Australian Government

Private Health Insurance Ombudsman

Annual Report 2011

Contacts

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(Translating and Interpreting Service)

Deaf, hearing or speech impaired: 13 36 77
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Readers with inquiries about the Ombudsman or this report should contact the Administration Officer at the above address. Information for Senators and Members is available from the Private Health Insurance Ombudsman, at the above telephone and facsimile numbers.

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Letter of Transmittal

Australian Government
Private Health Insurance Ombudsman

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

Dear Minister

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

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2010 to 30 June 2011.

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

Yours sincerely

Samantha Gavel

Samantha Gavel
Ombudsman
26 September 2011

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Ombudsman's Overview

Introduction

The Private Health Insurance Ombudsman (PHIO) protects the interests of consumers in relation to private health insurance. PHIO carries out this role through its independent complaints handling service, by identifying underlying problems in the practices of private health insurers or health providers relevant to the administration of private health insurance, and by encouraging health insurers to continuously improve their own complaints handling practices.

PHIO provides consumers with information and advice regarding private health insurance and produces and publishes a range of tools for consumers, including the consumer website www.privatehealth.gov.au. PHIO also provides advice to the Australian Government about issues affecting consumers in relation to private health insurance.

Samantha Gavel – Ombudsman

The activities of the office include:

- provision of an independent complaints handling service for resolving individual complaints and identifying the underlying systemic issues driving complaints;
- advice to industry and government about industry practices and issues of concern to consumers identified through our complaints handling and consumer enquiry services;
- consumer education and advice, through the publication of brochures and fact sheets and our two websites: www.phio.org.au and www.privatehealth.gov.au;
- publishing the annual *State of the Health Funds Report* to provide comparative information about the performance and service delivery of all private health insurers; and
- mediation between health insurers and healthcare providers in order to resolve disputes that may impact on consumers' entitlements under their private health insurance.

The activity of the office increased in 2010-11, particularly in relation to complaints handling, with a significant increase in overall complaint numbers. At the same time, the number of higher level complaints requiring more detailed investigation remained similar to last year. Pleasingly, in spite of this increased workload, consumer satisfaction with PHIO and its services remained high and we met or exceeded all of our Key Performance Indicators.

Highlights for the year included:

- the official launch of the major updates made to the www.privatehealth.gov.au website;
- positive feedback from consumers in relation to the updated site, with 85% of those

surveyed being satisfied with the information available on www.privatehealth.gov.au;

- the PHIO Industry Seminar which was held in March 2011;
- the release of a discussion paper relating to the industry consultation on Acute Care Certification issues;
- continuing high level of customer satisfaction with our complaints handling service, with 88% of those surveyed reporting they were satisfied or very satisfied with the service; and
- working with a number of individual insurers to improve customer service and their internal processes to reduce complaints about particular issues causing complaints from their members.

Health Insurance Complaints

PHIO received 3,070 complaints during 2010-11, which was an increase of 17% on the previous year. This jump in overall complaint numbers represents quite a radical change from the pattern of the past five years, which has seen only small but consistent increases in the number of complaints to PHIO. These previous increases were within expectations, given that fund membership levels also increased during that time.

The increase was most notable in the second half of the year. PHIO usually experiences a higher number of complaints at this time of year as fund premium increases are notified to members in March and April. There also tends to be more focus on private health insurance by the media at this time, because of the public release of the premium increase approvals by the Minister for Health and Ageing. Most people who contact PHIO at this time are not usually complaining about their premium increase per se, so it seems that the higher profile of health insurance at this time of year acts as a catalyst for people who may be experiencing a problem with their health insurance to contact their fund or PHIO about it.

In reviewing our complaints data, the issues in 2010-11 where there was an increase in complaints include level of cover, fund rule changes and general service issues. The increase in complaints about these issues is not across all insurers, but is generally confined to two or three of the larger insurers, who made changes to their products last year that affected large numbers of members. For example, one larger insurer changed the restrictions on a number of its policies to exclusions with effect from 1 July 2010 and also made changes to excesses on some policies later that year. In addition, another large insurer moved some of its major dental treatments into the general dental category, which reduced the benefits members received and also made some changes to ambulance policies. This insurer also had a higher level of complaints from members about the application of the Pre-Existing Condition rule and PHIO has been working with that fund to improve processes and reduce complaints about this issue. The impact of these issues led to a higher level of complaints to PHIO from members of these two funds.

As has been noted in previous reports, developing policies with restrictions and exclusions, or adding them to existing policies, assists funds in managing premium costs and meeting demand from consumers for more affordable policies.

Legislation requires that if a fund makes a detrimental change to a policy, it must inform members in advance of the change. The information the fund provides in its letter to members is very important in ensuring members understand the change and its impact on them. This enables the member to accept the change, or to look at other policy options if the change means their policy no longer meets their needs.

In the past, PHIO has focused on ensuring the information sent to members about detrimental rule changes is accurate and contains the information members need to know in order to make informed decisions about their cover. To assist with this aspect, PHIO encourages funds to send copies of their letters about such changes to PHIO before they go out.

It is disappointing to note that some of the letters about detrimental rule changes that were sent in 2010 did not contain adequate advice about changes to policies. Copies of these letters were not provided to PHIO for review, which meant we were not able to advise funds to include more specific information to assist members in understanding the impact of the changes. This resulted in higher levels of complaints from members of these funds to PHIO. PHIO has had a number of discussions with the funds concerned and they have agreed to improve their letters, as per PHIO's recommendations, in future. We will be closely monitoring this issue in the coming year and requesting that funds do follow up mail-outs and communication campaigns if the information provided to members about detrimental changes is not sufficient. We will also require funds to remedy any complaints that arise from the provision of inadequate information to members.

It is important to note that even where a fund has worked to ensure that a letter does contain the information members need to know about a change to their cover, complaints to the fund and to PHIO can reveal issues that are not well understood by members. For example, one fund removed obesity/lap band surgery from one of its policies last year. A number of members on the policy who had already had a lap band fitted understood they would no longer be covered for this surgery in future, but did not think they needed to upgrade their cover to one which covered this surgery because they had already had the procedure.

What members did not realise was that the item number for lap band surgery is the same, regardless of whether the lap band is being inserted, adjusted or removed. So when a small number of members needed to have their lap band removed or adjusted, they found they were no longer covered for this. In this case, the fund agreed to take a flexible approach to complaints and to write to members who had previously undergone lap band surgery advising them they needed to upgrade their policy if they might need an adjustment or removal of their lap band in future.

There were 716 higher level complaints investigated by PHIO in 2010-11, which was a small increase on the 684 higher level complaints investigated last year. It was pleasing to see that although complaint numbers increased overall, there was only a small increase in the number of higher level complaints requiring investigation by PHIO. This suggests that insurers were handling the complaints we referred back to them well, so that these complaints did not require formal investigation by PHIO. This is a positive indicator for the industry and for the work PHIO does with insurers to improve their internal complaints handling practices.

Out-of-Pocket Costs

Consumer surveys regularly show that consumers are more likely to be dissatisfied with their health insurance when they encounter out-of-pocket gaps for services they receive.[1] In early 2011, a healthcare

[1] See for example the Ipsos Report on Health Care and Insurance 2009 (available to subscribers only).

provider introduced a compulsory fee for incidental services at all of its hospitals. The fee was set at $25 for overnight patients and $15 for day procedure patients. According to the healthcare provider, the fee was intended to cover the cost of access to Wi-Fi technology, business centres and Foxtel television channels by patients and visitors. For patients admitted for day procedures, it also covered the provision of a robe and bag to store their belongings, which they could take home.

Almost immediately on the introduction of this fee, PHIO began to receive complaints from patients who could not, or did not wish to use the services covered by the fee. These patients indicated in their calls and letters to PHIO that they believed it was unfair for the provider to impose the fee on all patients, regardless of whether they wished to use the services covered by the fee. A number of health funds also complained to PHIO about the fee on behalf of their members.

PHIO raised these complaints with the healthcare provider. In its response to PHIO, the healthcare provider indicated it had made a significant investment in new technology at its hospitals, bringing them to a standard that private patients expect, and that these costs needed to be recouped via the compulsory incidentals fee, as they were not payable by health funds.

The provider also indicated its practice is to take all reasonable steps to advise patients of the fee prior to admission and considers that, in general, patients have a choice whether to incur the fee in choosing whether to be admitted to the hospital. The fee does not apply in all circumstances, and in cases of re-admission to hospital, the fee is charged once in a twelve-month period.

The healthcare provider recently advised it would no longer charge the fee for day-stay patients. PHIO believes this is a positive development. At the time of going to print, however, the fee is still in place for all overnight patients. It remains PHIO's view that that the fee should only be charged to patients who wish to incur this cost and it is to be hoped that the provider will review its decision to impose this fee on all patients, regardless of whether they wish to use the services it covers.

PHIO is continuing to receive complaints about this issue and is seeking advice from a number of sources in resolving this matter..

Industry Developments

A number of Brisbane-based insurers were affected by the Queensland floods in January 2011. These funds were able to put business continuity management plans into practice and there was minimal disruption to members. A number of funds, in consultation with the Private Health Administration Council (PHIAC) and the Department of Health and Ageing, put arrangements in place to assist members affected by the floods.

The Code Compliance Committee for the private health insurance industry Code of Conduct conducted a review of the Code during 2010-11. PHIO was given the opportunity to comment on improvements to the Code. The focus of PHIO's comments was on improving information for members when they join a fund; ensuring funds meet the Best Practice Guidelines for Pre-Existing Conditions and facilitating the provision of Transfer Certificates to streamline processes for transferring members. These suggestions were incorporated into the Code of Conduct.

The Australian Government announced funding in the 2011-12 Budget for the further development of a Personally Controlled Electronic Health Record (PCEHR) record for all Australians who choose to have one. There is the potential for this initiative to provide significant benefits for consumers, particularly those who are suffering from chronic conditions, provided that appropriate privacy and security controls are put in place.

As PCEHR data is sensitive personal and health information, the security of the information is paramount to ensure trust and participation by consumers and health care providers. Also important is the accuracy of the information, including the ability to correct information; secure back-up of data; and to limit access to appropriate people.

The aspect of the project of particular relevance to private health insurance consumers is the recognition of the public and private mix in relation to healthcare delivery and services. Participation by private (and public) providers will be encouraged and supported, and consumers will be able to use their PCEHR across public and private health care providers, where providers have chosen to participate.

Consumer Information and Advice

PHIO provides a number of brochures for consumers on issues identified through our complaints as areas where consumers need additional information. These include brochures on Waiting Periods, Doctors' Bills, Portability of Membership, and Choosing a Health Insurance Policy. During the year, two of our most popular brochures, "Making a Complaint" and "Health Insurance Choice" were translated into the six most commonly used community languages in Australia.[2]

PHIO also provides a number of consumer Fact Sheets on issues that cause complaints or are the subject of regular questions from consumers. These include Fact Sheets on Obstetrics and Pregnancy, Informed Financial Consent, Restrictions and Exclusions, and Premium Increases.

These brochures and Fact Sheets are available for viewing and/or downloading at www.phio.org.au or can be obtained in hard copy by contacting PHIO on 1800 640 695.

PHIO also provides an information and advisory service to consumers via the "Ask a Question" feature on the www.privatehealth.gov.au website, or by contacting PHIO by telephone on 1300 737 299 during business hours. These services enable consumers to obtain quick answers to questions they may have about private health insurance. The most common questions received in 2010-11 were about Lifetime Health Cover, the Medicare Levy Surcharge and Overseas Visitor cover. This service is separate from our complaints handling service, which is available through PHIO's complaints hotline on 1800 640 695 or PHIO's e-mail complaints form available at www.phio.org.au.

