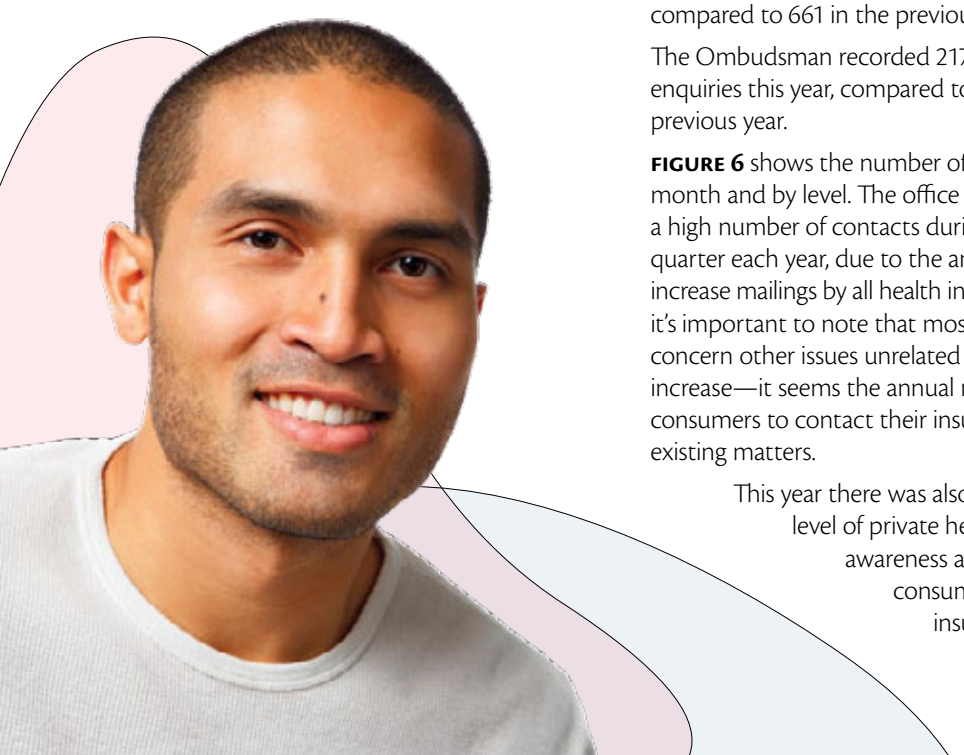
Complaint	Timeframe	Actions	Outcomes
Level 1 (Problem)	Immediate	If complainant has made insufficient effort to resolve the matter with insurer or provider, refer complaint to insurer on behalf of complaint or empower the complainant to take the matter up directly.	Referral to health insurer or provider.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

FIGURE 6: Complaint Level by Month



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

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



Workload

The office received 2955 complaints (Level 1, 2 and 3) in 2012–13, an average of 246 per month compared to 250 per month in the previous year. Of those complaints, 450 were Level 3 complaints, compared to 630 the previous year.

The office closed 3020 complaints in 2012–13, an average of 251 complaints per month. This is virtually identical to the figures from 2011–12, when 3025 complaints were closed. Of these complaints, 507 were Level 3 complaints, compared to 661 in the previous year.

The Ombudsman recorded 2175 consumer enquiries this year, compared to 1500 the previous year.

FIGURE 6 shows the number of complaints by month and by level. The office tends to receive a high number of contacts during the March quarter each year, due to the annual premium increase mailings by all health insurers. However, it's important to note that most complaints concern other issues unrelated to the premium increase—it seems the annual mailings remind consumers to contact their insurer regarding existing matters.

This year there was also a significant level of private health insurance awareness amongst consumers due to health insurance advertising

about the Lifetime Health Cover deadline and changes to the Australian Government Private Health Insurance Rebate.

Time Taken to Resolve Complaints

FIGURE 7 and **FIGURE 8** provide information on the time taken to resolve complaints this year compared to last year. The office continues to handle the majority of complaints within one month, with 89.1% finalised within 30 days this year—a pleasing improvement on the 83.8% in the previous year.

Who Was Complained About

FIGURE 9 shows most complaints (91%) were made about registered health insurers, followed by overseas visitors insurers (5%), practitioners (2% including doctors, dentists and other health care providers), hospitals (2%) and health insurance brokers (1%).

Complaints about Registered Health Insurers

FIGURE 10 provides a summary of all complaints (Levels 1, 2 and 3) for individual health insurers compared with their market share. This data is

FIGURE 7: Time Taken to Resolve Complaints

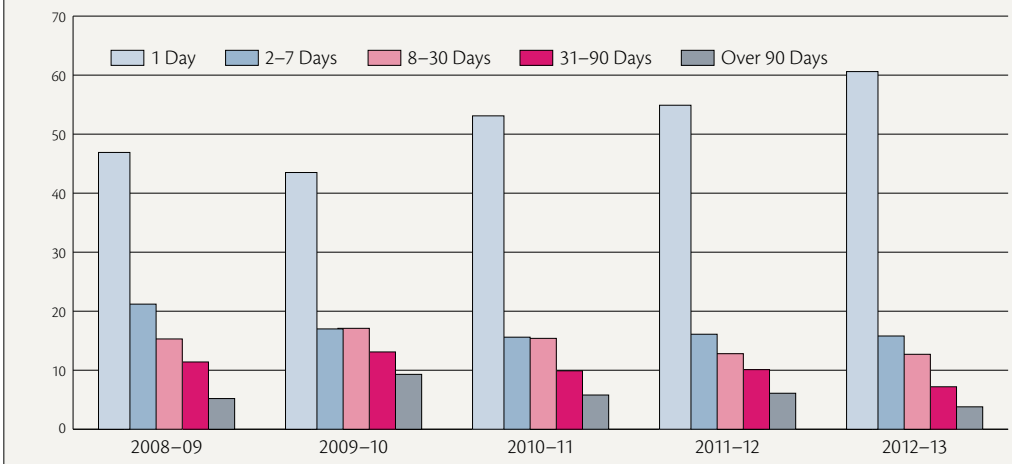


FIGURE 8: Complaints Closed Since Day of Lodgement 2012–13

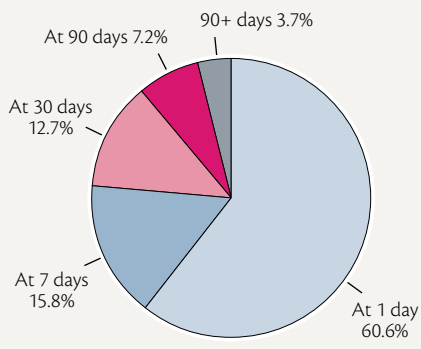


FIGURE 9: Complaint Objects, 2012–13

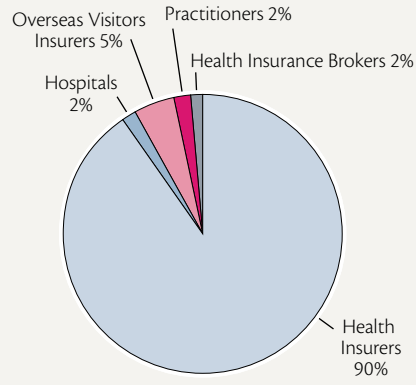


FIGURE 10: Complaints by Health Insurer Market Share, 2012–13					
Name of Insurer	Complaints	Percentage of Complaints	Disputes	Percentage of Disputes	Market Share
ACA	0	0.0%	0	0.0%	0.1%
Australian Health Management	169	6.7%	21	5.7%	3.0%
Australian Unity	142	5.6%	23	6.2%	3.2%
BUPA	662	26.3%	105	28.3%	26.7%
CBHS	26	1.0%	0	0.0%	1.3%
CDH (Cessnock)	0	0.0%	0	0.0%	<0.1%
CUA	12	0.5%	3	0.8%	0.4%
Defence	23	0.9%	3	0.8%	1.6%
Doctors	9	0.4%	1	0.3%	0.2%
GMHBA	45	1.8%	5	1.3%	1.8%
Grand United Corporate	15	0.6%	4	1.1%	0.4%
HBF	66	2.6%	8	2.2%	7.6%
HCI	1	0.0%	1	0.3%	0.1%
Health.com.au	25	1.0%	7	1.9%	<0.1%
Health Insurance Fund of Australia	22	0.9%	2	0.5%	0.6%
HealthGuard (GMF/Central West)	8	0.3%	2	0.5%	0.5%
Health-Partners	5	0.2%	0	0.0%	0.6%
HCF (Hospitals Contribution Fund)	284	11.3%	40	10.8%	10.7%
Latrobe	10	0.4%	3	0.8%	0.7%
Medibank	661	26.3%	97	26.1%	27.1%
Mildura	1	0.0%	1	0.3%	0.2%
National Health Benefits (Onemedifund)	0	0.0%	0	0.0%	0.1%
Navy	4	0.2%	0	0.0%	0.3%
NIB	221	8.8%	31	8.4%	7.6%
Peoplecare	7	0.3%	0	0.0%	0.5%
Phoenix	0	0.0%	0	0.0%	0.1%
Police	8	0.3%	0	0.0%	0.3%
Queensland Country Health	2	0.1%	0	0.0%	0.3%
Railway and Transport	7	0.3%	1	0.3%	0.4%
Reserve	3	0.1%	1	0.3%	<0.1%
St Lukes	8	0.3%	1	0.3%	0.4%
Teachers Health	50	2.0%	2	0.5%	1.8%
Teachers Union	8	0.3%	3	0.8%	0.4%
Transport	0	0.0%	0	0.0%	0.1%
Westfund	14	0.6%	5	1.3%	0.8%
	2518		370		

also presented for the higher category Level 3 complaints (Disputes). Analysing the information at this further level of detail provides a more realistic picture of the way insurers respond to their members' complaints. A high ratio of Level 3 complaints compared to market share points to a less than adequate internal dispute resolution process for complex issues within the insurer.

Complaints about Hospitals

The Ombudsman received 47 complaints about hospitals, a decrease on the 76 complaints received in the previous year.

Complaints about hospitals usually occur when patients experience unexpected gaps for a hospital admission. In most cases, there are adequate processes in place in private hospitals to ensure the provision of Informed Financial Consent (IFC) to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year. In 2012–13, the office recorded 54 IFC complaints relating to hospital bills, steady from the previous year.

The reasons why consumers 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).

IFC complaints against practitioners (including doctors, dentists and other practitioners) increased to 41 in the 2012–13 year. The office registered 31 complaints against practitioners in the previous year.

Complaints about Health Insurance Brokers

Complaints about brokers concern issues relating to the information provided on joining and the level of cover chosen. There were 34 complaints about brokers in 2012–13, steady from the 37 complaints the previous year.

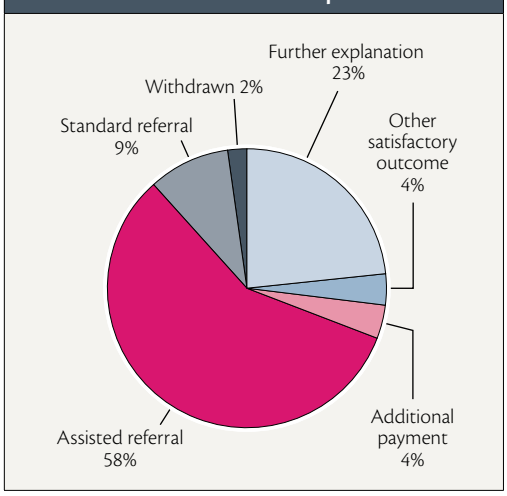
The major causes of complaint against brokers were the provision of oral advice to people joining or transferring between health insurers, and the difficulty in obtaining Clearance Certificates for transferring members. In cases of the former, complainants later found their new cover did not meet their needs or that they had been supplied with incorrect details about their new policies. For the latter issue, complainants often experienced administrative delays of weeks or even months when waiting on the provision of Clearance Certificates that would allow them to receive the correct premium and continuity of waiting periods.

Resolving Complaints

FIGURE 11 shows 23% of all complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint.

A further 58% of all complaints were referred directly to health insurers with the assistance of

FIGURE 11: Outcomes—All Complaints



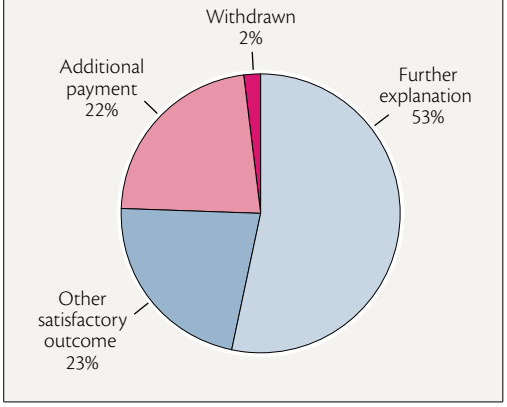
the Ombudsman's staff, on the understanding that the complainant could request a review of the complaint by the Ombudsman if they remained unsatisfied. The Ombudsman's arrangements for assisted referrals are designed to allow complainants and insurers to quickly resolve the majority of complaints using an informal approach, where the Ombudsman may suggest ways for the complaint to be resolved. Complainants are made aware that if they remain dissatisfied with the response they receive via the informal referral process, they are able to approach the Ombudsman again for a review of their case.