In addition, PHIO has adopted a process of surveying its clients on an on-going basis, rather than a yearly basis. The main advantage of this is the immediacy of the feedback we obtain from complainants, which allows us to address any concerns in a more timely manner.

Consumer Website www.privatehealth.gov.au

PHIO undertook a major review and refresh of the consumer website www.privatehealth.

[2] Source: Australian Bureau of Statistics; brochures available in Arabic, Chinese, Greek, Italian, Spanish and Vietnamese

gov.au in mid-2010. Updates to the site were informed by consumer focus testing, as well as feedback received through the website survey and the "Ask a Question" feature.

New features of the updated site include an improved design and location of information; an updated Lifetime Health Cover calculator and information about average dental charges by state.

The most important feature of the updated site was a new comparison search feature that enables consumers to compare health insurance policies across all 37[3] registered health insurers. It is the only independent source of this information for consumers in Australia. The new comparison search feature makes it easy for people to compare the different features of hospital and general treatment policies and provides consumers with a level of transparency about the differences between policies that has not previously been available to them. This will assist consumers in choosing policies that will better meet their needs from the many options available to them.

The new site was formally launched in November 2010. Feedback from consumers in relation to the updated site has been very positive. A recent survey of the site's use shows that consumers appreciate the improved design and location of information. More information about the website refresh is contained in the body of this Annual Report.

A significant challenge for the office is ensuring consumers are aware of the site and its resources. The launch of the updated site provided an opportunity to profile the site in the media and PHIO works to take advantage of any opportunities available to publicise the site. This includes regular contributions to newspaper articles and other publications. It also includes strategic linking to sites that can drive traffic to the site; some of the sites PHIO has linked with during the year include the Australian Taxation Office and the HealthInsite website. Both of these sites receive significant numbers of visitors who will now be able to access www.privatehealth.gov.au from these sites quickly and easily if they are looking for information about private health insurance.

In the coming year, we will continue to refine and improve the site to ensure it continues to meet consumers' needs for high quality, independent information about private health insurance. This will include improvements to the Agreement Hospital locator and a set of online tutorials to assist consumers in using the site and understanding private health insurance.

Acute Care Certification Consultation

PHIO has been working with State and Territory health departments and private health insurers to develop a consistent national approach to certification of long stay private patients in public hospitals. The consultation process has involved listening to both parties' views and concerns, gaining an understanding of the assumptions underlying them and collecting and analysing data measuring the scope of problems with the current system. A Discussion Paper was released to stakeholders for comment on 18 February 2011. Following receipt of comments on the Paper, PHIO will continue to work with all parties to resolve the issues identified in the Paper.

[3] Number of registered health insurers as at 30th June 2010, according to the PHIAC Annual Report of the Operations of the Private Health Insurers, page 9

PHIO Industry Seminar

Following on from the industry workshops conducted in 2009-10, PHIO held an industry seminar in March 2011. The aim of the seminar was to bring together industry stakeholders and PHIO staff members to focus on consumer issues in private health and best practice approaches in dealing with complaints. A series of speakers discussed a number of topics including Dr Mark Sinclair from the Australian Society of Anaesthetists on the topic of "Anaesthesia and Informed Financial Consent"; Chris Wheeler, NSW Deputy Ombudsman on the topic of "Complaint Handling for Better Outcomes"; and Anna Wise form the Consumers' Health Forum on the topic of "Private Health Insurance – What Consumers Want".

Corporate Governance

PHIO relocated its office to Level 22, 580 George Street, Sydney in July 2010. The new office is an appropriate size for staffing needs for the next 5 years, as well as addressing security, maintenance, access and energy efficiency requirements that were not being met in the previous premises.

In line with the Australian Government's commitment to promoting reconciliation with Indigenous Australia, PHIO developed a Reconciliation Action Plan for the office, which is available for viewing at www.phio.org.au.

Reforms to the *Freedom of Information Act 1982 (Cth)* (the FOI Act) in November 2010 introduced fundamental changes to the way information held by government is managed and accessed by members of the public. Some of the major changes include encouraging a pro-disclosure culture, the establishment of the Office of the Australian Information Commissioner and reforms to the ability to access information under the legislation.

Under these reforms, Commonwealth Government agencies are required to publish a broad range of information on their websites, and to make it available through online access where possible. In line with these requirements, PHIO has developed an agency plan, organisational chart and disclosure log which are available for viewing at www.phio.org.au.

PHIO has always had a policy of openness with the information it holds, with complainants being able to request information held about their individual complaint directly from PHIO, free of charge.

The Year Ahead

In the coming year, PHIO intends to continue its development of the consumer website PrivateHealth.gov.au, to ensure it continues to meet consumers' needs as an independent source of reliable information about private health insurance.

PHIO will also focus on ensuring its printed information is available for those consumers who do not have access to the internet. This is particularly relevant to consumers who live in regional and remote areas.

PHIO also intends to hold a series of industry workshops to assist insurers in identifying the causes of complaints through root cause analysis, to assist them in improving their processes and reducing complaints from their members.

PHIO will work with insurers to reduce complaints in those areas that have caused higher levels of complaint to the PHIO during 2010-11.

Role and Function

Introduction

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

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

Functions

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

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

- deal with complaints and conduct investigations;
- publish aggregate data about complaints;
- publish the *State of the Health Funds Report*;
- make recommendations to the Minister or Department of Health and Ageing;
- report to the Minister or the Department about the practices of particular private health insurers, private health providers and private health insurance brokers or other related parties;
- collect and publish information about complying health insurance products (i.e. manage the consumer website privatehealth.gov.au);
- promote a knowledge and understanding of the Ombudsman's functions;
- undertake any other functions that are incidental to the performance of any of the preceding functions.

Who Can Make a Complaint?

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

Persons Against Whom a Complaint May Be Made

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

What Can the Ombudsman Do With a Complaint?

The Ombudsman is able to deal with complaints by:

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

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

Rosie Edwards, Alison Leung, Ursula Schappi, Joanna Wong, David McGregor, Samantha Gavel, Damien Maynard, Leonie Hull, Jim Robertson, Kaylie Blyton, Kate Hocknull, Henny Oentojo, Hilary Bassingthwaighte, Tracey Salkeld, Amelia De Gregorio

What Happens at the End of a Complaint or Investigation?

The Ombudsman is able to recommend that:

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

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

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

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

How the Ombudsman's Staff Resolve Complaints

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

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

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

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

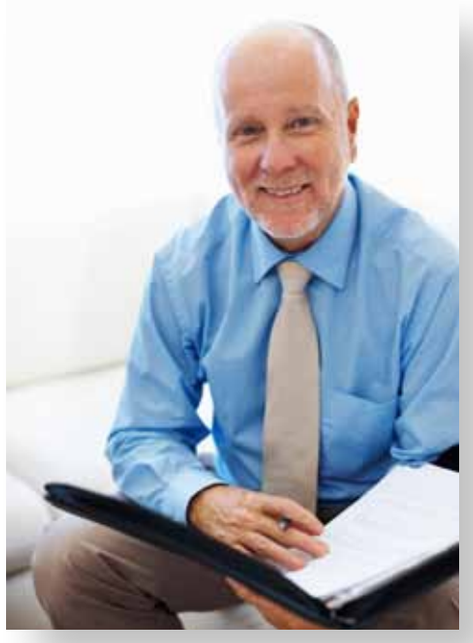
Performance

Performance Indicators

The 2010-11 Portfolio Statement for the Health and Ageing Portfolio outlines the Ombudsman's program to promote public confidence in private health insurance. The program's Key Strategic Directions are:

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

The following is a summary of performance outcomes against the program's formal performance indicators in 2010-11:



Qualitative Deliverable	2010-11 Reference Point or Target	2010-11 Result
Improve the quality and accessibility of private health insurance information		
Publish the annual *State of the Health Funds Report*	The *State of the Health Funds Report* is published by PHIO by 31 March 2011	Report published on 31 March 2011
Manage the private health insurance consumer website (www.privatehealth.gov.au)	Regular and timely updates of the website to ensure information is accurate and up-to-date	Website regularly updated in response to industry changes and issues of concern to consumers
Complaints handling service		
Effective complaints handling service	Service effectiveness as measured by client survey	88% of surveyed clients satisfied or very satisfied with service; 88% would recommend PHIO to others.

Qualitative Deliverable	2010-11 Budget Target	2010-11 Result
Protect the interests of health insurance consumers		
Number of high quality and timely advisory services, policy advice, and submissions and reports, measured by stakeholder feedback.	≥12	14
Complaints handling service		
Number of publications on PHIO complaints handling activity	6	6

Key Performance Indicators

Qualitative Indicators	2010-11 Reference Point or Target	2010-11 Result
Protect the interests of health insurance consumers		
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 funds, hospitals and providers, with over 83,000 brochures distributed throughout the year. The consumer website received 311,572 unique visitors throughout the year, an increase of 17% on the previous year.
Improve the quality and accessibility of private health insurance information		
Provision of independent and reliable information to consumers via the private health insurance consumer website (www.privatehealth.gov.au)	Measured by website survey and consumer focus testing which indicates that information provided is viewed as independent and reliable	85% of surveyed website clients satisfied with information and positive feedback from website users

Quantitative Indicators	2010-11 Budget Target	2010-11 Result
Protect the interests of private health insurance consumers		
Percentage of recommendations that have resulted in changes to insurer or industry practices.	75%	Not applicable (sample size ≤1)
Improve the quality and accessibility of private health insurance information		
Number of average daily visits to consumer website	710	1258
Percentage of information products useful or very useful for consumers	75%	95%
Complaints handling service		
Percentage of complaints finalised during the year	90%	97%
Percentage of complaints finalised within one month of receipt	80%	84%
Percentage of clients satisfied with complaint handling service	81%	88%

Complaints

The Ombudsman received 3070 complaints during 2010-11. This was an increase of 458 complaints (17%) on the previous year.

Of those complaints, 716 were classified as Level 3 Disputes, a 5% increase on the previous year. Level 3 complaints are those where the Ombudsman's staff acts on behalf of a complainant by requesting a report from a health fund or other object of complaint. The report is then reviewed and either closed as a satisfactory response or investigated further.

Figure 1 Total Complaints Received per Quarter

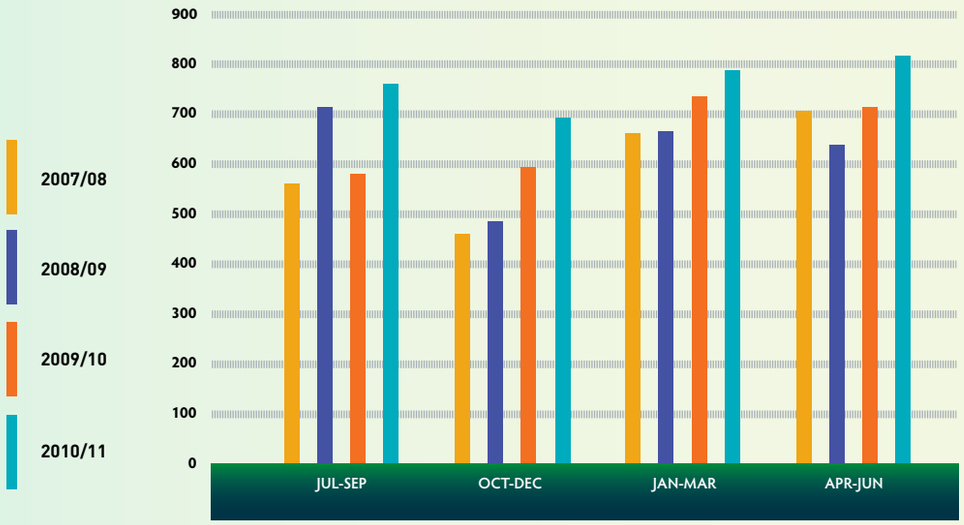


Figure 1 shows the distribution of complaints over the four quarters of the 2010-11 financial year.