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

Resolving Level 3 Complaints

In relation to higher Level 3 complaints investigated by the Ombudsman, **FIGURE 12** shows 53% were resolved by giving a more detailed explanation to the member; 2% were withdrawn by the complainant; and the remaining 45% were resolved by a payment or other satisfactory outcome.

FIGURE 12: Outcomes—Level 3 Disputes



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.

FIGURE 13: Complaints by Population Covered by State or Territory

Who Complained

The *Private Health Insurance Act 2007* (Cth) allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. The overwhelming majority of complaints were made by health insurance members (2916 or 98.7%). A further 20 complaints were made by practitioners, 15 by hospitals and 3 from health insurers.

How Complaints Were Made

Although the majority of complaints continue to be lodged by telephone, the proportion of complaints received online by internet or e-mail has risen steadily. In 2012–13, 60% of complaints were made initially by phone and 38% by internet or e-mail; this compares to 64% by phone and 33% by internet or e-mail in the previous year.

Other methods of complaint continued to be very low. Complaints by letter dropped from 2.8% to 1.7%; and the remainder of other complaint mediums—including fax, personal visit, and parliamentary representation—comprised less than 0.5%, as in the previous year.

90%

Percentage of our complainants would recommend PHIO to others.

Complaints by State or Territory

FIGURE 13 identifies where complaints originate on a state-by-state basis. This data is shown by state and territory, against the percentage of people who have private health insurance coverage. The figures show that proportionally Victorians, Queenslanders and Western Australians were more likely to have a health insurance complaint than other states. Last year South Australians also had a high proportion of complainants, but in this year complaints dropped considerably.

Investigations

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

Complaint Issues and Case Studies

Introduction

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

The number of complaints registered with the Ombudsman in 2012–13 was similar to the previous year—2955 compared to 2995. Complaints in recent years have remained at higher levels than prior to 2010, but higher level complaints requiring investigation by PHIO have gradually declined. A key function of the Ombudsman's office is to monitor the levels of complaint over time and investigate the causes of consumer dissatisfaction.

How Case Studies Are Chosen

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

Benefits and Level of Cover

Complaints	Key issues
960	▸ Inadequate levels of cover ▸ Delays in payment ▸ Hospital and medical gaps

The most significant area of complaint to the Ombudsman's office was benefits, with a total of 960 complaints for 2012–13, a reduction from the previous year's figure of 1091. The main areas of concern for consumers were inadequate levels of cover, delays in payment, and hospital and medical gaps. A complete list of the issues classified as benefit complaints is provided in **FIGURE 16** of this Report.

Benefit Restrictions Case Study

The number of people holding policies that restrict or exclude a range of medical services covered in hospital has gradually increased over the past few years. At the moment, approximately 45% of policies held by people in Australia include one or more exclusions or restrictions.

This case study illustrates the difficulties faced by an individual seeking medical treatment and not knowing whether their basic hospital cover will provide cover or not. Some of these lower cost policies are complex because they only pay benefits on a range of services and in practice it is sometimes difficult for a consumer, or even a

94%

Percentage of our complainants agreed our staff listened adequately to their concerns.

medical practitioner, to know in advance what is covered and what isn't.

Jade had been advised by her specialist that she needed to undergo a gynaecological procedure called a hysteroscopy, where a small scope is used to examine tissue and sometimes remove tiny portions of fibroid growth. The advice from her surgeon was that this was only a minor procedure which was always done as a day surgery procedure.

Jade knew that her health insurance policy paid lower benefits for more expensive surgeries like heart surgery, but she thought she would be covered for this procedure because it was relatively minor and wouldn't cost much. She contacted her insurer and during the course of a couple of phone calls, she was advised that she would be covered because she was covered for 'minor gynaecological procedures'.

Later on, Jade was advised she wasn't fully covered for her procedure because the insurer classified it as a major gynaecological procedure. Jade disputed this because she had definitely been told that her surgery was minor by her gynaecologist and she believed he would know more about the procedure than anyone.

The amount the insurer was going to pay for her day procedure was only the 'default benefit,' which is calculated as the amount a health insurer would pay a public hospital for the same service. In a private hospital, the default benefit does not pay for many costs like theatre charges, which are often far more than the daily 'bed cost' of staying in a hospital. For Jade, the cost she was going to be required to pay for her treatment was about $2000 and her insurer would pay approximately $300.

FIGURE 14: Complaint Issues, 2012–13

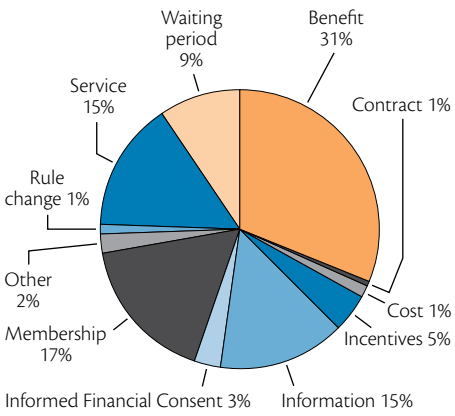
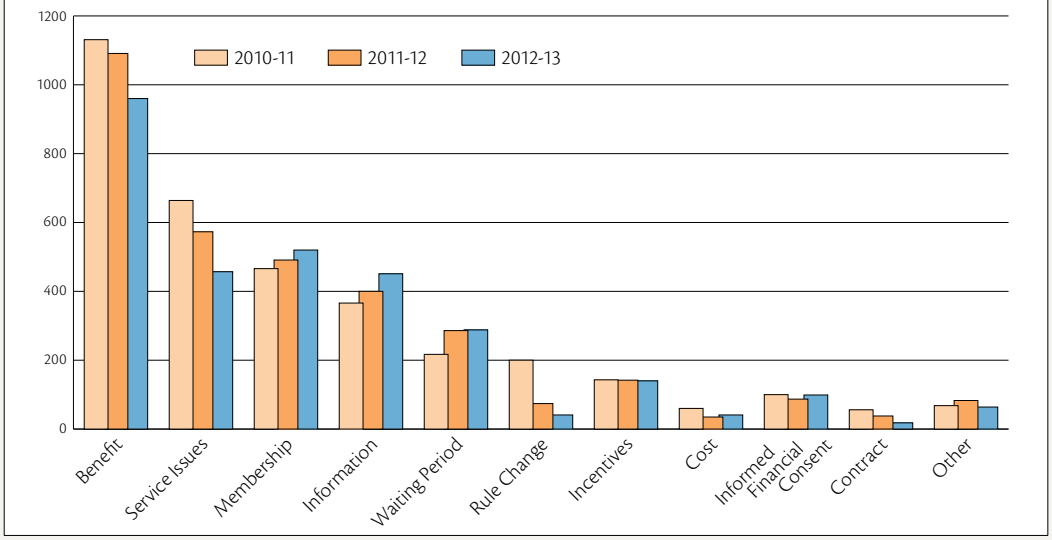


FIGURE 15: Complaint Issues, 2010–11 to 2012–13



Unhappy with the advice she had received from her insurer, Jade contacted PHIO for assistance. The PHIO officer was concerned about the advice given to Jade by the insurer that she was covered for "minor" gyneacological procedures, because this term is not clear to the consumer. The consumer and their surgeon will have their views of what constitutes a minor or major procedure and the insurer may have a different view.

In practice, insurers decide what is considered to be a major or minor procedure by keeping lists of item numbers that are covered or not covered. PHIO was concerned in Jade's case that this was not made clear to her during the phone calls she had made to the insurer. For this reason, PHIO agreed that Jade would have understood that she was covered for her procedure because a reasonable member of the general public would have understood the procedure to be minor. PHIO requested that the insurer pay the $2000 cost for the hospital bill and that it always provide a list of the Medicare item numbers that it does cover when receiving enquiries such as Jade's. This would have enabled her to provide the list to her surgeon's practice manager to confirm whether or not the surgeon was likely to use one of those item numbers.

Membership Issues

Complaints	Key issues
520	▸ Cancellation of policies ▸ Obtaining clearance certificates ▸ Suspending/resuming policies ▸ Continuity of benefits

Issues with membership and policy administration increased slightly from the previous year, with 520 complaints in 2012–13 compared to 492 the previous year. Almost 37% of these complaints were related to problems experienced by people in processing the cancellation of their health insurance policies. Difficulties in obtaining Clearance Certificates caused 29% of complaints. Suspending and resuming policies and continuity of benefits when transferring between insurers made up the majority of the remaining complaints.

Membership Cancellation Case Study

Membership payment and cancellation complaints commonly occur because health insurer computer systems don't always tell members that their membership is falling into arrears. Unlike general insurance, it is important to maintain your health insurance policy continuously to ensure waiting periods don't re-apply. There are also tax and Lifetime Health Cover implications for allowing a break in cover.

Unfortunately, some members don't find out that their policy hasn't been paid until it's too late—it is common for policies to be cancelled after a payment hasn't been made for two months. At this stage, if the consumer wants to reinstate the policy, it is at the discretion of the insurer and usually involves paying the arrears on the membership.

Leon had been on his parents' private health insurance policy since birth, but had reached the age of 25 and was told he needed to take out his own policy from then on. He received a letter from the health insurer about starting his own policy, with a special offer waiving the second month of premiums.

Leon accepted the offer and set up direct debits from his employer, the public school system, on the advice of the health insurer who said this was the easiest way to pay. However, his employment status then changed and he became a substitute teacher with varying hours of work each week.

He received a letter from his insurer six months into the policy saying that the policy had been cancelled due to a lack of payment. The cancellation was backdated by four months, so he hadn't been covered for some time. In addition, he would need to complete waiting periods again if he took out a new policy.

Leon was not happy that the first advice he received that payments weren't being made was a cancellation letter sent months after the fact. He raised the problem with his insurer who advised him to speak to his employer. The employer's pay office said that they had never received any notice to deduct premiums from his salary and that it was not their responsibility to check on such matters.

The insurer told Leon that they would reinstate his policy if he back-paid four months of premiums and paid one month in advance. They also told him that it was better if he paid his membership by direct debit on his bank account because payments by salary deduction often go wrong.

Leon was unhappy with being asked to pay five months' premiums in one go after not receiving any notice for several months after payments hadn't been made—he contacted PHIO for assistance.

PHIO's view is that it is ultimately the responsibility of a policy holder to ensure that payments are being made to a membership. PHIO believed in Leon's case that it was reasonable for him to be asked to back-pay some portion of the premiums that were not being forwarded by his pay office. PHIO has noted that insurers commonly include a disclaimer on all direct debit and salary deduction authorities that state that the policyholder agrees to be responsible if payments are not being made.

PHIO pointed out to the insurer that it had an obligation to advise Leon that something had gone wrong with his membership payments at the time arrears started accumulating on the policy. The health insurer's computer system should have sent a letter to Leon shortly after the policy commenced, advising him to make membership payments at a time when the cost would be more manageable for him. The insurer agreed to reduce the outstanding amount by 50% and reinstated the policy when Leon made the payment.

Service Issues

Complaints	Key issues
457	▸ Problems associated with direct debit systems ▸ General service issues

Another significant area of complaint to PHIO was service and payment administration, with 457 complaints, compared to 573 complaints last year. Of these, 144 were premium payment problems associated with direct debit systems, and the remainder were general service issues such as customer service issues or delays in service.

Service issues are not usually the sole reason for members' complaints, but poor customer service, in combination with existing problems, can cause a member to become more aggrieved and dissatisfied in their dealings with the insurer, until the service itself becomes a cause of complaint.

Information Complaints

Complaints	Key issues
451	▸ Oral advice provided by customer service staff ▸ Brochures, websites and health insurer notification letters

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. A total of 451 complaints about information were received—an increase from 400 complaints the previous year. Oral advice provided by customer service staff at health insurers made up the majority (63%) of these complaints, with brochures, websites and health insurer notification letters making up a further 25% of information complaints.

Oral Information Case Study

Due to the possible costs involved in hospital treatment, consumers are strongly encouraged to seek quotes from their doctors, hospitals and health insurers before undergoing treatment. Everyone has a responsibility to ensure consumers are provided with accurate and easy to understand information at the time they require it.

A very positive development in the health insurance industry in recent years has been the adoption of call recording of benefit quotes. This case is an example of how call recordings protect consumers and enable a complaint about incorrect or poor advice to be easily investigated and settled. For PHIO Dispute Resolution Officers in the old days, the difficulties of weighing up the evidence of oral advice and likely versions of events were considerable. and it is pleasing to see those days behind us.

Salma was organising a hospital admission and she contacted her health insurer to check that she would be covered for the hospital her surgeon worked at. On the first phone call to the insurer, Salma was told to find out what item number was going to be used by the surgeon and to phone back for a quote.

Salma phoned back a few minutes later. She spoke to another staff member who asked for the item number; Salma supplied the number and the staff member merely advised her that she would have to pay $250 for the hospital admission because she had an excess to pay on her policy.

It was only on a third call that Salma made to the insurer to confirm the date of her procedure that she was finally told the procedure wasn't covered on her policy and that she would be required to pay several thousand dollars for her treatment. This was in addition to charges for the surgeon, anaesthetist and pathology, which she hadn't been warned about when she had phoned the insurer to ask what she would have to pay for her procedure.

Initially the insurer said that it would honour the information it had given to Salma. When she received bills from several different doctors and the hospital, however, the claims went unpaid. Salma complained to the insurer and eventually to PHIO when they didn't respond to her.

The investigation officer listened to Salma's version of events and then asked the insurer to provide a copy of the phone call recordings to see if the incorrect information could easily be verified. The phone recording correlated with Salma's allegation of incorrect information, and PHIO noticed that very little warning was given to Salma about checking costs with her surgeon and anaesthetists to see if they were charging above what Medicare and her insurer would contribute.

In responding to PHIO, the insurer apologised for the poor communication and incorrect information that had been provided. In view of the error, and despite the fact that this procedure would not normally be covered under her policy, Salma's insurer agreed to cover the cost of her admission, except for her $250 excess.

Waiting Periods and Pre-Existing Conditions

Complaints	Key issues
207	▸ Waiting period applied correctly ▸ Compliance with PEC *Best Practice Guidelines*

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

PHIO received 207 complaints about the PEC waiting period during the year—the same number as the previous year. PHIO's role in investigating complaints about this waiting period is to ensure that the insurer has applied the waiting period correctly, and that the insurer and hospital have complied with the PEC *Best Practice Guidelines*. A copy of the Guidelines is available from the PHIO website.

Pre-Existing Conditions Case Study

A pre-existing condition is defined as any ailment, illness or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy.

In order to decline a claim within the first year of membership, it is only necessary for the insurer to show that signs or symptoms were apparent prior to the commencement of the person's policy or upgrade. However, by the same rule, if the evidence shows that signs and symptoms began

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Pre-Existing Condition matters investigated in 2012–13.

FIGURE 16: Complaint Sub-Issues

Benefit	2011–12	2012–13
Accident and emergency	20	15
Accrued benefits	8	7
Ambulance	47	37
Amount	21	32
Delay in payment	172	157
Excess	35	40
Gap—Hospital	44	32
Gap—Medical	47	56
General treatment (extras/ancillary)	102	69
High cost drugs	7	15
Hospital exclusion/restriction	215	180
Insurer rule	185	140
Limit reached	27	22
New baby	20	7
Non-health insurance	20	15
Non-health insurance—overseas benefits	6	9
Non-recognised other practitioner	17	26
Non-recognised podiatry	22	19
Other compensation	11	6
Out-of-pocket not elsewhere covered	8	16
Out of time	27	15
Preferred provider schemes	23	36
Prostheses	15	12
Workers compensation	1	2

Contract	2011–12	2012–13
Hospitals	24	13
Preferred provider schemes	9	3
Second tier default benefit	5	2

Cost	2011–12	2012–13
Dual charging	5	3
Rate increase	30	38

Informed Financial Consent	2011–12	2012–13
Doctors	31	41
Hospitals	54	54
Other	5	5

Incentives	2011–12	2012–13
Lifetime Health Cover	124	106
Medicare Levy Surcharge	10	12
Rebate	7	10
Rebate tiers and surcharge changes	N/A	13

Information	2011–12	2012–13
Brochures and websites	45	53
Lack of notification	53	55
Oral advice	261	289
Radio and television	1	1
Standard Information Statement	N/A	11
Written advice	40	45

Membership	2011–12	2012–13
Adult dependants	23	7
Arrears	69	43
Authority over membership	13	14
Cancellation	148	192
Clearance Certificates	89	152
Continuity	93	56
Rate and benefit protection	4	8
Suspension	61	55

Service	2011–12	2012–13
Customer service advice	164	63
General service issues	139	111
Premium payment problems	153	144
Service delays	132	151

Waiting Period	2011–12	2012–13
Benefit limitation period	4	2
General	18	28
Obstetric	45	35
Other	12	16
Pre-Existing conditions	207	207

(continued)

Other	2011–12	2012–13
Access	0	0
Acute care certificates	1	1
Community rating	0	0
Complaint not elsewhere covered	45	37
Confidentiality and privacy	19	9
Demutualisation/sale of health insurers	1	1
Discrimination	5	3
Non-English speaking background	0	0
Non-Medicare patient	4	7
Private patient election	8	6
Rule change	74	41

even one day after the member's commenced date, then the insurer cannot decline the claim.

If an insurer is presented with two contradictory pieces of evidence about a claim, then the onus falls on the insurer to verify which set of evidence is correct. It is not sufficient for an insurer to simply use one set of evidence while disregarding the other, as the difference of even a few days can change the outcome of a case.

Four months after starting her new hospital insurance policy, Jane booked into a private hospital for a sinus endoscopy and nasal surgery to treat sinusitis and headaches. When she contacted her insurer to check if she would be covered, the insurer advised her that she was still within her 12-month waiting period for pre-existing conditions and that they could not confirm if she would be covered until her condition had been assessed by the insurer's medical advisor.

The insurer posted a medical form to Jane's address for her doctor to complete, so the insurer could determine if the condition being treated was pre-existing to the commencement of her policy. Jane's General Practitioner completed the form and sent it back to the fund along with the referral letter to Jane's ear, nose and throat specialist.

According to the form completed by her GP, Jane had first presented to the doctor on the 4th of July after experiencing a headache for two days. This would place the onset of her symptoms at the 2nd of July, two days after commencing her new hospital policy on the 30th of June.

However, according to the GP's referral letter to the specialist dated the 29th of August, Jane had experienced 'a couple of months' of headaches and other symptoms related to sinusitis.

The insurer interpreted the phrase 'a couple of months' to mean that Jane had experienced two months of symptoms at the date of the referral on the 29th of August—this would place the onset of symptoms at the 29th of June, one day prior to Jane joining her new insurer. Since this would mean that the symptoms preceded Jane's insurance start date, the insurer deemed her condition to be pre-existing and declined to pay benefits for her hospital admission.

At this point Jane contacted the Ombudsman's office. She believed the insurer had misinterpreted the referral letter to the specialist and that they had disregarded the GP's statement that the onset of her symptoms was on the 2nd of July, not the 29th of June.

PHIO reviewed the case and decided to contact the GP to confirm whether the onset of Jane's symptoms was the 29th of June, as the insurer believed, or the 2nd of July, as Jane stated.

The Ombudsman's dispute resolution team.

The GP was able to supply his contemporaneous notes, showing the full history of Jane's consultations. The GP's notes confirmed that her first consultation about her headache and sinus symptoms was on the 4th of July and that she had presented after experiencing two days of symptoms. This confirmed that symptoms had indeed started on the 2nd of July, two days after joining her insurer.

PHIO considered that although the onset of symptoms was very close to the commencement date of the policy, there must statistically be, amongst the thousands of people who take out policies each year, a small number whose medical symptoms genuinely started after taking out a policy. These people have a right to have their cases assessed based on the evidence provided, and for no assumptions to be made in relation to their policy start date.

Furthermore, it was noted that Jane had commenced her policy at the beginning of the financial year. Many people start a policy on the 1st of July because they are aware that their income will exceed the Medicare Levy Surcharge income threshold in the upcoming financial year; to avoid the Surcharge, they need to hold private hospital cover. For these reasons, the 1st of July is one of the most common days for someone of Jane's age to take out of a health insurance policy, and therefore there was nothing unusual about her policy commencing on that day.

On reviewing the case, the insurer agreed that the GP's notes made it clear that the onset of symptoms was acute and that Jane's condition commenced on the 2nd of July. The fund agreed to reverse its initial decision and pay benefits for Jane's hospital admission.

Informed Financial Consent and Hospitals

Complaints	Key issues
54	▸ Unexpected costs for hospital admission ▸ Hospital gaps

Complaints about hospitals usually occur when patients experience unexpected costs for a hospital admission, or "hospital gaps". In most cases, private hospitals have good processes in place to ensure the provision of Informed Financial Consent (IFC) to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year. In 2012–13 the office recorded 54 Informed Financial Consent (IFC) complaints against hospitals, a similar amount as the previous year.

Informed Financial Consent and Hospitals Case Study

Mia had held a private health insurance policy for a number of years and her private hospital admissions for the delivery of her first two children had been covered by her insurer. She was admitted to hospital for her third child and, as had occurred on the two previous admissions, she was not advised of any out-of-pocket costs before or during the admission.

A few weeks after she had given birth to her third child and left the hospital, however, she received a bill of more than $4000 from the hospital. She contacted the hospital thinking it must be an error, but was told that no, she wasn't fully covered and the $4000 was to cover the amount her health insurer didn't pay for her admission. She was told to contact her health insurer about the issue. After she did so and was told that her cover didn't fully cover obstetrics, she phoned PHIO.

Mia had held the same level of hospital cover for a number of years. The policy had a number of restrictions. It had covered obstetrics in the past, but the insurer had removed full benefits for obstetrics several years earlier.

On raising the matter with the insurer, PHIO was supplied with a number of letters that had been sent to Mia about her cover. Unfortunately, she hadn't responded to them or noticed that her policy no longer covered obstetrics. Mia had changed her address during that period and it is possible that she had not received important information about changes to her cover.

According to Mia, the hospital had not obtained informed financial consent from her for the $4000 out-of-pocket cost, so PHIO contacted the hospital to ask what information had been provided to Mia on admission about this cost.

The hospital initially provided PHIO with a response that included a generic paragraph, signed by Mia, in which she agreed to pay whatever charges her health insurer didn't pay. PHIO did not accept this response as reasonable because it is industry best practice that hospitals must check a patient's cover with their insurer prior to admission wherever possible; if the patient is not fully covered, the hospital must warn the patient of any costs they will incur.

In Mia's case, on reviewing the hospital and insurer records, it became apparent that the hospital had actually performed an eligibility check of her health insurance policy prior to her admission. The insurer's records showed a message was returned to the hospital indicating Mia was not fully covered under her policy for obstetrics. The hospital failed to advise Mia that it had this information. PHIO believed that reducing the outstanding hospital account was warranted, because the hospital had specifically advised her that it had checked her policy.

Nevertheless, in investigating the complaint, PHIO could not overlook the fact that Mia had held a lower level of hospital cover and there was some obligation on her part to check her hospital cover from the time benefits had been removed. Records indicated that Mia had been sent a number of letters advising of the change to her cover and cover details, both at her old address and new address. In the end, PHIO arranged for the hospital to reduce the outstanding account by 50% as a reasonable outcome, given the details of the case.

Rule Changes

Complaints	Key issues
41	▸ Changes to policies ▸ Adequate notice to consumers

PHIO received 41 rule change complaints in 2012–13, compared to 74 the previous year.

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

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

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

Health Insurer Premium Increases

Complaints	Key issues
38	▸ Premium increases

The Ombudsman has received a relatively low number of premium increase complaints for a number of years. During the year, the Ombudsman received only 38 complaints (approximately 1% of all complaints) about premium increases, which was an increase from the 30 received the previous year.

Overseas Visitors Health Cover

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

This year, the Ombudsman assisted 138 consumers with complaints about OVHC and OSHC, steady from the 127 complaints received in 2011–12. Of those complaints, 32 were investigated as Level 3 Disputes.

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.

The high cost of medical and hospital care for uninsured visitors to Australia can come as a surprise to the visitors or their Australian family and friends. A public hospital admission for an uninsured patient can cost over $1500 a day for the accommodation alone, in addition to which they will also incur medical fees for the doctors. Pharmaceutical items can also cost far more for visitors than they do for Medicare-eligible Australian residents who can usually benefit from subsidised prices under the government's Pharmaceutical Benefits Scheme.

To insure themselves against potential medical expenses, overseas visitors can take out OVHC. A number of insurers offer cover specifically for people who aren't eligible for Medicare benefits, including: Australian Unity, BUPA, HBF, HIF, Medibank Private, NIB (trading as IMAN) and HCF (diplomats and 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. Information to assist overseas visitors with selecting health insurance is available at PrivateHealth.gov.au.

Who Was Complained About?

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

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

Complaint Issues

Complaints investigated by the office in relation to OVHC are similar to those received about domestic policies, except for a higher proportion of complaints about waiting periods and other restrictions on the policy. Nine per cent of the complaints received in 2012–13 were about the Pre-Existing Condition waiting period, an improvement on the 14% of complaints in the previous year. Ten per cent of complaints were about delays in payment, the same as last year, and a further 9% were about oral advice. A full list of the complaint issues and sub-issues is included in **FIGURE 18**.

Complaints about the application of the PEC waiting period tend to be complicated because information about a person's medical history before coming to Australia is held overseas. In addition, the length of the PEC waiting period varies between OVHC policies. Some policies apply the waiting period for twelve months, while others do not pay benefits for PECs at all, even if the member has held the policy for over 12 months.