Figure 2 shows the total number of complaints received per year for the last twelve years. The increase in the number of complaints in the 2000-01 year was associated with a large increase in the number of Australians covered by private health insurance following the introduction of the 30% Health Insurance Rebate and Lifetime Health Cover.

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

Consumer Enquiries

Enquiries are instances where the Ombudsman's staff provided advice or information, where the matter does not meet the definition of a complaint. In 2010-11, 1216 consumer enquiries were recorded. While this was a 30% decrease on last year's figure of 1757 enquiries, it still far exceeds the figure of 605 enquiries in 2008-09.

The majority of enquiries (1100 enquiries, or 90%) are received via the Ombudsman's consumer website www.privatehealth.gov.au. Using the "Ask A Question" feature on the website, consumers can contact the Ombudsman by filling out a form. Some of the decrease in enquiries is attributable to the re-organisation of the website in July 2010, which allowed consumers to more easily locate the information they required. (See: Consumer Website section for more information.)

Recording and Categorisation of Complaints

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

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

- type of approach;
- degree of effort required by Ombudsman staff to resolve the matter; and
- any potential sensitivity.

Currently complaints are categorised as follows:

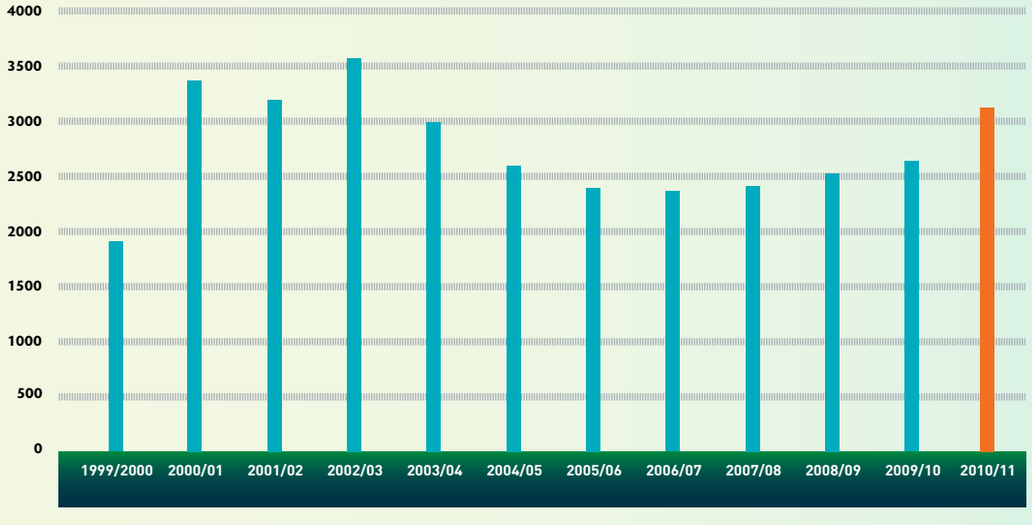
Complaint Level 1 (Problems): Moderate level of complaint

Level 1 complaints are dealt with by referring the complainant back to the health insurer, health care provider or health insurance broker 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 2010-11, 82% of Level 1 complaints were resolved as "Assisted Referrals," where the Dispute Resolution Officer referred a complaint directly to the insurer or service provider on behalf of the complainant. This approach ensures a quicker turnaround time and enables the appropriate person within an organisation to assist the complainant. The Ombudsman's client satisfaction survey indicates that complainants are more often satisfied with the office if assistance is provided by staff members in this way.

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

Figure 2 Total Complaints Received per Year



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

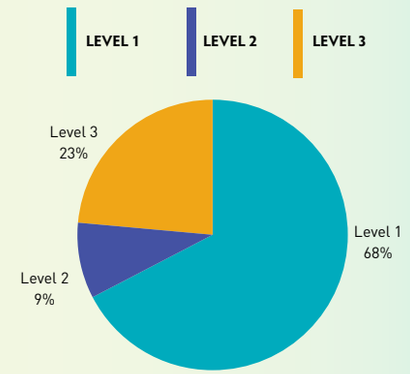
Level 2 complaints are dealt with by staff investigating issues of grievance and providing additional information or a clearer explanation directly to the complainant. Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy they have purchased, including concerns about service levels provided by the insurer or provider, price increases, benefit limitations and waiting periods.

The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

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

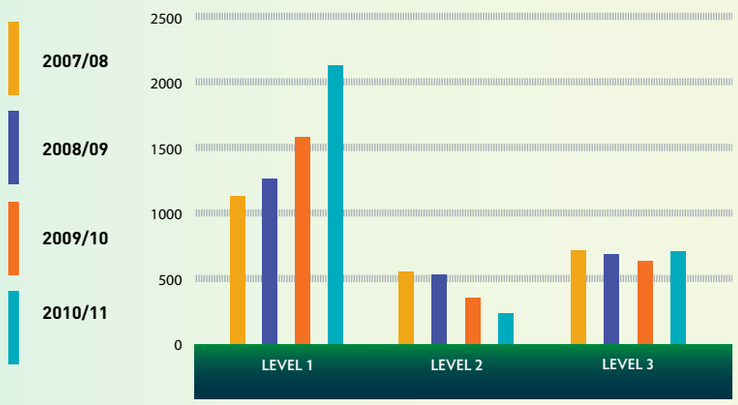
Level 3 complaints are dealt with by Ombudsman staff contacting the health insurer, health care provider or health insurance broker about the matter and requesting a formal report. Issues in this category will have previously been the subject of dispute between the complainant and the respondent and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

Figure 4 Complaints by Category 2010–11



Figures 3 and 4 show the ratio of complaints by level. This year, 2093 complaints were classified as Level 1, 261 as Level 2, and 716 as Level 3. There was a significant increase in the number of Level 1 complaints from the previous year, and reductions in the number of Level 2 complaints. Level 3 complaint levels have remained steady for several years.

Figure 3 Complaints Received per Year by Category



Complaint Audit and Escalation

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

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

Complaints Handling Procedures

The process and timeframes for the different complaint categories are shown in **Figure 5.**

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

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

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

Figure 5 Steps In Handling Approaches To The Ombudsman

LEVEL 1 [PROBLEM]

Timeframe
Immediate.

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

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

LEVEL 2 [GRIEVANCE]

Timeframe
Usually within 24 hours

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

Outcomes
Detailed information provided which appropriately resolves the issue.

LEVEL 3 [DISPUTE]

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

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

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

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

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

David McGregor - Director, Policy and Client Services

Workload

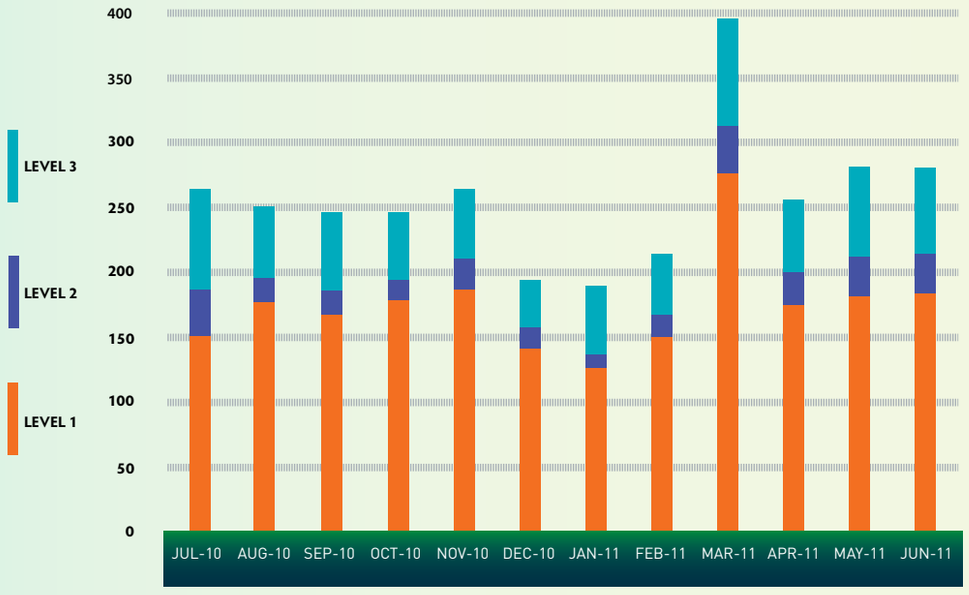
The office received 3070 complaints (Level 1, 2 and 3) in 2010-11, an average of 255 per month compared to 218 per month in the previous year. Of those complaints, 716 were Level 3 complaints, compared to 684 the previous year.

The office closed 3142 complaints in 2010-11, an average of 262 per month compared to 218 in 2009-10. Of these complaints, 729 were Level 3 complaints compared to 694 the previous year.

The Ombudsman recorded 1216 consumer enquiries this year, compared to 1757 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 March to July each year, due to the annual premium adjustments for all health insurers.

Figure 6 Total Complaints Received by Month



Time Taken to Resolve Complaints

Figures 7 and 8 provide information on the time taken to resolve complaints this year compared to last year. There has been a small improvement in the time taken to handle complaints, with 84.1% of complaints handled within one month, compared to 82.1% the previous year and 83% the year before that.