FIGURE 17: Overseas Visitors Cover Complaints by Insurer [1]

Insurer	2010–11	2011–12	2012–13
AHM	3	3	9
Australian Unity	1	7	15
BUPA	19	41	30
HBF	1	1	1
HCF	0	1	0
HIF	0	0	3
Medibank Private	13	34	34
NIB	7	12	11
Worldcare/ Allianz (Lysaght Peoplecare)	20	29	30
	64	128	133

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

Though numerically small, during the year PHIO has received some complaints that involve significant out-of-pocket expenses incurred by overseas visitors attending public hospitals. The charges by public hospitals for Medicare-ineligible patients such as overseas visitors can be much higher than the cost of treatment in private hospitals with which the insurer has a contract. For this reason, at least one insurer has chosen to design overseas visitor policies that have less expensive premiums because they pay full benefits in private hospitals, but only a low, set benefit in a public hospital. This benefit is insufficient to cover the cost of a public hospital admission, and in some cases the out-of-pocket costs incurred by these policy holders can be many thousands of dollars.

The problem with these policies is that overseas visitors are unlikely to understand the difference between a public and private hospital, and may inadvertently attend a public hospital, or be misadvised by family members that a public hospital will be less expensive. In some cases, the patient has no option but to attend a public hospital, because of a medical emergency or the need for treatment that is not available in the private system.

Following PHIO's investigation of several complaints about this issue, PHIO wrote to one insurer to request a number of policy design changes and the provision of more comprehensive information to members. The insurer has agreed to review the policy design and information provided to members in order to address PHIO's concerns.

Overseas Student Health Cover

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

FIGURE 18: Overseas Visitors Cover Complaints by Sub-issues, Cases in 2012–13

Benefit sub-issue	
Accident and emergency	1
Ambulance	1
Amount	2
Delay in payment	15
Gap—Hospital	5
Gap—Medical	1
General treatment (extras/ancillary)	2
Hospital exclusion/restriction	9
Insurer rule	10
New baby	1
Non-recognised other practitioner	1

Cost sub-issue	
Rate increase	1

Incentives sub-issue	
Medicare Levy Surcharge	3

Information sub-issue	
Brochures and websites	4
Lack of notification	6
Oral advice	13
Written advice	4

Informed Financial Consent sub-issue	
Doctors	3
Hospitals	7

Membership sub-issue	
Arrears	1
Cancellation	10
Continuity	4
Suspension	1

Other sub-issue	
Confidentiality and privacy	1
Rule change	1

Service sub-issue	
Customer service advice	2
General service issues	9
Premium payment problems	4
Service delays	4

Waiting Period sub-issue	
General	1
Obstetric	4
Pre-Existing condition	14

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

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

Temporary Graduate (Sub Class 485) Visa

PHIO has received advice from the Department of Immigration and Citizenship (DIAC) regarding new health insurance requirements for the Temporary Graduate (Subclass 485) visa. The new arrangements mean that Subclass 485 visa applicants can meet the health insurance requirement of their visa by taking out an OVHC policy that has the same level of cover that is required for the 457 visa.

PHIO will be liaising with insurers that sell OVHC to ensure their staff members are aware of the new requirement and are able to advice visa applicants appropriately. PHIO will also be updating consumer website PrivateHealth.gov.au with more information.

General Issues

Access and Public Awareness

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

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

People who are deaf, hearing or speech impaired can contact the office through the National Relay Service by telephone 1800 555 677.

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 2012–13:

- Details of the Ombudsman's services were referenced in various government publications and in publications produced by other agencies and consumer bodies;
- Health insurers provided information about the availability of the Ombudsman's services and contact details in brochures, publications and in some correspondence to their members. These details were also included on health insurers' websites;
- The Ombudsman also contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites;
- The Ombudsman published a regular quarterly report which was distributed in both printed format and on the PHIO website;
- The Ombudsman hosted an internet site where consumers could access a range of brochures, consumer bulletins, quarterly bulletins, annual reports and factsheets. The site enabled consumers to make enquiries, lodge complaints and request printed copies of brochures. Website users could also subscribe to updates via an e-mail newsletter or through RSS feeds. The website also linked to other useful sites. The website is located at www.phio.gov.au;
- The Ombudsman conducted a number of media interviews and spoke at several health industry conferences during the year; and
- The Ombudsman undertook a consumer awareness initiative in May and June 2013 to promote the consumer website PrivateHealth.gov.au as a source of independent consumer advice about private health insurance.

Client Survey

About the Survey

The Ombudsman regularly carries out a postal survey of randomly selected complainants. Each fortnight, surveys are posted to a sample of complainants whose cases have been closed during the previous period. The office received 185 responses (34%)—a good participation rate for a postal survey of this kind.

The aim of the survey was to gauge how well PHIO was meeting its clients' needs and to identify any areas where improvements could be made. Overall, 85% of clients were satisfied or very satisfied with the handling of their complaint. The Ombudsman's office will continue to focus on achieving a client satisfaction rating of 85% or better in 2013–14.

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 94%. This indicates there is a strong correlation between the ratings of our service to the financial or other outcome that the office is able to achieve for the complainant, regardless of whether they are satisfied with the way the Ombudsman's staff members deal with their complaint.

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

This year, 83% of respondents were happy with the time taken to resolve complaints, similar to the 85% of respondents in the previous year.

In summary, of the respondents to the survey:

Needs met	2010–11	2011–12	2012–13
Overall satisfaction	88%	90%	85%
Agreed that staff listened adequately	91%	96%	94%
Satisfied with staff manner	88%	91%	88%
Resolved complaint or provided adequate explanation	89%	90%	88%
Thought PHIO acted independently	85%	90%	89%
Would recommend PHIO to others	88%	94%	90%
Happy with time taken to resolve complaint	92%	85%	83%

Health Policy—Liaison with Other Bodies

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

Some significant activities included:

- Submission to the ACCC's report to the Senate on Anti-Competitive and Other Practices by Health Funds and Providers in relation to private health insurance;
- Provision of advice to the Private Health Insurance Industry Code Compliance Committee in relation to the voluntary industry code; and
- 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.

Relations with Stakeholders

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

In September 2012, the Ombudsman hosted an industry seminar in Melbourne for health fund staff and other industry stakeholders. The seminar theme was 'Consumer Issues in Private Health' and received positive feedback from attendees. The presentations included:

- Recent Privacy Issues including E-health and Data Breach Notification—Professor John McMillan, Australian Information Commissioner;
- Private Health Insurance: What Consumers Want—Ms Anna Greenwood, Deputy Chief Executive Officer, Consumers Health Forum;

- Reducing Complaints about Pre-Existing Conditions—Dr Peter Taylor and Dr Stuart Randell, PT&A Health, with case studies by David McGregor and Kaylie Blyton from PHIO;
- ACCC Update—Mr Bruce Cooper, General Manager, Intelligence, Infocentre and Policy Liaison Branch, Australian Competition & Consumer Commission;
- Choice's Role and Insights into Consumer Issues in Private Health—Ms Uta Mihm, Choice;
- Motivational Session: Integrity and Resilience—Mr Darrell Hair, Darrell Hair Associates—Management Consultants; and
- Recent Changes to the PHI Industry Code of Conduct—Mr Rob Seljak, Chief Executive Officer, Teachers' Union Health and Chair, PHI Code Compliance Committee; and Mr Wayne Cooper, Independent Auditor.

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.

Health Insurance Insider is the Ombudsman's consumer e-bulletin, which is published online on a six-monthly basis. Recent topics have included what consumers need to know about waiting periods, and what to do if you need to go to hospital.

New topics continue to be added to the Ombudsman website's Facts and Advice section. This section provides factsheets about topics which are regularly raised by consumers, such as why and how health premiums are increased, and how to plan to be covered for pregnancy and obstetrics services. Recent additions include factsheets on dental and oral surgery, orthodontics, and insulin pumps. This area will continue to be reviewed and updated in response to consumer needs.

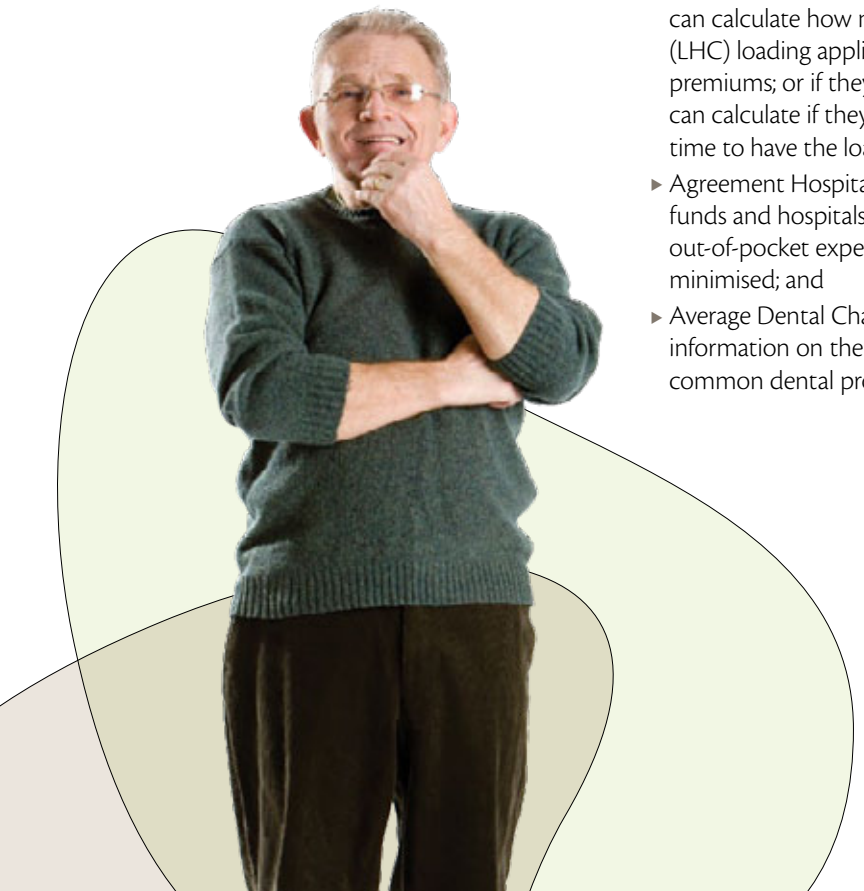
Each year the Ombudsman produces a State of the Health Funds report to assist consumers to compare insurers and make decisions about their health insurance. The report and individual health insurer report cards can be viewed online at www.phio.gov.au.

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

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

Consumer Website PrivateHealth.gov.au

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



The website's major features include:

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

Usage

The website received 621,865 unique visitors throughout the year, an increase of 41% on the previous year.

In May and June 2013, the website experienced a higher level of traffic as seen in **FIGURE 19**. The Department of Health and Ageing's annual Lifetime Health Cover mailing to new migrants and Australians turning 31 and media discussion of the potential Medicare Levy Surcharge tax implications for the upcoming 2013–14 financial year resulted in an increased level of private health insurance awareness amongst consumers. The Ombudsman also undertook a consumer awareness intiative in May and June 2013 to promote the website as a source of independent consumer advice about private health insurance.

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

Website Enquiries

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

As seen in **FIGURE 21**, the office responded to 1480 consumer enquiries through the website in 2012–13, compared to 1313 in the previous year. Approximately 68% of enquiries received by the office are received via the consumer website.

The most frequently raised questions are about the following topics:

- Lifetime Health Cover, especially regarding how this affects new migrants to Australia and Australians returning from overseas. The LHC rules determine how much a person pays for hospital insurance;
- The Medicare Levy Surcharge for high income earners and how to avoid the Surcharge by purchasing appropriate private hospital insurance;
- The Australian Government Private Health Insurance Rebate and the recent changes—from the 1st of July 2012 the Rebate became income tested; and from the 1st of July 2013 the Rebate does not apply to the Lifetime Health Cover portion of hospital premiums;
- Waiting periods for people who are currently uninsured;
- How to use the website, locate information and compare policies;
- How to choose a health insurance policy; and
- Overseas visitors health cover, especially for Subclass 457 visa holders and overseas student visa holders.