Figure 7 Time Taken to Finalise Complaints

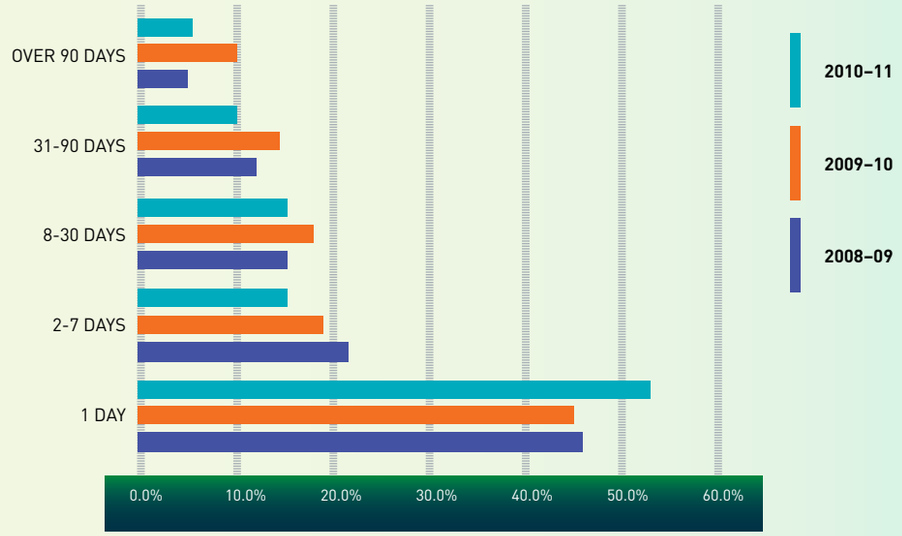


Figure 8 Complaints closed since day of lodgement 2010-11

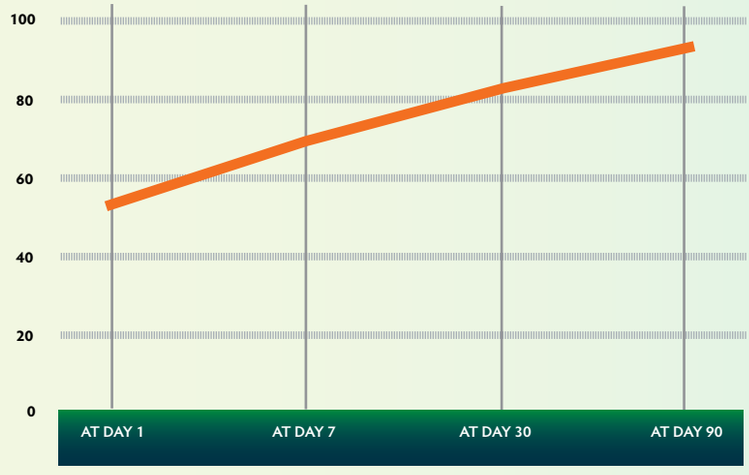
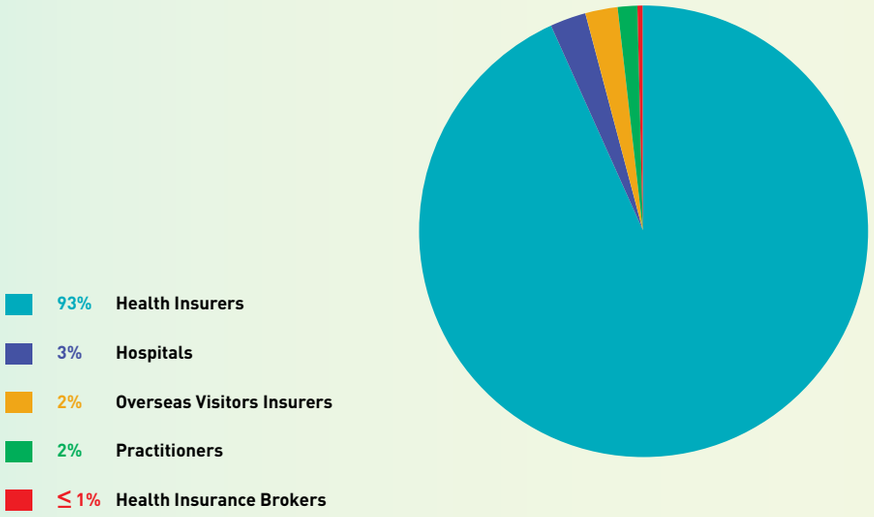


Figure 9 Objects of Complaint 2010–11



Who Was Complained About

Figure 9 shows most complaints were made about registered health insurers, followed by hospitals, overseas visitor policies, practitioners, and health insurance brokers.

Complaints about Registered Health Insurers

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

Complaints about Hospitals

The Ombudsman received 75 complaints about hospitals, a decrease from 138 complaints in the previous year.

Complaints about hospitals usually occur when patients experience unexpected gaps for a hospital admission. In most cases, there are adequate processes in place in private hospitals to ensure the provision of Informed 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 2010-11 the office recorded 57 IFC complaints against hospitals, compared to 34 the previous year, an increase which is probably attributable to the introduction of incidental fees at some hospitals. PHIO will continue to monitor and investigate complaints about this issue for trends in the industry.

The reasons why people are faced with hospital gap charges varies. Most gaps occurred because people held policies with restrictions on certain treatments, or because patients were within waiting periods. The office also assisted a small number of consumers who were asked to pay unexpected hospital gaps because their health insurer did not have a contractual agreement with the hospital they were intending to visit.

Figure 10 Complaints by Health Insurer Market Share (01 July 2010 - 30 June 2011)

NAME OF INSURER	COMPLAINTS	PERCENTAGE OF COMPLAINTS	DISPUTES	PERCENTAGE OF COMPLAINTS	MARKET SHARE
ACA	1	0.0%	0	0.0%	0.1%
Australian Health Management	114	4.1%	28	4.6%	3.0%
Australian Unity	112	4.0%	33	5.4%	3.0%
BUPA (HBA/Mutual Community)	312	11.2%	57	9.4%	9.7%
CBHS	28	1.0%	6	1.0%	1.3%
CDH (Cessnock)	0	0.0%	0	0.0%	<0.1%
CUA	3	0.1%	0	0.0%	0.4%
Defence	24	0.9%	4	0.7%	1.5%
Doctors	0	0.0%	0	0.0%	0.1%
GMHBA	45	1.6%	6	1.0%	1.7%
Grand United Corporate	17	0.6%	4	0.7%	0.3%
HBF	62	2.2%	15	2.5%	7.6%
HCI	0	0.0%	0	0.0%	0.1%
HIF	12	0.4%	2	0.3%	0.5%
HealthGuard (GMF/Central West)	16	0.6%	2	0.3%	0.7%
Health-Partners	6	0.2%	3	0.5%	0.5%
HCF (Hospitals Contribution Fund)	165	5.9%	18	3.0%	9.0%
Latrobe	19	0.7%	5	0.8%	0.7%
Manchester Unity	55	2.0%	20	3.3%	1.3%
MBF Alliances	71	2.5%	10	1.6%	1.7%
MBF-BUPA	624	22.3%	152	25.0%	15.7%
Medibank	805	28.8%	168	27.6%	28.4%
Mildura	1	0.0%	0	0.0%	0.3%
National Health Benefits (Onemedifund)	0	0.0%	0	0.0%	0.1%
Navy	0	0.0%	0	0.0%	0.3%
NIB	189	6.8%	44	7.2%	7.3%
Peoplecare	3	0.1%	0	0.0%	0.4%
Phoenix	0	0.0%	0	0.0%	0.1%
Police	6	0.2%	3	0.5%	0.3%
Queensland Country Health	3	0.1%	1	0.2%	0.2%
Reserve	0	0.0%	0	0.0%	<0.1%
Railway and Transport	19	0.7%	3	0.5%	0.4%
St Lukes	3	0.1%	0	0.0%	0.4%
Teachers Health	54	1.9%	16	2.6%	1.8%
Teachers Union	5	0.2%	2	0.3%	0.4%
Transport	3	0.1%	0	0.0%	0.1%
Westfund	16	0.6%	7	1.1%	0.8%
TOTAL for health insurers	**2793**	**100%**	**609**	**100%**	**100%**

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 doctors decreased in the 2010-11 year. The office registered 50 complaints against practitioners (including doctors, dentists, and other practitioners) compared to 104 in the previous year. In total, 43 complaints were made about IFC against doctors and other practitioners, compared to 130 the previous year.

Complaints about Brokers

Most complaints about brokers concern issues relating to the information provided on joining and the level of cover chosen. There were 11 complaints about brokers in 2010-11, a small increase from 8 complaints the previous year.

Resolving Complaints

Figure 11 shows 21% of complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint.

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

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

Resolving Level 3 Complaints

In relation to higher Level 3 complaints investigated by the Ombudsman, 49% were resolved by giving a more detailed explanation to the member; 1% was withdrawn by the complainant; and the remaining 50% were resolved by a payment or other satisfactory outcome.

Figure 11 Outcome - All complaints

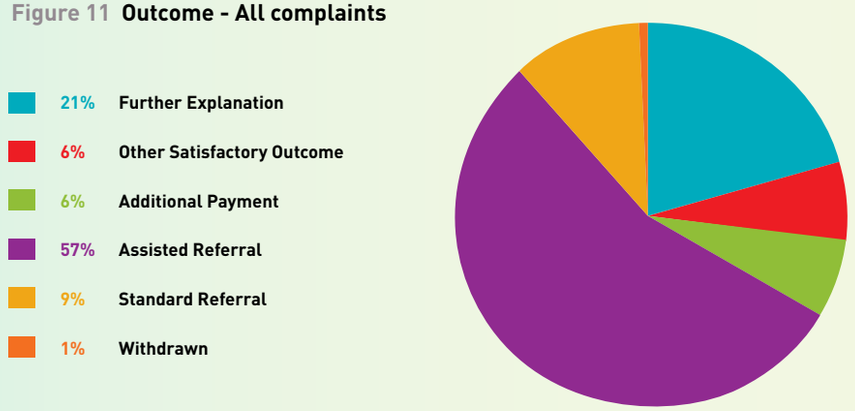
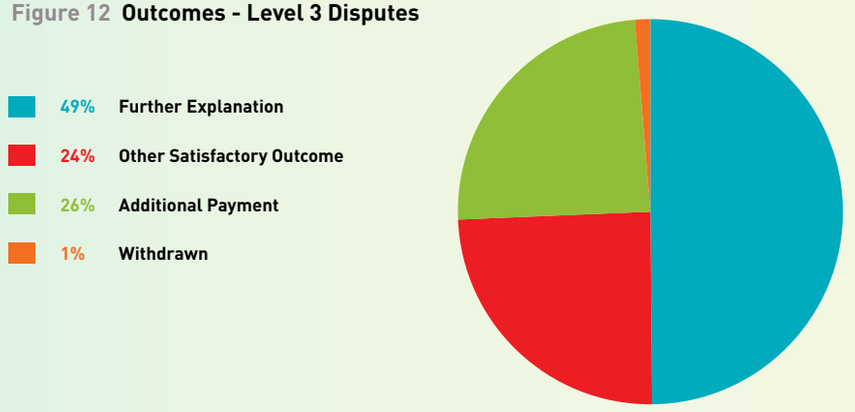


Figure 12 Outcomes - Level 3 Disputes



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.

Who Complained

The *Private Health Insurance Act 2007* allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. Overwhelmingly, 97.7% of complaints were made by health insurance members (2998). 54 complaints were made by practitioners and 16 by hospitals.

How Complaints Were Made

64% percent of complaints were made initially by telephone, 32% were lodged through the internet or by email, 3% by letter, and less than

1% by fax, personal visit to the Ombudsman's office in Sydney or by parliamentary representation.

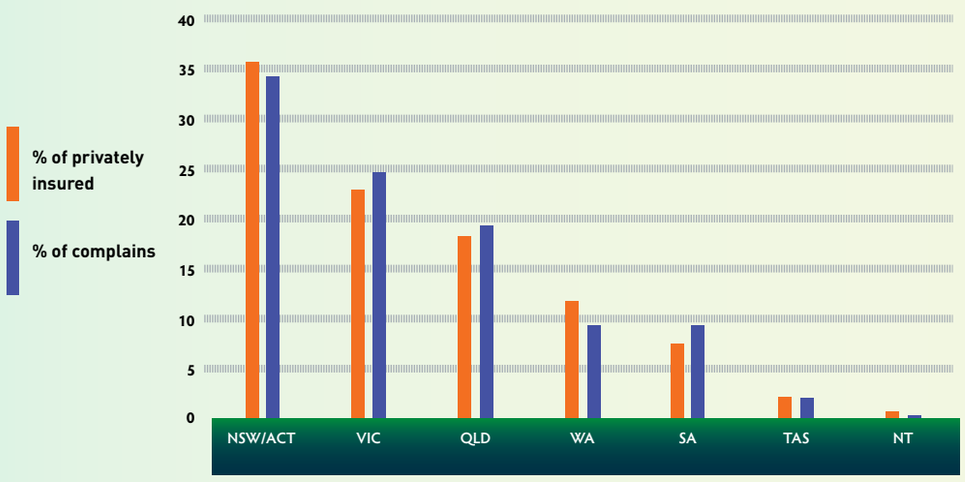
Complaints by State/Territory

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

Investigations

From 1 July 2010 to 30 June 2011 there were no investigations under section 244 of the *Private Health Insurance Act 2007* (or under the preceding Act).