FIGURE 19: PrivateHealth.gov.au Unique Visitors, 2012–13

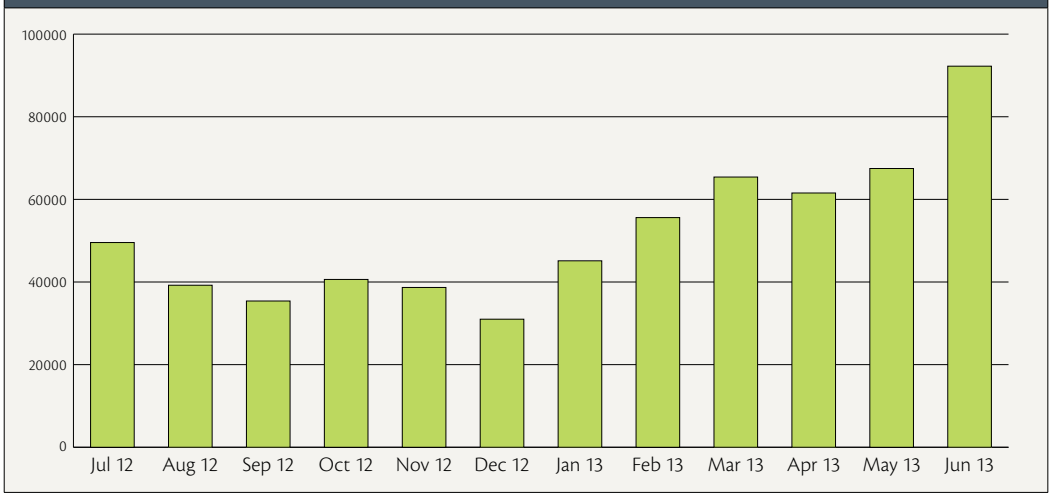


FIGURE 20: PrivateHealth.gov.au Visitors by year

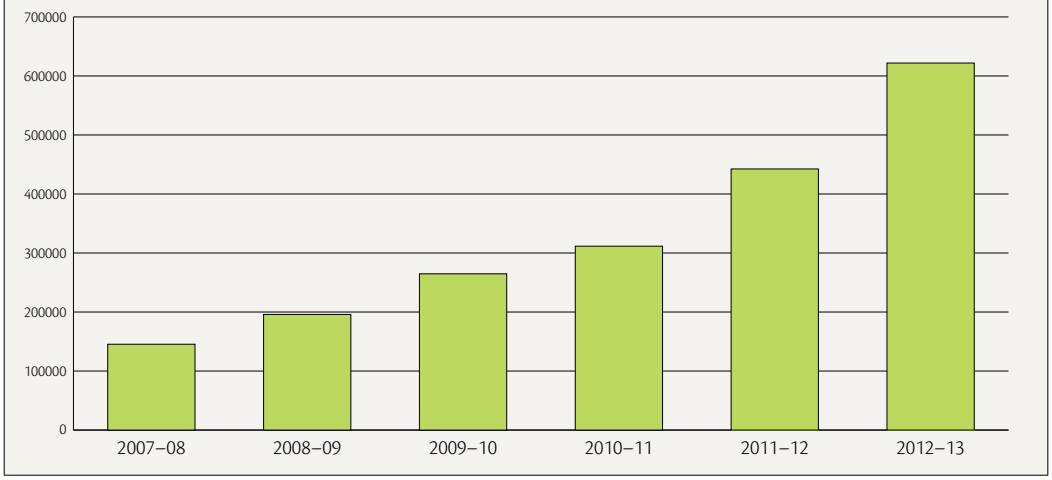
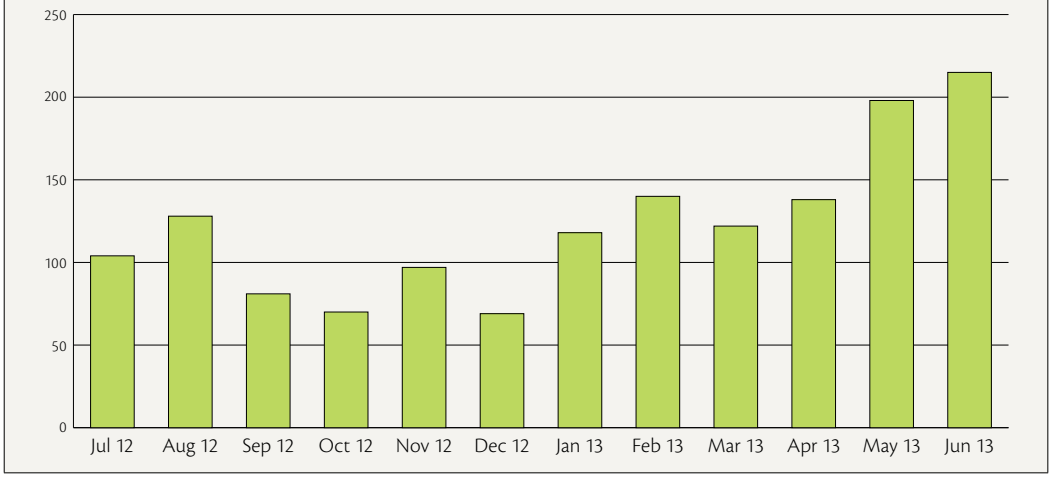


FIGURE 21: PrivateHealth.gov.au Consumer Enquiries, 2012–13



Survey Results

During the year, 865 users completed a survey about the website. The key ratings for the site are summarised in **FIGURE 22**. Survey results are used to highlight areas where improvements can be made to the website, to track satisfaction with the site and whether changes have been successful.

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

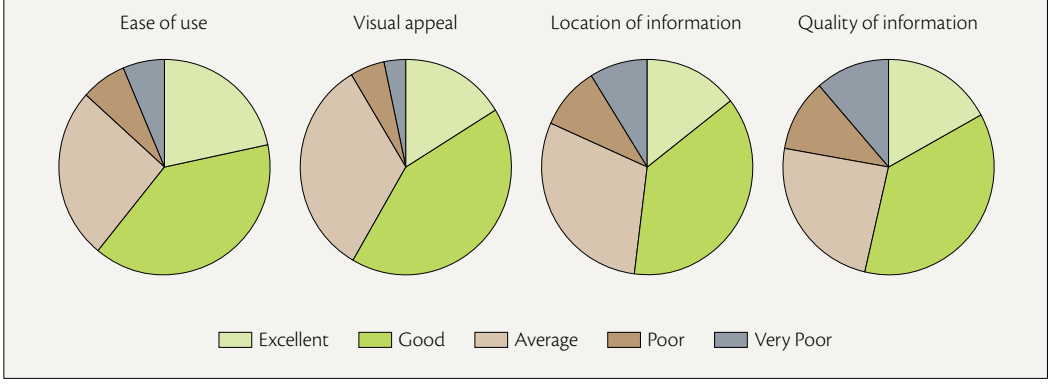
Website Developments

PHIO continued to develop and improve the website and the behind-the-scenes system insurers use to keep their policy information accurate, in response to changes in the private health insurance industry and feedback from consumers and stakeholders. Developments in 2012–13 include:

- Standard Information Statements and Rebate Changes: effective from 1 July 2012, the Australian Government Private Health Insurance Rebate became income-tested. This meant that for individuals and families earning over certain income thresholds, the rebate became reduced or removed. The SIS was modified to show 100% premiums as well as the existing 30% rebated premiums. The explanatory note on the SIS and the website were modified accordingly;
- Ambulance information: website information on ambulance cover was reviewed and updated to reflect the different ambulance scenarios on a state-by-state basis. Ambulance remains a complex area for consumers, as their coverage and insurance options can vary greatly depending on their state of residence;
- Per person and per policy excess limit: the display of excess limits on hospital policies was clarified to allow consumers to more easily compare policies;
- SIS Data Release Authority Releases: from time to time, funds may choose to release SIS data to authorised third parties. This year the process was refined to allow funds to have more control over the selection of released data.

PHIO also made a number of website updates and content management developments as a result of the Australian Government's changes to the Private Health Insurance Rebate and Medicare Levy Surcharge, and changes in the Department of Health and Ageing's health insurance requirements for applicants to certain visa subclasses.

FIGURE 22: PrivateHealth.gov.au Website Survey



Appendix: Statutory Reporting Information

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 issues which lead to complaints. The office is also responsible for regular reporting to government and industry, and the provision of advice and information about private health insurance to consumers.

The ability within a small organisation to accomplish these tasks places a significant reliance on all staff to work as a team and to fully understand the fundamentals associated with the whole private health insurance industry. 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. The office also has a small number of staff to manage its reporting, advice and information, and corporate services functions.

Organisational Structure

At 30 June 2013, the permanent staff employed by the Private Health Insurance Ombudsman comprised:

Full-time and part-time employees	Female	Male	EFT[1]
SES 2	1	–	1.0
EL 2	1	1	1.4
EL 1	3	–	2.3
APS 6	2	–	2.0
APS 5	4	1	4.8
APS 4	1	–	0.7
APS 3	1	–	0.7

[1] Equivalent full-time employee.

Statutory Positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry Date
Ms Samantha Gavel	Ombudsman	3 years	2014

Staff Employment Status

All Ombudsman staff members are employed under the provisions of the *Public Service Act 1999* and are required to adhere to the Public Service Values and Code of Conduct. All staff members, other than Senior Executive Service

staff, are covered under an Enterprise Agreement in accordance with the *Fair Work Act 2009*.

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

Workplace structures, systems and procedures are in place to assist employees in balancing their work and family responsibilities effectively. The following table shows the numbers and status of staff who were employed on 30 June 2013:

Occupational Group	Women	Men	Total	NESB1[4]
SES[2]	1	0	1	0
Other[3]	12	2	14	3
	13	2	15[5]	3

[2] Senior Executive Service, Ombudsman.
[3] All other staff—temporary and permanent.
[4] Non-English speaking background, first generation.
[5] Includes part-time employees and those on maternity leave. Actual EFT = 12.8.

Staff Development and Training

During the 2012–13 financial year, $56,969 was spent directly on the Ombudsman's staff attending training and development courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff. Staff training and development 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.

Performance Appraisal

The Ombudsman has a Performance Development Program to measure staff performance and provide for staff training and development. The Program is used to assist the Ombudsman with general staff management and annual salary reviews.

All staff members are subject to a half-yearly and an annual performance appraisal. Salary and promotion advancement is based on performance and productivity. A total of $46,400 in performance bonuses was paid in 2012–13; this figure has been aggregated to preserve employees' privacy.

Industrial Democracy

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

Corporate Governance

As a small office with duties specified by the *Private Health Insurance Act 2007* (Cth), the business of the Ombudsman's office is well defined. In accomplishing the tasks envisaged under the Act, there is a need for procedures to be in place to monitor both performance and process, together with the appropriate management and staff policies. Within this environment, staffing and accounting practices provide the following framework of the office's management activities.

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 and Accountability Act 1997* (Cth).

Consultancy Services

The PHIO engages consultants where it lacks specialist expertise or when independent research, review or assessment is required. Consultants are typically engaged to investigate or diagnose a defined issue or problem; carry

out defined reviews or evaluations; or provide independent advice, information or creative solutions to assist in PHIO's decision-making.

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

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

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

Human Solutions continued to maintain and develop the consumer website (PrivateHealth.gov.au) under the contract awarded in 2006. The contract was extended for a further two years and will expire in May 2013, with an option to extend it for a further year to May 2014.

During 2012–13, PHIO did not engage any consultancy services of $10,000 or more.

Information Systems

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

Payroll Services

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

Service Charter

In line with requirements for all Australian Government agencies, the Ombudsman has a Service Charter which was last reviewed in 2010–11.

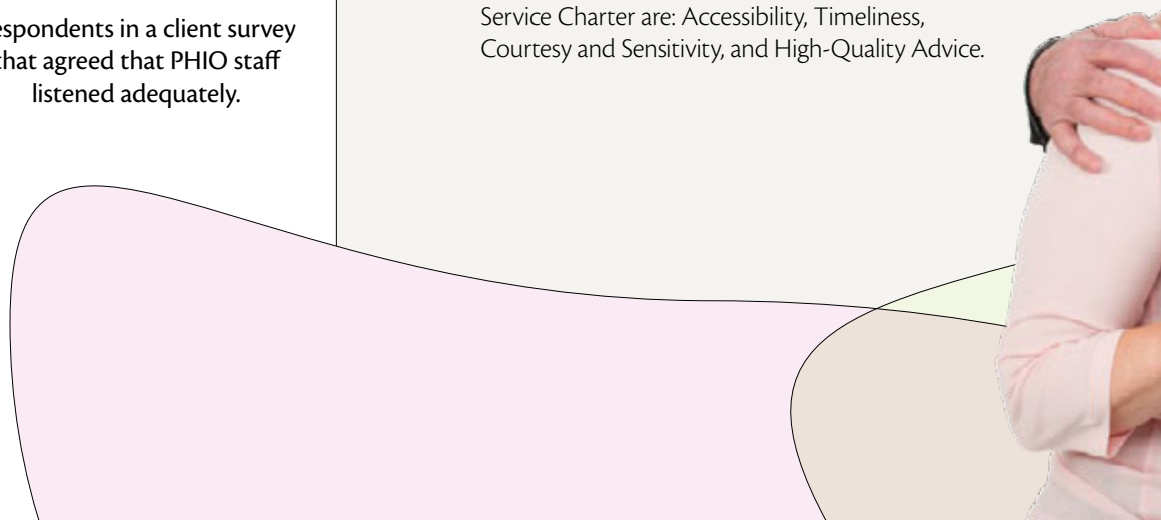
The Service Charter covers all of the Ombudsman's clients and sets out the service delivery standards which they can expect from the office. The Charter was developed in consultation with staff and clients; copies of the charter are routinely sent out to people who contact the office (in the brochure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

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

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

94%

Respondents in a client survey that agreed that PHIO staff listened adequately.