Figure 13 Complaints by Population Covered by State and Territory



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*, which states that the complaint must be about a health insurance arrangement. For reporting purposes, complaints are classified in terms of broad issues and sub-issues. The most significant type of complaints concern benefits, followed by service issues, information, membership issues and waiting periods. **Figures 14 and 15 (over)** illustrate the proportion of complaints corresponding to each issue type.

There was a significant increase in the number of complaints registered with the Ombudsman in 2010-11 compared to the previous year, increasing from 2618 to 3070 in total. On analysing these complaints, the increase was not uniform across all issues – as shown in **Figure 16 (over)**, certain sub-issues experienced higher increases than others, with the most significant increases for Benefit: Level of Cover and General Service Issues. The Ombudsman will continue to monitor complaints for trends within the industry.

The following case studies highlight some of the common types of complaints received by the Private Health Insurance Ombudsman. They 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.

Figure 14 Percentage of Complaint Issues 2010/11

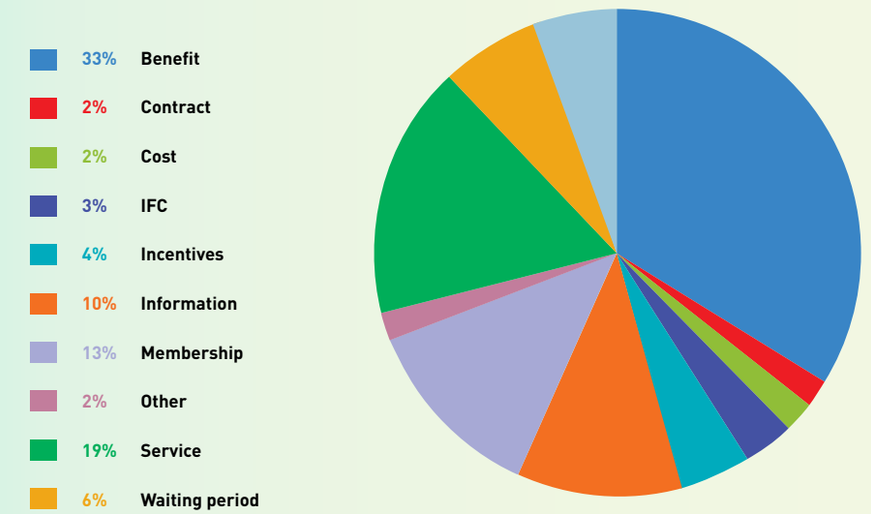
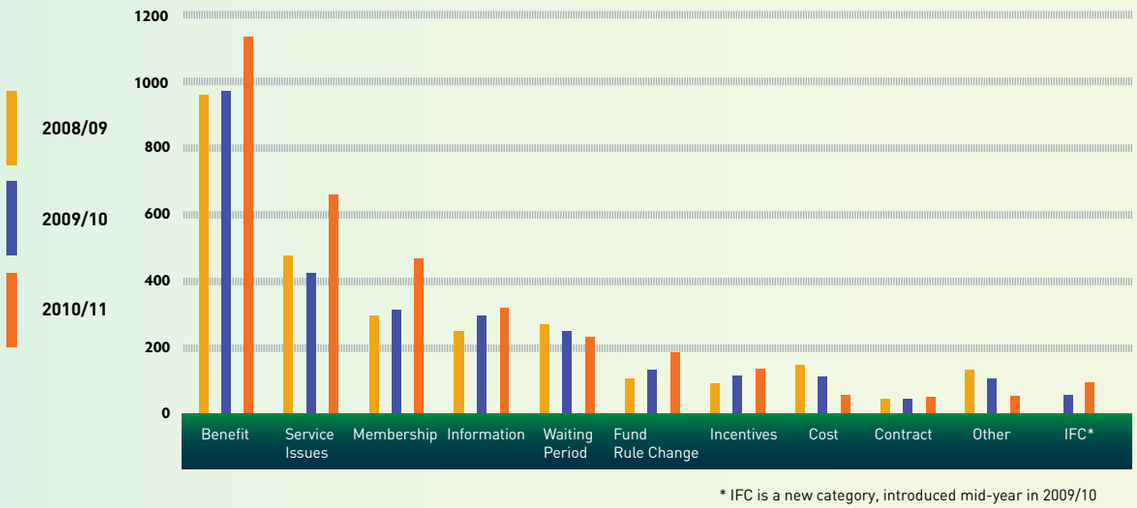
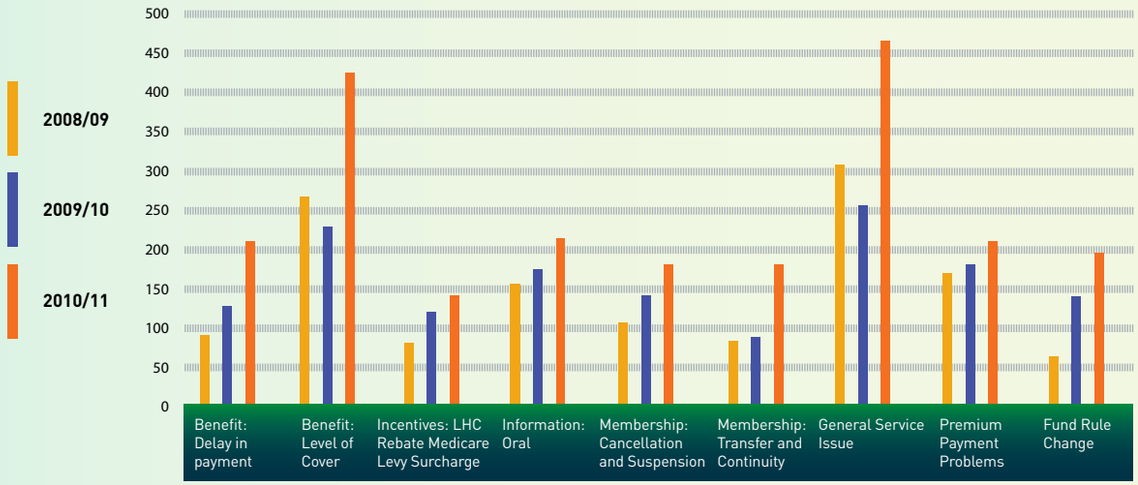


Figure 15 Complaint Issues 2008/09 to 2010/11



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

Figure 16 Complaint Sub-issues with Significant Increases



Benefits and Level of Cover

The most significant area of complaint to the Ombudsman's office was benefits, with a total of 1131 complaints for the 2010-11 year, a significant increase on the previous year's figure of 971. The main areas of concern for consumers were inadequate levels of cover, delays in payment, inadequate benefit amounts, and hospital and medical gaps.

One issue which was raised with some frequency was gastric banding and other obesity-related bariatric surgeries, which are becoming more common solutions offered to obese patients in Australia. The procedure is not cosmetic and is included in the Medicare Schedule of Benefits. However, a number of health insurance policies, especially basic policies, do restrict or exclude the service, so it is important that consumers seeking such treatment ensure their policy covers gastric banding.

Once a person has a gastric band fitted, this may not be the end of their treatment. A number of patients who have a gastric band fitted will develop a problem with the band later, so it's important for consumers to keep their cover for gastric banding and related procedures in case they develop a problem later on and require subsequent revision or removal of the gastric band in the private system.

For funds who decide to remove gastric banding benefits, to minimise complaint issues they need to pay particular attention to informing members of the full implications of such a change, especially those members who have previously used the service. The fund should provide opportunities to upgrade and be prepared to allow flexibility in exceptional cases.

CASE STUDY:

Gastric Banding and Revisions

Mrs White had previously undergone Gastric Banding Surgery when she received a letter from her insurer informing her that Gastric Banding procedures would no longer be covered on her hospital policy as of 1 July 2010. The letter explained that if Mrs White wanted to continue to be covered for gastric banding procedures she would be required to upgrade her current hospital policy before 1 July, as the fund would grant continuity of cover and she would not be required to re-serve the waiting periods.

As Mrs White had already been fitted with a gastric band, she did not think it was necessary to upgrade her hospital policy to continue having cover for a procedure she was unlikely to need again. With this in mind, Mrs White did not upgrade her hospital cover.

In December 2010, Mrs White experienced complications with her gastric band and found that she required a revision surgery to resolve the complications. Mrs White contacted her insurer to check that she would be covered for the revision procedure in a private hospital. The insurer informed Mrs White that she was no longer covered for gastric banding procedures and would need to upgrade her hospital policy and serve a 12 month waiting period before she could be covered.

It was at this point that Mrs White contacted the PHIO, as she did not believe that her health insurer had adequately warned in their correspondence that she would not be covered for any type of gastric banding surgery, including all related surgery such as adjustments, revisions and removal of the gastric band.

Mrs White had understood the information provided by the insurer meant that her hospital policy would no longer cover the initial surgery to fit the gastric band. Mrs White was of the opinion that the health insurer should have further explained in their letter that all gastric banding and related procedures would no longer be covered.

PHIO raised Mrs White's concerns with the insurer, as it is known that for this type of treatment, up to 5% of patients require follow up treatment for adjustments or removal of gastric bands due to complications. As part of its investigation, PHIO reviewed the information the fund had sent to members alerting them of this significant change in benefits. Although the insurer's letter did alert members to the change, PHIO found that the terminology used by the fund was targeted at members considering gastric banding surgery in the future.

In PHIO's view, there was a significant chance that members could misunderstand this information and conclude that the change in benefit only related to the initial surgery to fit the gastric band. There wasn't sufficient warning that this change would impact on any future complications as a result of the surgery.

The PHIO requested the insurer allow Mrs White to upgrade her cover effective 1 July 2010 with payment of the required premium adjustment. The fund agreed to this request: Mrs White paid the required premium and moved to a more appropriate level of cover, which enabled her to have her revision procedure.

Service Issues

Another significant area of complaint was service and payment administration with 664 complaints. Of these, 462 were general service related problems and 216 were premium payment problems associated with direct debit systems. However, service issues are not usually the sole reason for members' complaints; poor customer service in combination with existing problems can cause a member to become more aggrieved and dissatisfied in their dealings with the fund, until the service itself becomes a cause of complaint.

CASE STUDY:

Customer Service Delays

Ms Blue called a health insurer to obtain a quote on purchasing insurance. The insurer's salesperson quoted her for a medium hospital policy with medium extras, and advised that her hospital excess of $500 would be waived once per person per calendar year. Ms Blue was happy with the quote and the policy, and proceeded to purchase the cover.

Two weeks later, Ms Blue called back to her new fund about an administrative matter. During the call, she asked about the $500 excess waiver and was advised that no such waiver existed. When Ms Blue explained she had been offered the waiver in her previous call, the customer service officer said the matter would need to be reviewed by a team leader.

The customer service officer later called Ms Blue and confirmed that call recordings showed she had been given incorrect information about the waiver on joining the fund; however, the insurer would not be able to offer the waiver. Ms Blue asked to listen to the call recording herself and was advised to send the request to their service team by fax. In the same contact, Ms Blue ordered membership cards.

One week later, Ms Blue had not yet heard from the fund so she called back to check on the progress of her request and her membership cards. She was then told that the fax had not been received and nor had the cards been requested.

Finally, after calling back some days later and being advised that nothing could be done about the excess misinformation and that her cards had still not been ordered, Ms Blue contacted the Ombudsman's office. The Ombudsman was able to refer the matter to a senior person at the insurer who resolved Ms Blue's issues with a single contact.