External Review and Scrutiny

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

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

There were no other reviews conducted of the PHIO.

Fraud Control

Staff members are trained in fraud awareness and procedures, which are in place to notify the Australian Federal Police and/or the Director of Public Prosecutions if loss occurs as a result of fraud. A formal fraud procedure manual has been produced and all staff made aware of their obligations and responsibilities. No cases of fraud were detected during the year. The Ombudsman has reported the office's fraud data to the Australian Institute of Criminology in accordance with the Commonwealth Fraud Control Guidelines.

Work Health and Safety

The Ombudsman complies with all provisions of the *Work Health and Safety Act 2011* and has a First Aid Officer and an Occupational Health and Safety Officer. 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.*

Advertising and Market Research

Under section 311A of the *Commonwealth Electoral Act 1918*, the Ombudsman is required to disclose payments of $12,100 or more (inclusive of GST) to specific types of organisations. These organisations are advertising agencies, market research organisations, polling organisations, media advertising organisations, and direct mail organisations. Details of payments to these organisations for 2012–13 are set out below.

Name of Organisation	Purpose	Amount Paid
Universal McCann	Media advertising for the Consumer Awareness Campaign	$149,600

The Ombudsman did not conduct any other non-campaign advertising or market research in 2012–13 that meets the reporting requirements.

Mandatory Statement

During 2012–13, the Ombudsman conducted the following advertising campaign: Consumer Awareness Campaign. Further information on this advertising campaign is available at www.phio.gov.au and in the reports on Australian Government advertising prepared by the Department of Finance and Deregulation. Those reports are available at www.finance.gov.au/advertising/index.html.

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 3.5 Stars under the National Australian Built Environment Rating: Water and 5 Stars under the National Environment Building Rating: Energy. The building 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 2012–13 financial year.

Changes to Disability Reporting

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

The Commonwealth Disability Strategy has been overtaken by a new National Disability Strategy 2010–2020 which sets out a 10-year national policy framework to improve the lives of people with disability, promote participation and create a more inclusive society. A high-level two-yearly report will track progress against each of the six outcome areas of the Strategy and present a picture of how people with disability are faring. The first of these reports will be available in 2014, and will be available at www.fahcsia.gov.au.

The Social Inclusion Measurement and Reporting Strategy agreed by the government in December 2009 will also include some reporting on disability matters in its regular How Australia is Faring Report and, if appropriate, in strategic change indicators in agency annual reports. More detail on social inclusion matters can be found at www.socialinclusion.gov.au.

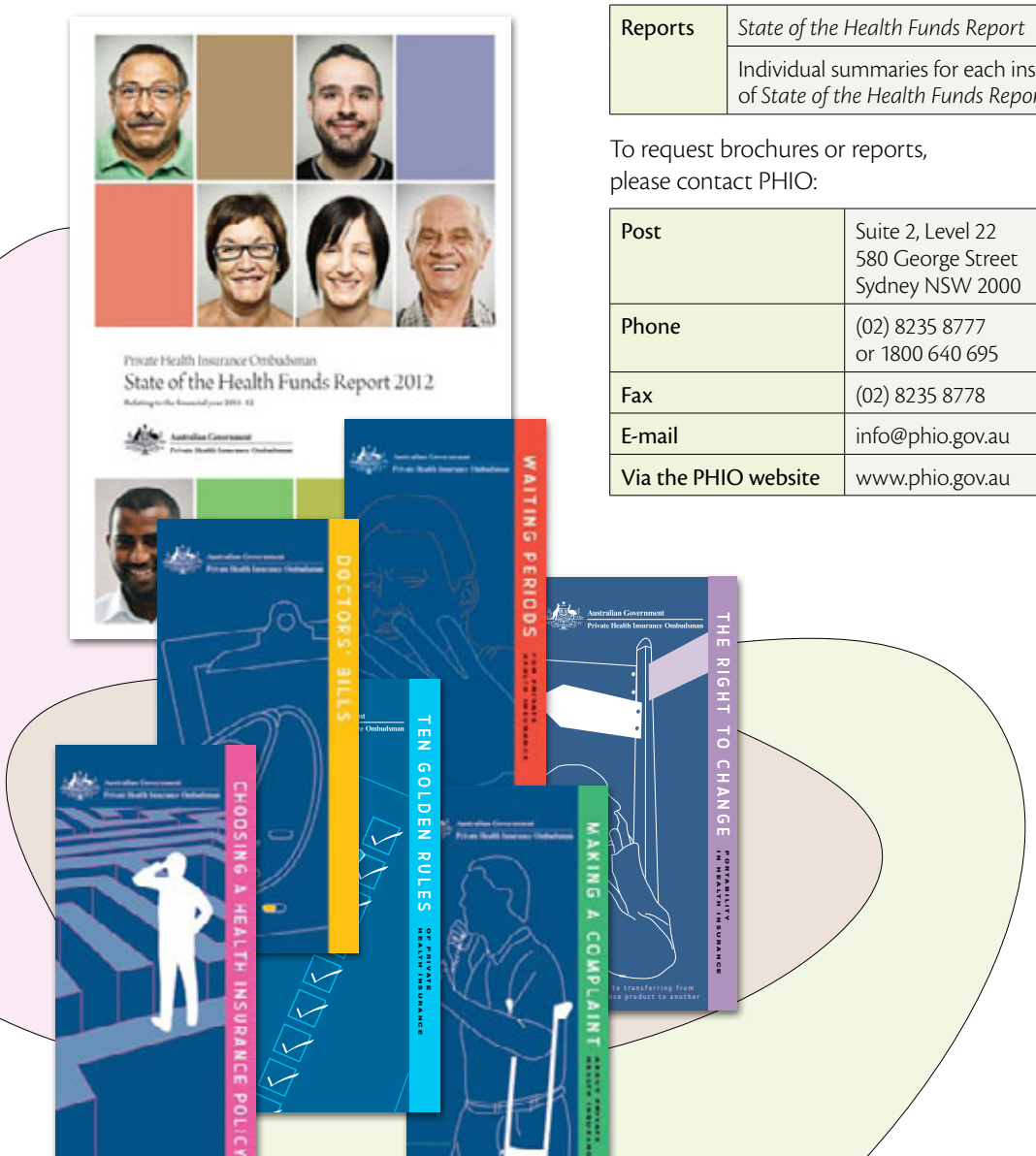
Freedom of Information and Information Publication Scheme

Agencies subject to the *Freedom of Information Act 1982* (*FOI Act*) are required to publish information to the public as part of the Information Publication Scheme (IPS). This requirement is in Part II of the *FOI Act* and has replaced the former requirement to publish a section 8 statement in an annual report. Each agency must display on its website a plan showing what information it publishes in accordance with the IPS requirements. The PHIO IPS and FOI Requests—Disclosure Log can be found at www.phio.gov.au.

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

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

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



PHIO Publications

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

Brochures	Making a Complaint
	The 10 Golden Rules of Private Health Insurance
	About Our Service
	Doctors' Bills
	The Right to Change — Portability in Health Insurance
	Waiting Periods
	Health Insurance Choice
	PrivateHealth.gov.au

Reports	*State of the Health Funds Report*
	Individual summaries for each insurer of *State of the Health Funds Report*

To request brochures or reports, please contact PHIO:

Post	Suite 2, Level 22 580 George Street Sydney NSW 2000
Phone	(02) 8235 8777 or 1800 640 695
Fax	(02) 8235 8778
E-mail	info@phio.gov.au
Via the PHIO website	www.phio.gov.au

Financial Information

Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

I have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2013, which comprise: a Statement by the Ombudsman; Statement of Comprehensive Income; Balance Sheet; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments; Schedule of Contingencies; and Notes to and forming part of the Financial Statements, including a Summary of Significant Accounting Policies.

Chief Executive's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

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

Independence

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

Opinion

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

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

(b) give a true and fair view of the matters required by the Finance Minister's Orders including the Private Health Insurance Ombudsman's financial position as at 30 June 2013 and of its financial performance and cash flows for the year then ended.

Australian National Audit Office

Ron Wah
Audit Principal

Delegate of the Auditor-General

Canberra
29 August 2013

Statement by the Ombudsman

Australian Government
Private Health Insurance Ombudsman

STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2013 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, as amended.

Signed

Samantha Gavel

Samantha Gavel
Chief Executive and Chief Financial Officer
29 August 2013

Suite 2, Level 22, 580 George St, Sydney NSW 2000
Complaints Hotline 1800 640 695
Phone: 02 8235 8777 **Fax** 02 8235 8778 **Email** info@phio.org.au **Web** www.phio.org.au
ABN 61 673 137 709

Statement of Comprehensive Income

For the period ended 30 June 2013

	Notes	2013 ($)	2012 ($)
EXPENSES			
Employee benefits	3A	**1,261,893**	1,236,090
Supplier	3B	**980,129**	847,985
Depreciation and amortisation	3C	**382,006**	354,609
Finance costs	3D	**418**	4,719
Total expenses		**2,624,446**	2,443,403
LESS:			
OWN-SOURCE INCOME			
Own-source revenue			
Sale of goods and rendering of services	4A	**31,916**	19,636
Other revenue	4B	**156,612**	152,403
Total own-source revenue		**188,528**	172,039
Gains			
Other	4C	**16,000**	16,000
Total gains		**16,000**	16,000
Net cost of (contribution by) services		**2,419,919**	2,255,364
Revenue from government	4D	**2,052,000**	1,896,000
Deficit		**(367,919)**	(359,364)
OTHER COMPREHENSIVE INCOME			
Other comprehensive income		**–**	–
Total other comprehensive income		**–**	–
Total comprehensive loss		**(367,919)**	(359,364)

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

Balance Sheet

As at 30 June 2013

	Notes	2013 ($)	2012 ($)
ASSETS			
Financial Assets			
Cash and cash equivalents	5A	**79,016**	91,451
Trade and other receivables	5B	**1,805,166**	1,905,047
Total financial assets		**1,884,182**	1,996,498
Non-Financial Assets			
Leasehold improvements	6A,C	**126,679**	161,650
Property, plant and equipment	6B,C	**54,884**	65,160
Intangibles	6D,E	**650,738**	799,277
Other non-financial assets	6F	**36,518**	5,585
Total non-financial assets		**868,819**	1,031,672
Total assets		**2,753,001**	3,028,170
LIABILITIES			
Payables			
Suppliers	7A	**65,415**	76,464
Other payables	7B	**73,399**	89,889
Total payables		**138,814**	166,353
Provisions			
Employee provisions	8A	**388,357**	328,486
Other	8B	**39,988**	39,570
Total provisions		**428,345**	368,056
Total liabilities		**567,159**	534,409
Net assets		**2,185,843**	2,493,761
EQUITY			
Contributed equity		**2,382,041**	2,322,041
Reserves		**99,981**	99,981
Retained surplus		**(296,180)**	71,739
Total equity		**2,185,842**	2,493,761

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

Statement of Changes in Equity

For the period ended 30 June 2013

	Retained surplus		Asset revaluation reserve		Contributed equity		Total equity	
	2013 ($)	2012 ($)	**2013 ($)**	2012 ($)	**2013 ($)**	2012 ($)	**2013 ($)**	2012 ($)
Opening balance								
Balance carried forward from previous period	**71,739**	431,103	**99,981**	99,981	**2,322,041**	2,248,041	**2,493,761**	2,779,125
Adjusted opening balance	**71,739**	431,103	**99,981**	99,981	**2,322,041**	2,248,041	**2,493,761**	2,779,125
Comprehensive income								
Other comprehensive income	**–**	–	**–**	–	**–**	–	**–**	–
Deficit for the period	**(367,919)**	(359,364)	**–**	–	**–**	–	**(367,919)**	(359,364)
Total comprehensive income	**(367,919)**	(359,364)	**–**	–	**–**	–	**(367,919)**	(359,364)
Contributions by owners								
Departmental capital budget	**–**	–	**–**	–	**60,000**	74,000	**60,000**	74,000
Sub-total transactions with owners	**–**	–	**–**	–	**60,000**	74,000	**60,000**	74,000
Closing balance as at 30 June	**(296,180)**	71,739	**99,981**	99,981	**2,382,041**	2,322,041	**2,185,842**	2,493,761

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

Cash Flow Statement

For the period ended 30 June 2013

	Notes	2013 ($)	2012 ($)
OPERATING ACTIVITIES			
Cash received			
Appropriations		**2,172,000**	2,130,000
Sales of goods and rendering of services		**31,270**	19,636
Net GST received		**117,976**	176,050
Other		**–**	1,722
Total cash received		**2,321,246**	2,327,408
Cash used			
Employees		**1,202,022**	1,201,559
Suppliers		**1,002,872**	824,414
Other		**566**	–
Total cash used		**2,205,460**	2,025,973
Net cash from (used by) operating activities	9	**115,786**	301,435
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**14,471**	43,998
Purchase of intangibles		**173,750**	262,728
Total cash used		**188,221**	306,726
Net cash used by investing activities		**(188,221)**	(306,726)
FINANCING ACTIVITIES			
Cash received			
Contributed equity		**60,000**	74,000
Total cash received		**60,000**	74,000
Net increase (decrease) in cash held		**(12,435)**	68,709
Cash and cash equivalents at the beginning of the reporting period		**91,451**	22,742
Cash and cash equivalents at the end of the reporting period	5A	**79,016**	91,451

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

Schedule of Commitments

As at 30 June 2013

	2013 ($)	2012 ($)
BY TYPE		
Commitments receivable		
Net GST recoverable on commitments	**86,118**	111,716
Total commitments receivable	**86,118**	111,716
Commitments payable		
Other commitments		
Operating leases	**785,724**	1,067,300
Other	**161,572**	161,572
Total other commitments	**947,296**	1,228,872
Net commitments by type	**861,178**	1,117,156
BY MATURITY		
Commitments receivable		
One year or less	**41,438**	41,722
From one to five years	**44,680**	69,994
Total operating lease income	**86,118**	111,716
Commitments payable		
Operating lease commitments		
One year or less	**294,247**	297,377
From one to five years	**491,477**	769,923
Total operating lease commitments	**785,724**	1,067,300
Other commitments		
One year or less	**161,572**	161,572
From one to five years	**–**	–
Total other commitments	**161,572**	161,572
Net commitments by maturity	**861,178**	1,117,156

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

Note: Commitments are GST inclusive where relevant.