Membership and Premium Payments

Issues with membership and policy administration increased in 2010-11, with a total of 466 complaints. Most complaints (75%) were related to problems experienced by people when cancelling, transferring or suspending their health insurance policy. The other significant cause of complaints was issues with policies falling into arrears due to premium payment problems.

Health Insurer Premium Increases

The Ombudsman has received a relatively low number of premium increase complaints for a number of years. This can be attributed to two developments in recent years. Average premium increases for individual policy holders have been lower, and there has been greater transparency by funds in communicating with members about the reasons for health insurance premium increases. During the year, the Ombudsman received only 58 (2%) complaints about premium increases, which was a reduction from the 75 complaints received the previous year.

Information

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 366 complaints about information were received, with almost 60% relating to oral advice provided by customer service staff at health insurers, and 29% relating to consumers believing they weren't advised of a change to their policy or because they didn't receive a letter.

CASE STUDY:

Telephone Advice and Call Recording

Ms Green received a quote of $1900 from her hearing aid provider for a new pair of hearing aids. Shortly after receiving the quote, Ms Green phoned her health

Leonie Hull - Principal Policy Officer

insurer to confirm her benefit entitlement before going ahead with the purchase of the hearing aids. As a pensioner, this was particularly important to Ms Green, as she was not in a position to afford a large out-of-pocket expense.

After discussing the matter with her health insurer, Ms Green had understood that she would be receiving a benefit of $800 per hearing aid for a total benefit of $1600, which would leave her with only $300 to pay out of her own pocket. Based on the information she received from her health insurer, Mr Green proceeded to order and pay for a new pair of hearing aids.

However, when Ms Green lodged a claim with her health insurer, she received a significantly lower benefit than expected. Ms Green received a benefit of only $800, leaving her with an out of pocket expense of $1100.

Ms Green visited one of her insurer's retail centres to request a review of her claim because she felt a mistake had been made. The insurer reviewed the claim but explained that the benefit of $800 was correct as this was the maximum amount payable for hearing aid appliances on her level of cover.

Ms Green explained to staff that she had phoned the fund prior to purchasing her

hearing aids and had been advised that she would receive a total benefit of $1600. On hearing this, the fund agreed to review their call recordings to ascertain what Ms Green had been advised in relation to her hearing aid benefit.

Regrettably, Ms Green did not hear back from her insurer. She then contacted the PHIO, concerned that she would be left with a much larger out of pocket expense than she had anticipated.

In investigating this complaint, PHIO requested that the insurer review their call recordings from the day that Ms Green contacted the fund to check her hearing aid benefit. The response from the insurer was that they did have a call recording and were able to confirm that Ms Green had indeed been advised that she could claim $800 per hearing aid. The insurer agreed to honour the verbal mis-information and paid Ms Green an additional $800.

Fund Rule Changes

PHIO received 200 fund rule change complaints during the year, higher than last year's figure of 143 complaints and part of a trend of increased complaints about this issue over several years.

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

CASE STUDY:

Communicating Changes in Hospital Cover

Mrs Pink had been paying for a basic health insurance policy for a number of years. She initially chose a basic level of cover on the recommendation of a salesperson at the health insurer. The cover didn't include everything, but would cover her in a private hospital for most things she thought a younger person would be likely to need.

In early 2010 she received a lengthy letter from her insurer advising her that her premiums were to be increased in April and later on her policy would be changed in June. The letter included quite a number of changes, explained over two pages interspersed with messages explaining the company's reasons for increasing premiums and reducing benefits on some services. Unfortunately, important information about new exclusions on her policy was only included near the end of the letter.

Mrs Pink didn't discover the change in her circumstances until she was admitted to a hospital where she was advised by the admissions staff that she wouldn't be covered for her procedure and would have to pay several thousand dollars to receive treatment in a private hospital. The other alternative for her was to attempt to arrange treatment as a public patient. While switching to treatment in the public system after arranging private treatment is possible, PHIO often hears from consumers that it is a complex and inconvenient process: new consultations need to be arranged with doctors and the patient must join the public hospital waiting list.

Mrs Pink chose to complain to her insurer and the PHIO about the change to her

hospital policy. In its investigation, the PHIO reviewed the letter sent by the insurer containing the message that her cover had been reduced. Although the letter contained the information about the included and excluded services, this warning was at the bottom of the second page and was not given any prominence. As the policy Mrs Pink held now only covered six selected procedures, the message that most services were now not covered in a private hospital should have been highlighted under a clearly headed paragraph.

Another issue the PHIO considered was that the insurer had been waiving all waiting periods for people on this policy who phoned to upgrade cover before the changes came into effect. This offer was not advertised in the letter sent to members and was only offered if a person had understood the changes in the letter and chosen to phone the insurer to change cover.

Based on the relatively poor communication of the change to Mrs Pink, PHIO requested that the fund allow her to upgrade her cover from the date of the change and maintain cover for services, including the one she was seeking treatment for. This outcome would put Mrs Pink back into the position that she would have been in had the mistake not have occurred. In Mrs Pink's case, if she fully understood the change to her cover she would have changed to a higher cover and started paying a higher premium from the date that her old policy conditions had changed.

Pre-Existing Conditions

Health insurers are able to apply a twelve-month waiting period to new members if treatment is for a pre-existing condition (PEC). Details about how the PEC waiting period is applied can be obtained by referring to our brochure "Waiting Periods" and our fact sheet on Pre-Existing Conditions, which are available at www.phio.org.au or by phoning our office.

PHIO received 149 complaints about the PEC waiting period during the year. PHIO's role in investigating complaints about this waiting period is to ensure that the fund has applied the waiting period correctly and that the fund and hospital have complied with the Best Practice Guidelines. A copy of the guidelines for the industry is also available from the PHIO website.

Amelia De Gregorio - Senior Dispute Resolution Officer, Jim Robertson - Dispute Resolution Officer, and Kaylie Blyton - Manager, Dispute Resolution

CASE STUDY:

Pre-Existing Conditions and Requesting a Review

Ms Grey joined her husband's existing hospital policy in November 2009 after becoming a permanent resident of Australia. Seven months after joining her hospital cover, Ms Grey experienced vomiting which worsened over a week. After visiting a GP, Ms Grey was sent for CT scans which showed she had a uterine fibroid. Following this diagnosis, Ms Grey was referred to a gynaecologist who advised that she would require surgery to have the uterine fibroid removed.

Ms Grey contacted her health fund about her pending admission and was sent PEC medical certificates. Ms Grey had the medical certificates completed by her GP and Gynaecologist and returned these to the fund. Based on the information provided by Ms Grey's doctors, the fund's medical advisor determined that the treatment was for a PEC as they deemed she would have exhibited signs and symptoms of a uterine fibroid in the six months prior to joining the fund in November 2009. In reaching this conclusion, the fund's Medical Advisor took into account the information provided by Ms Grey's gynaecologist indicating that the fibroid was of considerable size which would have caused pressure and vomiting.

Ms Grey disputed this decision, claiming that she did not exhibit any signs or symptoms until June 2010 when she first visited a GP. She also advised her fund that she did not attend a doctor for any illness within the six-month period proceeding her joining the hospital policy.

Ms Grey was not satisfied with her fund's decision and contacted the PHIO to request a review of her case. She explained that she had undergone a full medical in September 2009 as a requirement of her permanent resident visa application. This was followed by another medical check which she had performed overseas in a private hospital. She was certain that neither of these medical checks had indicated that she had a uterine fibroid and for this reason she strongly disagreed with the funds decision to decline hospital benefits on the basis that her treatment was for a PEC.

On investigating this complaint, the PHIO contacted the fund and requested a copy of the medical certificates along with a copy of the fund's Medical Advisor's Report. In addition to this, Ms Grey was able to request a copy of her medical report from the health check she had undergone in October 2009.

In light of the new information provided to the fund's Medical Advisor for review, it was concluded that Ms Grey's uterine fibroid was not a PEC and the Medical Advisor overturned their original decision. This resulted in the fund agreeing to pay full benefits toward Ms Grey's hospital admission for the treatment of her uterine fibroid.

Informed Financial Consent and Hospitals

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 2010-11, the office recorded 57 Informed Financial Consent (IFC) complaints against hospitals, compared to 34 the previous year, an increase which is probably attributable to the introduction of incidental fees at some hospitals as discussed in the following case study.

CASE STUDY:

Hospital Group's Mandatory Incidental Fee

This case concerns a large hospital group charging an out-of-pocket fee to patients for the use of Foxtel and Wi-Fi services during their hospital admission. PHIO has received a significant number of complaints about this fee, as patients are required to pay the fee, regardless of whether they wish to use these services. In this case, the patient is legally blind and is not able to use these services, yet the hospital insisted that the patient pay this fee or they would seek recovery action for the debt.

Ms Red needs medical treatment in hospital every three to four months. Ms Red presented to hospital earlier this year and was advised a $25 fee had been introduced for every admission to the hospital for the use of Foxtel and Wi-Fi services. Ms Red protested against the imposition of this fee as she is blind and uses hearing books; she does not watch television or use Wi-Fi services. The hospital insisted Ms Red pay this fee or it would be pursued through debt recovery action. Ms Red was quite upset about this as she is a frequent patient at the hospital. Ms Red requested PHIO investigate her complaint on the basis that she was not given a choice about whether to pay the fee or not.

This case raises a number of concerns. Firstly, it does not seem reasonable to impose a fee on all patients for discretionary services that some will not wish to use or, like Ms Red, they are not able to use. In its response to this office about Ms Red's complaint, the hospital group indicated that it obtains Informed Financial Consent (IFC) from patients to incurring the fee. An important tenet of IFC is the ability of the patient to choose whether they will pay the charges or seek other treatment options if they are unable or unwilling to incur the cost.

The Ombudsman recommended the hospital group waive the fee incurred by Ms Red; refund the fees charged to other patients that have complained about the issue to PHIO, a hospital or their health insurer; and agree to charge this fee only to patients who consent to incurring it in order to have access to Foxtel or Wi-Fi services.

The hospital group agreed to waive the fee incurred by Ms Red, however, rejected the Ombudsman's other recommendations. The reason given to PHIO was that the fee is

charged for access to these services, rather than for specific use. There is a limit to the number of occasions on which the fee may be charged, and the fee is waived for certain groups such as day chemotherapy patients and psychiatric patients.

At the time of writing, PHIO is continuing to receive complaints about this issue and is seeking advice from a number of sources in resolving this matter.

Overseas Visitors Health Cover

The Ombudsman assisted 58 consumers with complaints about Overseas Visitors Cover (for visitors to Australia); this is a decrease on the 71 complaints received in 2009-10.

Overseas visitor covers are not "complying health insurance policies" under the Act and these complaints are therefore not included in Figure 10, which lists complaints by each health insurer.

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

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

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

Some Overseas Visitor Health Cover (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

Rosie Edwards - Accounts, Tracey Salkeld - Administrative Assistant, Joanna Wong - Financial Controller, and Henny Oentojo - Executive Assistant

needs. Information to assist overseas visitors with selecting health insurance is available at www.privatehealth.gov.au.

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

Changes for the Overseas Student Health Cover Deed

In 2010-11, the Ombudsman contributed to the Department of Health & Ageing's review of the Overseas Student Health Cover (OSHC) Deed. OSHC was introduced in March 1989 to provide self-funded medical and hospital cover for overseas students and their dependents.

Five insurers re-entered into Deeds of Agreement with the Department of Health & Ageing for the period of 1 July 2011 to 1 July 2016, including: Australian Health Management, BUPA Australia, Lysaght Peoplecare (subcontracting to OSHC Worldcare), Medibank Private and NIB.

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

Major changes to the Deed include:

- Insurers can choose to impose a 12-month waiting period on obstetric services, similar to Australian residents' insurance;
- Emergency treatment continues to be exempt from the 12-month pre-existing condition waiting period and has now been more clearly defined; and
- Waiting periods for both in-hospital and out-of-hospital psychiatric treatment for a pre-existing psychiatric condition has been reduced from 12 months to 2 months, providing greater protection for students with mental health issues and in line with provisions of Australian residents' insurance.

Figure 17 **Complaint Sub-issues**

		2009–10	2010-11
Benefit	Accident and Emergency	8	10
Benefit	Accrued Benefits	6	5
Benefit	Ambulance	33	47
Benefit	Amount	116	50
Benefit	Delay in Payment	135	216
Benefit	Excess	45	47
Benefit	Gap - Hospital	59	51
Benefit	Gap - Medical	97	65
Benefit	High Cost Drugs*	-	7
Benefit	Level of Cover	236	427
Benefit	Limit Reached	45	29
Benefit	New Baby	13	7
Benefit	Non Health Insurance	5	25
Benefit	Non-Recognised Other Practitioner	42	28
Benefit	Non-Recognised Podiatry	26	28
Benefit	Other Compensation	6	6
Benefit	Out of Pocket Not Elsewhere Covered	29	27
Benefit	Out of Time	22	29
Benefit	Preferred Provider Schemes	27	27
Benefit	Prostheses	18	10
Benefit	Workers Compensation	1	3
Contract	2nd Tier Default Benefit	3	9
Contract	Hospitals	25	24
Contract	Preferred Provider Schemes	14	23
Cost	Dual Charging	3	2
Cost	Premiums	75	58
IFC	Doctors	33	39
IFC	Hospitals	34	57
IFC	Other	2	4
Incentives	Problems (LHC 30% rebate Medicare levy)	120	143
Information	Brochures and Websites	26	39
Information	Lack of Notification	96	59
Information	Oral	167	219
Information	Radio and Television	5	4
Information	Written Advice	21	46
Membership	Adult dependents	11	26
Membership	Arrears	62	68
Membership	Authority Over Membership	12	13
Membership	Cancellation/Suspension	141	176
Membership	Rate & Benefit Protection	5	10
Membership	Transfer/Continuity	90	177
Service	General Service Issues	252	462
Service	Premium Payment Problems	180	216
Waiting Period	Benefit Limitation Period	2	1
Waiting Period	General	18	26
Waiting Period	Obstetric	52	32
Waiting Period	Other	14	9
Waiting Period	Pre Existing Ailment	170	149
Other	Access	10	0
Other	Acute Care Certificates	3	3
Other	Community Rating	0	1
Other	Complaint Not Elsewhere Covered	51	34
Other	Confidentiality & Privacy	18	27
Other	Demutualisation/Sale Health Insurers	3	5
Other	Discrimination	2	1
Other	Fund Rule Change	143	200
Other	Non-Medicare Patient*	-	1
Other	Non-English Speaking Background	2	0
Other	Private Patient Election	2	3

* New sub-issue introduced in 2010-11

General Issues

Access and Public Awareness

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

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

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

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

To raise public awareness of the services provided by the Ombudsman, the following strategies were employed during 2010-11:

- Details of the Ombudsman's services were referenced in various government publications and in publications produced by other agencies and consumer bodies.
- Health insurers provide information about the availability of the Ombudsman's services and contact details in brochures, publications and in some correspondence to their members. These details are also included on health insurers' websites.
- The Ombudsman also contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites.
- The Ombudsman publishes a regular quarterly report which is distributed in both printed format and on the PHIO website.
- The Ombudsman hosts an internet site where consumers can access a range of brochures, Quarterly Bulletins, annual reports and fact sheets. The site enables consumers to make enquiries, lodge complaints, and request printed copies of brochures. Website users can subscribe to updates via an email newsletter or through RSS feeds. The website also links to other useful sites. The website is located at www.phio.org.au
- The Ombudsman conducted a number of media interviews and spoke at a number of health industry conferences during the year.

Relations with Stakeholders

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

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

The Ombudsman's website includes a Facts and Advice section, which provides factsheets about topics which are regularly raised by

consumers, such as why and how health premiums are assessed, and how to plan to be covered for pregnancy and obstetrics services. Factsheets on Podiatric Surgery, Assisted Reproductive Services, Plastic and Reconstructive Surgery, and Mental Health Treatment were added during this year. This area will continue to be reviewed and updated in response to consumer needs.

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

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

The Ombudsman held an industry Seminar in March 2011, focusing on consumer issues in private health. The seminar was well attended by fund and industry contacts. The presentations included:

- Dr Mark Sinclair, Chairman, Economics Advisory Committee of the Australian Society of Anaesthetists, on *Anaesthesia in 2011 and the Issue of Informed Financial Consent;*
- Ms Anna Wise, Senior Policy Manager, Consumers Health Forum, on *Private Health Insurance: What Consumers Want;*
- Mr Alastair Wilson, Acting Assistant Secretary, Private Health Insurance Branch of Department of Health & Ageing, on *Improving Private Health Insurance For Consumers;*
- Mr Shaun Gath, Chief Executive Officer, Private Health Insurance Administration Council, on *Regulating Private Health Insurance – PHIAC's Perspective;*
- Mr Chris Wheeler, Deputy Ombudsman, NSW Ombudsman, on *Managing Complainant Conduct for Better Outcomes;*
- Mr Rob Edwards, The Health Presenter on *Preventative Health;* and
- Mr Rob Seljak, Chief Executive Officer, Teachers' Union Health and Chair, PHI Code Compliance Committee, on *Recent Changes to PHI Industry Code of Conduct.*

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 128 responses (36.4%), a reasonable participation rate for a postal survey.

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

Overall, 88% of clients were satisfied or very satisfied with the overall handling of their complaint. This was steady from the satisfaction levels of the previous two years. This year also saw a marked improvement in the time taken to resolve complaints, with 92% of respondents happy with the turnaround time, up from 77% in the previous year.

Analysis of the results has shown that for complainants who obtain a payment or other outcome from a health insurer, satisfaction levels with the office were at 98%. This indicates that complainants correlate the service that the office provides directly with the outcome that the office is able to achieve, regardless of whether they are satisfied with the way the Ombudsman's staff deal with their complaint.

The challenge for the Ombudsman's office is to improve satisfaction levels for the complainants who indicated they weren't satisfied with the Ombudsman's office, who did not receive an outcome to their complaint that was satisfactory from their perspective.

Dispute Resolution Officers – Ursula Schappi, Damien Maynard and Kate Hocknull

In summary, of the respondents to the survey:

PHIO Client Satisfaction Results	2008/09	2009/10	2010/11
Overall Satisfaction	88%	87%	88%
Agreed that staff listened adequately	98%	96%	91%
Satisfied with Staff Manner	89%	86%	88%
Resolved complaint or provided adequate explanation	87%	89%	89%
Thought PHIO acted independently	87%	85%	85%
Would recommend PHIO to others	91%	87%	88%
Happy with time taken to resolve complaint	83%	77%	92%

Health Policy – Liaison with Other Bodies

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

Some significant activities included:

- submission to the ACCC's report to the Senate on Anti-Competitive and Other Practices by Health Funds and Providers in relation to private health insurance;
- submission to the Productivity Commission Study of the Performance of Public and Private Hospitals;
- 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;
- submission to the Department of Health and Ageing in relation to the revision of Overseas Student Health Cover.

Consumer Information Website

www.privatehealth.gov.au

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

Usage

The website recorded 311,572 unique visitors during the year, an increase of 17% on the previous year. Analysis of the available data suggests that growth of the site's usage can be attributed to the site becoming better known via recommendations and search results, as well as regular reminders of the site's existence in annual mailings of standard information statements and Lifetime Health Cover letters.

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

The office responded to 1109 consumer enquiries through the website in 2010-11, making up 89% of the total number of enquiries received by the office.

The most frequently raised questions are about the following topics:

- Lifetime Health Cover, especially about how this affects new migrants to Australia and Australians returning from overseas. The Lifetime Health Cover rules determine how much a person pays for hospital insurance;

Tanya Snowden – Project Officer

- The Medicare Levy Surcharge for high income earners and how to avoid the Surcharge by purchasing appropriate private hospital insurance;
- Waiting periods for people who are currently uninsured;
- How to use the website, locate information and compare policies;
- How to choose a health insurance policy; and
- Overseas visitors health cover, especially for subclass 457 visa holders and student visa holders.

Website Refresh

With the aim of improving the website's usefulness and appeal, the website underwent a full review and refresh in 2010. During the redesign and reorganisation process, PHIO consulted with consumer, industry and government stakeholders to ensure the new website would most effectively meet consumer needs.

The new website went live in July 2010 with a fresh look and new features allowing consumers to more easily find the information that they need about health insurance and to compare a range of policies. The new features include:

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

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

Survey Results

During the year, 706 users completed a survey about the website. The survey was one of a number of sources of feedback from consumers which was used to inform improvements to the website. In particular, survey respondents highlighted the difficulties they had in locating particular information they were looking for on the website. Survey results are used to highlight areas where improvements can be made to the website, to track satisfaction with the site and whether changes have been successful.

Since the website redesign went live in July 2010, feedback on both "Ease of Use" and "Location of Information" has improved considerably, and visual appeal also rates very highly. PHIO will continue to monitor user feedback and work on improving survey results. The key ratings for the site are summarised in **Figure 20.**

Further Website Developments

In 2011, PHIO received additional funding from the Department of Health & Ageing to maintain and improve the website. Under the Memorandum of Understanding with the Department, new developments which are expected to be released in the 2011-12 year include:

- Agreement Hospitals Locator will switch to a map-based format, allowing users to more easily locate private hospitals in their area and to check with which funds these hospitals have agreements;
- Health Fund Information page design will be improved so consumers can more easily locate the information they need and also access key performance information about each fund;
- Website animated videos will provide simple, visual guides on topics including how to compare policies, the major website features, and how the private health insurance system works.