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

Other commitments comprise of a contract for maintenance and development of the PrivateHealth.gov.au website. Payments are per the contract agreement. The contract will expire after 31 May 2014.

Schedule of Contingencies

As at 30 June 2013

There were no contingent assets and liabilities as at 30 June 2013.

Notes—Table of Contents

Note 1: Summary of Significant Accounting Policies

1.1 Objectives of the entity

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

The entity is structured to meet the following outcome:

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

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

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

1.2 Basis of Preparation of the Financial Statements

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

The financial statements have been prepared in accordance with:

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

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

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

The financial statements are presented in Australian dollars and values are rounded to the nearest dollars unless otherwise specified.

Unless an alternative treatment is specifically required by an accounting standard or the FMOs, assets and liabilities are recognised in the 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 executor contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the schedule of commitments or the schedule of contingencies.

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

The Australian Government continues to have regard to developments in case law, including the High Court's most recent decision on Commonwealth expenditure in Williams v Commonwealth (2012) 288 ALR 410, as they contribute to the larger body of law relevant to the development of Commonwealth programs. In accordance with its general practice, the Government will continue to monitor and assess risk and decide on any appropriate actions to respond to risks of expenditure not being consistent with constitutional or other legal requirements.

1.3 Significant Accounting Judgements and Estimates

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

1.4 New Australian Accounting Standards

Adoption of New Australian Accounting Standard Requirements

No accounting standard has been adopted earlier than the application date as stated in the standard. Other new standards, revised standards, interpretations and amending standards that were issued prior to the sign-off date and are applicable to the current reporting period did not have a financial impact, and are not expected to have a future financial impact on the Private Health Insurance Ombudsman.

Future Australian Accounting Standard Requirements

Other new standards, revised standards, interpretations and amending standards that were issued prior to the sign-off date and are applicable to the future reporting period are not expected to have a

future financial impact on the Private Health Insurance Ombudsman.

1.5 Revenue

Revenue from the sale of goods is recognised when:

(a) the risks and rewards of ownership have been transferred to the buyer;

(b) the entity retains no managerial involvement or effective control over the goods;

(c) the revenue and transaction costs incurred can be reliably measured; and

(d) it is probable that the economic benefits associated with the transaction will flow to the entity.

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

(a) the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and

b) the probable economic benefits associated with the transaction will flow to the entity.

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

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

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

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.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition, unless received from another Government agency or authority as a consequence of a restructuring of administrative arrangements (refer to Note 1.6).

Revenue from Government

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

1.6 Gains

Resources Received Free of Charge

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

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

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

1.7 Transactions with the Government as Owner

Equity Injections

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

Restructuring of Administrative Arrangements

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

Other Distributions to Owners

The FMOs require that distributions to owners be debited to contributed equity unless it is in the nature of a dividend. In 2012–13, there were no distributions to owners.

1.8 Employee Benefits

Liabilities for 'short-term employee benefits' (as defined in AASB 119 *Employee Benefits*) and termination benefits due within 12 months of the end of reporting period are measured at their nominal amounts.

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

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

Leave

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

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

Separation and Redundancy

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

Superannuation

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

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

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

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

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

1.9 Leases

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

Where an asset is acquired by means of a finance lease, the asset is capitalised at either the fair value of the lease property or, if lower, the present value of minimum lease payments at the inception of the contract and a liability is recognised at the same time and for the same amount.

The discount rate used is the interest rate implicit in the lease. Leased assets are amortised over the period of the lease. Lease payments are allocated between the principal component and the interest expense.

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

The entity has no finance leases.

1.10 Cash

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

(a) cash on hand; and

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

1.11 Financial Assets

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

1.12 Financial Liabilities

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

1.13 Contingent Liabilities and Contingent Assets

Contingent liabilities and contingent assets are not recognised in the balance sheet but are reported in

the relevant schedules and notes. They may arise from uncertainty as to the existence of a liability or asset or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but no virtually certain and contingent liabilities are disclosed when settlement is greater than remote.

1.14 Acquisition of Assets

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

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

1.15 Property, Plant and Equipment

Asset Recognition Threshold

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

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

Revaluations

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

Asset Class	Fair Value Measured At
Leasehold improvements	Depreciated replacement cost
Property, plant and equipment	Market selling place

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

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

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

Depreciation

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

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

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

Asset Class	2013	2012
Leasehold improvements	Lease term	Lease term
Property, plant and equipment	4 to 10 years	4 to 10 years

Impairment

All assets were assessed for impairment at 30 June 2013. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

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

Derecognition

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

1.16 Intangibles

The entity'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 entity's software are 5 to 7 years (2011–12: 5 to 7 years).

All software assets were assessed for indications of impairment as at 30 June 2013.

1.17 Taxation

The entity 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:

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

(b) for receivables and payables.

Note 2: Events After the Reporting Period

1. The *Statute Stocktake (Appropriations) Act 2013* received Royal Assent on 1 July 2013. This Act repeals annual Appropriation Acts from 1999–2000 until 2009–2010. An amount of $1,762,722 relating to Appropriation Acts 2007–2008 and 2008–2009 will lapse on 1 July 2013 when the *Statute Stocktake (Appropriations) Act 2013* becomes effective.
2. The Minister for Finance and Deregulation signed a determination titled *Instrument to Reduce Appropriations (No. 1 of 2013–2014)* which took effect on 13 August 2013. The amount of the reduction for the Private Health Insurance Ombudsman is $7,000 and has been reflected in reduction of Appropriation revenue for 2012–13.

Note 3: Expenses

Note 3A: Employee Benefits

	2013 ($)	2012 ($)
Wages and salaries	**1,054,496**	1,039,535
Superannuation:		
Defined contribution plans	**59,885**	64,267
Defined benefit plans	**97,295**	87,546
Leave and other entitlements	**39,865**	34,532
Other employee expenses	**10,353**	10,210
Total employee benefits	**1,261,893**	1,236,090

Note 3B: Suppliers

Goods and services		
Accounting and audit	**47,119**	45,264
Brochures and printing	**55,038**	67,041
Consultants	**1,320**	1,898
Insurance	**9,478**	9,673
Legal	**6,525**	6,850
Campaign advertising	**135,969**	–
Media and non-campaign advertising	**33,354**	40,898
Mediation	**12,928**	5,636
Recruitment	**3,559**	1,380
Stationery	**1,581**	1,622
Staff development	**39,948**	48,227
Travel and accommodation	**41,418**	56,211
Website	**141,875**	185,647
Other	**182,317**	110,241
Total goods and services	**712,431**	580,588

Goods and services are made up of:		
Rendering of services—external parties	**712,431**	580,588
Total goods and services	**712,431**	580,588

Other supplier expenses		
Operating lease rentals—external parties:		
Minimum lease payments	**258,350**	257,834
Workers compensation expenses	**9,348**	9,563
Total other supplier expenses	**267,698**	267,397
Total supplier expenses	**980,129**	847,985

Note 3C: Depreciation and Amortisation

	2013 ($)	2012 ($)
Depreciation:		
Property, plant and equipment	**23,480**	20,986
Leasehold improvements	**36,237**	37,726
Total depreciation	**59,717**	58,712
Amortisation:		
Web development	**314,763**	288,404
Intangibles	**7,526**	7,493
Total amortisation	**322,289**	295,897
Total depreciation and amortisation	**382,006**	354,609

Note 3D: Finance Costs

	2013 ($)	2012 ($)
Unwinding of discount	**418**	4,719
Total finance costs	**418**	4,719

Note 4: Income

OWN-SOURCE REVENUE

Note 4A: Sale of Goods and Rendering of Services

	2013 ($)	2012 ($)
Rendering of services—external parties	**31,916**	19,636
Total sale of goods and rendering of services	**31,916**	19,636

Note 4B: Other Revenue

	2013 ($)	2012 ($)
MoU for website improvements	**136,000**	152,000
Other income	**20,612**	403
Total other revenue	**156,612**	152,403

Note 4C: Other Gains

	2013 ($)	2012 ($)
Resources received free of charge	**16,000**	16,000
Total other gains	**16,000**	16,000

REVENUE FROM GOVERNMENT

Note 4D: Revenue from Government

	2013 ($)	2012 ($)
Appropriations:		
Departmental appropriation	**2,052,000**	1,896,000
Total revenue from Government	**2,052,000**	1,896,000

Note 5: Financial Assets

Note 5A: Cash and Cash Equivalents

	2013 ($)	2012 ($)
Cash on hand or on deposit	**79,016**	91,451
Total cash and cash equivalents	**79,016**	91,451

Note 5B: Trade and Other Receivables

Goods and Services:		
Goods and services—external	**646**	–
Total goods and services	**646**	–
Appropriations receivable:		
For existing programs	**1,762,722**	1,882,722
Total appropriations receivable	**1,762,722**	1,882,722
Other receivables:		
GST receivable from the Australian Taxation Office	**41,798**	22,325
Total other receivables	**41,798**	22,325
Total trade and other receivables (net)	**1,805,166**	1,905,047
Receivables are expected to be recovered in:		
No more than 12 months	**42,444**	22,343
More than 12 months	**1,762,722**	1,882,704
Total trade and other receivables (net)	**1,805,166**	1,905,047
Receivables are aged as follows:		
Not overdue	**1,805,166**	1,905,047
Total receivables (gross)	**1,805,166**	1,905,047

Note 6: Non-Financial Assets

Note 6A: Leasehold Improvements

	2013 ($)	2012 ($)
Leasehold improvements:		
Fair value	**207,041**	205,071
Accumulated depreciation	**(80,362)**	(43,421)
Total leasehold improvements	**126,679**	161,650

No indicators of impairment were found for leasehold improvements.

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

Note 6B: Property, Plant and Equipment

	2013 ($)	2012 ($)
Property, plant and equipment:		
Fair value	**123,247**	110,747
Accumulated depreciation	**(68,363)**	(45,587)
Total property, plant and equipment	**54,884**	65,160

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

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

Revaluations of non-financial assets

All revaluations were conducted in accordance with the revaluation policy stated at Note 1. The last revaluation was conducted on 30 June 2011 by the Australian Valuation Office.

Note 6C: Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment (2012–13)

	Leasehold Improvements ($)	Property, Plant & Equipment ($)	Total ($)
As at 1 July 2012			
Gross book value	**205,071**	**110,747**	**315,818**
Accumulated depreciation and impairment	**(43,421)**	**(45,587)**	**(89,008)**
Net book value 1 July 2012	**161,650**	**65,160**	**226,810**
Additions	**1,970**	**12,501**	**14,471**
Depreciation expense	**(36,941)**	**(22,775)**	**(59,716)**
Net book value 30 June 2013	**126,679**	**54,886**	**181,565**
Net book value as of 30 June 2013 represented by:			
Gross book value	**207,041**	**123,248**	**330,289**
Accumulated depreciation and impairment	**(80,362)**	**(68,362)**	**(148,724)**
	126,679	**54,886**	**181,565**

Note 6C (Cont'd): Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment (2011–12)

	Leasehold Improvements ($)	Property, Plant & Equipment ($)	Total ($)
As at 1 July 2011			
Gross book value	171,175	100,645	271,820
Accumulated depreciation and impairment	(5,695)	(24,601)	(30,296)
Net book value 1 July 2011	165,480	76,044	241,524
Additions	33,896	10,102	43,998
Depreciation expense	(37,726)	(20,986)	(58,712)
Net book value 30 June 2012	161,650	65,160	226,810
Net book value as of 30 June 2012 represented by:			
Gross book value	205,071	110,747	315,818
Accumulated depreciation and impairment	(43,421)	(45,587)	(89,008)
	161,650	65,160	226,810

Note 6D: Intangibles

	2013 ($)	2012 ($)
Computer software:		
Purchased	**1,989,547**	1,815,797
Accumulated amortisation	**(1,389,923)**	(1,075,160)
Total computer software	**599,624**	740,637
Other intangibles:		
Purchased	**75,262**	75,262
Accumulated amortisation	**(24,148)**	(16,622)
Total other intangibles	**51,114**	58,640
Total intangibles	**650,738**	799,277

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 6E: Reconciliation of the Opening and Closing Balances of Intangibles (2012–13)

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

Note 6E (Cont'd): Reconciliation of the Opening and Closing Balances of Intangibles (2011–12)

	Computer software purchased ($)	Other intangibles purchased ($)	Total ($)
As at 1 July 2011			
Gross book value	1,560,409	67,922	1,628,331
Accumulated amortisation and impairment	(786,756)	(9,129)	(795,885)
Net book value 1 July 2011	773,653	58,793	832,446
Additions	255,388	7,340	262,728
Amortisation	(288,404)	(7,493)	(295,897)
Net book value 30 June 2012	740,637	58,640	799,277
Net book value as of 30 June 2012 represented by:			
Gross book value	1,815,797	75,262	1,891,059
Accumulated amortisation and impairment	(1,075,160)	(16,622)	(1,091,782)
	740,637	58,640	799,277

Note 6F: Other Non-Financial Assets

	2013 ($)	2012 ($)
Prepayments	**36,518**	5,585
Total other non-financial assets	**36,518**	5,585
Total other non-financial assets—are expected to be recovered in:		
No more than 12 months	**36,518**	5,585
Total other non-financial assets	**36,518**	5,585

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

Note 7: Payables

Note 7A: Suppliers

	2013 ($)	2012 ($)
Trade creditors and accruals	**65,415**	76,464
Total supplier payables	**65,415**	76,464
Supplier payables expected to be settled within 12 months:		
External parties	**65,415**	76,464
Total	**65,415**	76,464
Total supplier payables	**65,415**	76,464

Settlement is usually made within 30 days.

Note 7B: Other Payables

	2013 ($)	2012 ($)
GST payable to Australian Taxation Office	**236**	–
Lease liabilities	**49,536**	68,711
Other	**23,627**	21,178
Total other payables	**73,399**	89,889

Note 8: Provisions

Note 8A: Employee Provisions

	2013 ($)	2012 ($)
Leave	**388,357**	328,486
Total employee provisions	**388,357**	328,486

Employee provisions are expected to be settled in:		
No more than 12 months	**299,522**	266,922
More than 12 months	**88,836**	61,564
Total employee provisions	**388,357**	328,486

Note 8B: Other Provisions

Provision for restoration obligations	**39,988**	39,570
Total other provisions	**39,988**	39,570

Other provisions are expected to be settled in:		
More than 12 months	**39,988**	39,570
Total other provisions	**39,988**	39,570

	Provision for restoration ($)	Total ($)
Carrying amount 1 July 2012	**39,570**	**39,570**
Unwinding of discount	**418**	**418**
Closing balance 2013	**39,988**	**39,988**

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

Note 9: Cash Flow Reconciliation

	2013 ($)	2012 ($)
Reconciliation of cash and cash equivalents as per Balance Sheet to Cash Flow Statement		
Cash and cash equivalents as per:		
Cash flow statement	**79,016**	91,451
Balance sheet	**79,016**	91,451
Difference	**–**	–
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	**(2,419,919)**	(2,255,364)
Add revenue from Government	**2,052,000**	1,896,000
Adjustments for non-cash items		
Depreciation / amortisation	**382,006**	354,609
Net write down of non-financial assets	**–**	–
Finance cost	**418**	4,719
Changes in assets / liabilities		
Decrease in net receivables	**99,881**	411,675
(Increase) / decrease in prepayments	**(30,933)**	1,897
Increase in employee provisions	**59,871**	34,531
Increase in supplier payables	**11,366**	43,179
Increase / (decrease) in other payables	**(38,904)**	(189,811)
Net cash from operating activities	**115,786**	301,435

Note 10: Senior Executive Remuneration

Note 10A: Senior Executive Remuneration Expenses for the Reporting Period

	2013 ($)	2012 ($)
Short-term employee benefits:		
Salary	**230,196**	213,748
Annual leave accrued	**18,775**	16,179
Total short-term employee benefits	**248,971**	229,927
Post-employment benefits:		
Superannuation	**35,989**	31,746
Total post-employment benefits	**35,989**	31,746
Other long-term employee benefits:		
Long service leave	**8,449**	7,281
Total other long-term employee benefits	**8,449**	7,281
Total senior executive remuneration expenses	**293,409**	268,954

1. Note 10A is prepared on an accrual basis.
2. Note 10A excludes acting arrangements and part-year service where total remuneration expensed as a senior executive was less than $180,000.

Note 10B: Average Annual Reportable Remuneration Paid to Substantive Senior Executives during the Reporting Period

Average annual reportable remuneration paid to substantive senior executives in 2013

Average annual reportable remuneration[1]	Substantive senior executives (No.)	Reportable salary[2] ($)	Contributed ($) superannuation[3]	Reportable allowances[4] ($)	Bonus paid[5] ($)	Total reportable remuneration ($)
Total reportable remuneration (including part-time arrangements):						
$210,000 to $239,999	**1**	**203,022**	**35,989**	**–**	**–**	**239,011**
Total	**1**					

Average annual reportable remuneration paid to substantive senior executives in 2012

Average annual reportable remuneration[1]	Substantive senior executives (No.)	Reportable salary[2] ($)	Contributed ($) superannuation[3]	Reportable allowances[4] ($)	Bonus paid[5] ($)	Total reportable remuneration ($)
Total reportable remuneration (including part-time arrangements):						
$180,000 to $209,999	1	173,208	31,746	–	–	204,954
Total	1					

[1] This table reports substantive senior executives who received remuneration during the reporting period. Each row is an averaged figure based on headcount for individuals in the band.

[2] 'Reportable salary' includes the following:
a) gross payments (less any bonuses paid, which are separated out and disclosed in the 'bonus paid' column);
b) reportable fringe benefits (at the net amount prior to 'grossing up' for tax purposes);
c) exempt foreign employment income; and
d) salary sacrificed benefits.

[3] The 'contributed superannuation' amount is the average cost to the entity for the provision of superannuation benefits to substantive senior executives in that reportable remuneration band during the reporting period.

[4] 'Reportable allowances' are the average actual allowances paid as per the 'total allowances' line on individuals' payment summaries.

[5] 'Bonus paid' represents average actual bonuses paid during the reporting period in that reportable remuneration band. The 'bonus paid' within a particular band may vary between financial years due to various factors such as individuals commencing with or leaving the entity during the financial year.

Note 11: Remuneration of Auditors

	2013 ($)	2012 ($)
Fair value of the services provided:		
Revenue received free of charge	**16,000**	16,000
Total	**16,000**	16,000

Financial statement audit services were provided free of charge to the entity.

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

Note 12: Financial Instruments

Note 12A: Categories of Financial Instruments

	2013 ($)	2012 ($)
Financial Assets		
Cash and cash equivalents	**79,016**	91,451
Trade and other receivables	**646**	–
Total	**79,663**	91,451
Carrying amount of financial assets	**79,663**	91,451
Financial Liabilities		
Trade creditors	**65,415**	76,464
Total	**65,415**	76,464
Carrying amount of financial liabilities	**65,415**	76,464

Note 12B: Fair Value of Financial Instruments

	Carrying amount 2013 ($)	Fair value 2013 ($)	Carrying amount 2012 ($)	Fair value 2012 ($)
Financial Assets				
Cash and cash equivalent	**79,663**	**79,663**	91,451	91,451
Total	**79,663**	**79,663**	91,451	91,451
Financial Liabilities				
Trade creditors	**65,415**	**65,415**	76,464	76,464
Total	**65,415**	**65,415**	76,464	76,464

Note 12C: Credit Risk

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

Note 12D: 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 12E: Market Risk

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

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

Note 13: Appropriations

Table A: Annual Appropriations ('Recoverable GST exclusive')

	2013 Appropriations			Appropriation applied in 2013 (current and prior years) ($)	Variance ($)
	Appropriation Act Annual Appropriation ($)	*FMA Act* Section 31 ($)	Total approp. ($)		
DEPARTMENTAL					
Ordinary annual services[1]	**2,119,000**	**188,528**	**2,307,528**	**2,244,435**	**63,094**
Total departmental	**2,119,000**	**188,528**	**2,307,528**	**2,244,435**	**63,094**

	2012 Appropriations			Appropriation applied in 2012 (current and prior years) ($)	Variance ($)
	Appropriation Act Annual Appropriation ($)	*FMA Act* Section 31 ($)	Total approp. ($)		
DEPARTMENTAL					
Ordinary annual services	1,970,000	172,039	2,142,039	2,204,000	(61,961)
Total departmental	1,970,000	172,039	2,142,039	2,204,000	(61,961)

Table B: Departmental and Administered Capital Budgets ('Recoverable GST exclusive')

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

	2012 Capital Budget Appropriations		Capital Budget Approp. applied in 2012 (current and prior years)		Variance ($)
	Appropriation Act Annual Capital Budget ($)	Total Capital Budget Approp. ($)	Payments for non-financial assets[2] ($)	Total payments ($)	
DEPARTMENTAL					
Ordinary annual services—Departmental Capital Budget[1]	74,000	74,000	74,000	74,000	–

[1] Departmental Capital Budgets are appropriated through Appropriation Acts (No.1,3,5). They form part of ordinary annual services, and are not separately identified in the Appropriation Acts. For more information on ordinary annual services appropriations, please see Table A: Annual appropriations.

[2] Payments made on non-financial assets include purchases of assets, expenditure on assets which has been capitalised, costs incurred to make good an asset to its original condition, and the capital repayment component of finance leases.

Table C: Unspent Departmental Annual Appropriations ('Recoverable GST exclusive')

Authority	2013 ($)	2012 ($)
2007–2008 Appropriation Act 1	**1,692,722**	1,742,722
2008–2009 Appropriation Act 1	**70,000**	140,000
2012–2013 Appropriation Act 1	**7,000**	–
Cash on hand or on deposit	**79,016**	91,451
Total	**1,848,738**	1,974,173

Note 14: 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 14A: Net Cost of Outcome Delivery

	Outcome 1	
	2013 ($)	2012 ($)
Expenses		
Departmental	**2,624,446**	2,443,403
Total	**2,624,446**	2,443,403
Other own-source income		
Departmental	**204,528**	188,039
Total	**204,528**	188,039
Net cost/(contribution) of outcome delivery	**2,419,918**	2,255,363

Note 14B: Major Classes of Departmental Expense, Income, Assets and Liabilities by Outcome

	Outcome 1	
	2013 ($)	2012 ($)
Departmental Expenses:		
Employee benefits	**1,261,893**	1,236,090
Supplier expenses	**980,129**	847,985
Depreciation and amortisation	**382,006**	354,609
Finance cost	**418**	4,719
Total	**2,624,446**	2,443,403
Departmental Income:		
Revenue from Government	**2,052,000**	1,896,000
Other own-source revenue	**204,528**	188,039
Total	**2,256,528**	2,084,039
Departmental Assets		
Financial assets	**1,884,182**	1,996,498
Non-financial assets	**868,819**	1,031,672
Total	**2,753,001**	3,028,170
Departmental Liabilities		
Payables	**138,814**	166,353
Provisions	**428,345**	368,056
Total	**567,159**	534,409

Note 15: Net Cash Appropriation Arrangements

	2013 ($)	2012 ($)
Total comprehensive income (loss) less depreciation/amortisation expenses previously funded through revenue appropriations[1]	**14,087**	(4,755)
Plus: depreciation/amortisation expenses previously funded through revenue appropriation	**(382,006)**	(354,609)
Total comprehensive loss—as per the Statement of Comprehensive Income	**(367,919)**	(359,364)

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

Note 16: Compliance with Statutory Conditions for Payments from Consolidated Revenue Fund

During 2012–13 additional legal advice was received that indicated there could be breaches of Section 83 under certain circumstances with payments for long service leave, goods and services tax and payments under determinations of the Remuneration Tribunal. The agency has reviewed its processes and controls over payments for these items to minimise the possibility for future breaches as a result of these payments. The agency has determined that there is a low risk of the certain circumstances mentioned in the legal advice applying to the agency. The agency is not aware of any specific breaches of Section 83 in respect of these items.

Glossary

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

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

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

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

Health fund: see Health insurer.

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

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

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

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

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

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

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

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

Medicare: Australia's universal public health care system.

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

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

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

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

PHIO: Private Health Insurance Ombudsman.

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

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

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

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

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Notes

Australian Government

Private Health Insurance Ombudsman

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