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

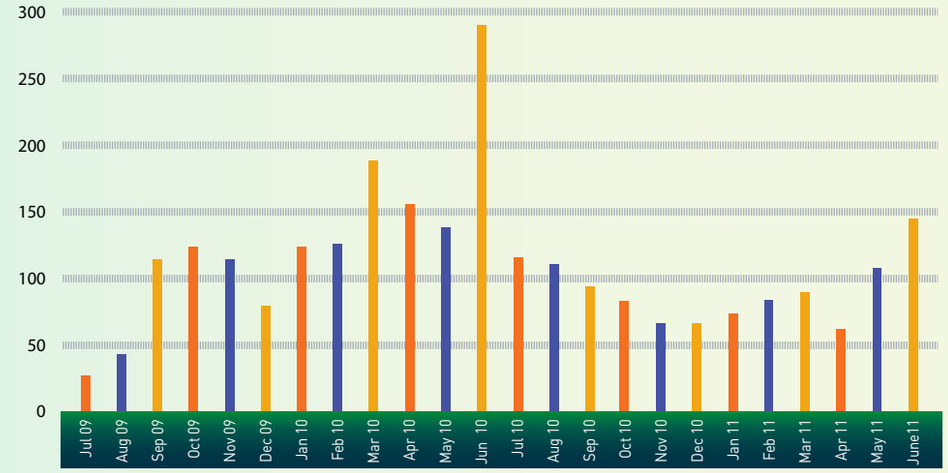
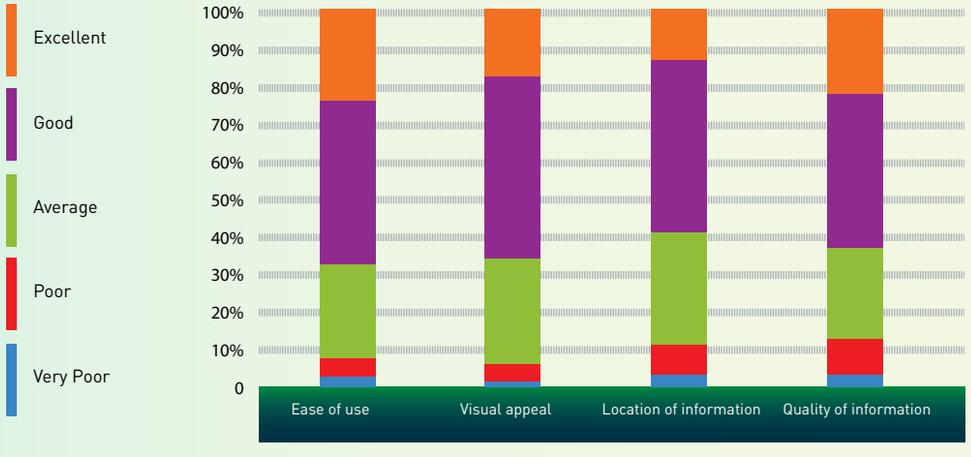


Figure 20 **Website Survey Ratings for www.privatehealth.gov.au**



Appendices

Statutory Reporting Information

Corporate Governance

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

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

Management of Human Resources

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

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

Organisational Structure

As at 30 June 2011, the permanent staff employed by the Private Health Insurance Ombudsman comprised:

Full-time and part-time employees	Female	Male	EFT
SES 2	1	-	1
EL 2	1	1	1.4
EL 1	2	-	1.4
APS 6	3	-	2.6
APS 5	3	2	4.3
APS 4	1	-	0.4
APS 3	1	-	0.2

EFT: 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 Development and Training

During the 2010-11 financial year, $35,084 was spent directly on PHIO staff attending training and development courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff. Staff training and development is an important priority for the office, to ensure staff members have the appropriate skills and knowledge to provide high level advice and services to consumers, as well as providing for staff career development, satisfaction and retention.

Staff Employment Status

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

All staff 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 employees in balancing their their work and family responsibilities effectively. The following table shows the numbers and status of staff who were employed on 30 June 2010.

Occupational Group	Women	Men	Total	NESB1
SES	1	0	1	0
Other	10	3	13	4
Total	**11**	**3**	**15***	**4**

SES: Senior Executive Service, Ombudsman
Other: All other staff – temporary and permanent
NESB1: Non-English speaking background, 1st generation
* Includes part-time employees and those on maternity leave. Actual EFT = 11.3

Performance Appraisal

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

All staff members are subject to a half-yearly and an annual performance appraisal. Salary and promotion advancement is based on performance and productivity.

Industrial Democracy

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

Accounting

The office utilises the MYOB suite of accounting programs internally and has contracted Complete GST Solutions for day-to-day administration of general accounting functions.

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

Outcomes and Outputs

The 2010-11 Portfolio Budget Statement (PBS) indicates that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 9, Private Health.

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

The Private Health Insurance Ombudsman's agency outcome is specified as *Public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting.*
The Ombudsman reports on achievements towards this outcome and a set of performance indicators (see the Performance section of this report for more information).

Consultancy Services

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

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

Human Solutions continued to maintain and develop the consumer website (privatehealth.gov.au) under the contract awarded in 2006. The contract was extended for a further two years and will expire in May 2013.

Resolution Consulting Services undertook a review of the PHIO's processes and controls to identify any areas of non compliance. The review concluded that the PHIO has in place processes and procedures which have adequate risk management and key controls are in place.

During 2010-11, 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 *Mind Your Own Business (MYOB) Accounting and Asset Manager.* In addition, the Ombudsman has a purpose-built Complaints Management and Reporting system on-site. PHIO's Internet service is supplied by iiNET.

Payroll Services

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

Fraud Control

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

Service Charter

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

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

Occupational Health and Safety

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

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

No reportable incidents occurred during the year.

Equal Employment Opportunity

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

Alison Leung - Senior Project and Policy Officer and Hilary Bassingthwaighte - Director, Programmes and Education

Advertising and Market Research

The Ombudsman did not conduct any advertising or market research in 2010-11 that meets the reporting requirements under Section 311A of the *Commonwealth Electoral Act 1918.*

Ecologically Sustainable Development and Environment Performance

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

The Ombudsman's office is located in a building that has achieved 3 Stars under the National Australian Built Environment Rating: Water and 2.5 Stars under the National Environment Building Rating: Energy. 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 2010-11 financial year.

Freedom of Information Statement

This statement is published to meet the requirements of *Section 8 of the Freedom of Information Act 1982 (FOI Act)*. It is correct as at 30 June 2011.

Establishment

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

Public Information

Reforms to the *Freedom of Information Act 1982* were introduced in November 2010. These reforms included the introduction of the Information Publication Scheme (IPS) for Australian Government agencies. The scheme aims to transform the FOI framework from one that responds to individual requests for access to documents to one that requires agencies to take a proactive approach to publishing information. The scheme commenced on 1 May 2011 and the Ombudsman has published its Information Publication Plan at www.phio.org.au. The FOI Act specifies nine categories of information that agencies must publish, in addition to the information publication plan:

1. details of the agency's structure (for example, in the form of an organisation chart);
2. details of the agency's functions, including its decision making powers and other powers affecting members of the public;
3. details of statutory appointments of the agency;
4. the agency's annual reports;
5. details of consultation arrangements for members of the public to comment on specific policy proposals;
6. information in documents to which the agency routinely gives access in response to requests under the FOI Act;
7. information that the agency routinely provides to Parliament;
8. details of an officer (or officers) who can be contacted about access to the agency's information or documents under the FOI Act;
9. the agency's operational information (which is information that assists the agency to exercise its functions or powers in making decisions or recommendations that affect members of the public. This includes the agency's rules, guidelines, practices and precedents relating to those decisions and recommendations.).

Requests

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

The Ombudsman has a policy of openness with the information it holds, with the exception of any material which would be deemed exempt.

Documents Available Free of Charge

The following brochures are available free of charge upon request:

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

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

Access to Documents

People may obtain documents:

- from the office of the Ombudsman located at Suite 2, Level 22, 580 George Street, Sydney NSW 2000
- by telephoning (02) 8235 8777 or 1800 640 695 (Free-call)
- by fax on (02) 8235 8778
- by e-mail to info@phio.org.au
- from the web site http://www.phio.org.au

Information and Procedures for Freedom of Information Act Requests

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

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

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

External Review and Scrutiny

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

Courts

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

Commonwealth Ombudsman

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

Other

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

Service Charter

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

Financial Information

Australian National
Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Ageing

I have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2011, 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; Schedule of Asset Additions; and Notes comprising a Summary of Significant Accounting Policies and other explanatory information.

Private Health Insurance Ombudsman's Responsibility for the Financial Statements

The Ombudsman is responsible for the preparation of financial statements that give a true and fair view in accordance with the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, including the Australian Accounting Standards, and for such internal control as the Ombudsman determines is necessary to enable the preparation of the financial statements that 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 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 agency'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 agency's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Ombudsman as well as evaluating the overall presentation of the financial statements.

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 2011 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
19 August 2011

Private Health Insurance Ombudsman

STATEMENT BY THE OMBUDSMAN

In my opinion, the attached financial statements for the year ended 30 June 2011 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

19 August 2011

Private Health Insurance Ombudsman Statement of Comprehensive Income

FOR THE PERIOD ENDED 30 JUNE 2011

	Notes	2011 $	2010 $
EXPENSES			
Employee benefits	2A	1,154,236	1,016,342
Supplier	2B	846,770	673,504
Depreciation and amortisation	2C	313,695	255,585
Finance costs	2D	1,676	-
Write-down and impairment of assets	2E	8,489	53,196
Total expenses		2,324,866	1,998,627
LESS:			
OWN-SOURCE INCOME			
Own-source revenue			
Sale of goods and rendering of services	3A	24,591	-
Other	3B	45,186	100,390
Total own-source revenue		69,777	100,390
GAINS			
Other	3C	16,000	15,690
Total gains		16,000	15,690
Net cost of (contribution by) services		2,239,089	1,882,547
Revenue from Government	3D	1,826,000	1,964,000
Surplus (Deficit)		(413,089)	81,453
OTHER COMPREHENSIVE INCOME			
Changes in asset revaluation reserves		99,981	-
Total other comprehensive income		99,981	-
Total comprehensive income (loss)		(313,108)	81,453

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

Private Health Insurance Ombudsman Balance Sheet

AS AT 30 JUNE 2011

	Notes	2011 $	2010 $
ASSETS			
Financial Assets			
Cash and cash equivalents	4A	22,742	54,193
Trade and other receivables	4B	2,316,722	2,355,722
Total financial assets		2,339,464	2,409,915
Non-Financial Assets			
Leasehold improvements	5A,C	165,480	37,000
Property, plant and equipment	5B,C	76,044	59,625
Intangibles	5D,E	832,446	837,078
Other	5F	7,482	13,200
Total non-financial assets		1,081,452	946,903
Total Assets		3,420,916	3,356,818
LIABILITIES			
Payables			
Suppliers	6A	33,285	142,490
Other payables	6B	279,700	-
Total payables		312,985	142,490
Provisions			
Employee provisions	7A	293,955	256,628
Other	7B	34,851	-
Total provisions		328,806	256,628
Total Liabilities		641,791	399,118
Net Assets		2,779,125	2,957,700
EQUITY			
Contributed equity		2,248,041	2,110,041
Reserves		99,981	-
Retained surplus		431,103	844,192
Total Equity		2,779,125	2,954,233

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

Private Health Insurance Ombudsman Statement of Changes in Equity

FOR THE PERIOD ENDED 30 JUNE 2011

	RETAINED SURPLUS		ASSET REVALUATION RESERVE		CONTRIBUTED EQUITY		TOTAL EQUITY	
	2011 $	2010 $	2011 $	2010 $	2011 $	2010 $	2011 $	2010 $
OPENING BALANCE								
Balance carried forward from previous period	844,192	762,739	-	-	2,110,041	2,110,041	2,954,233	2,872,780
Adjusted opening balance	844,192	762,739	-	-	2,110,041	2,110,041	2,954,233	2,872,780
COMPREHENSIVE INCOME								
Other comprehensive income	-	-	99,981	-	-	-	99,981	-
Surplus (Deficit) for the period	(413,089)	81,453	-	-	-	-	(413,089)	81,453
Total comprehensive income	(413,089)	81,453	99,981	-	-	-	(313,108)	81,453
CONTRIBUTIONS BY OWNERS								
Departmental capital budget	-	-	-	-	138,000	-	138,000	-
Sub-total transactions with owners	-	-	-	-	138,000	-	138,000	-
Closing balance as at 30 June	431,103	844,192	99,981	-	2,248,041	2,110,041	2,779,125	2,954,233

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

Private Health Insurance Ombudsman Cash Flow Statement

FOR THE PERIOD ENDED 30 JUNE 2011

	Notes	2011 $	2010 $
OPERATING ACTIVITIES			
Cash received			
Appropriations		2,065,000	1,845,000
Sales of goods and rendering of services		24,591	100,000
Other		31,760	16,600
Total cash received		2,121,351	1,961,600
Cash used			
Employees		1,116,909	954,307
Suppliers		828,040	654,884
Net GST paid		16,557	-
Total cash used		1,961,506	1,609,191
Net cash from (used by) operating activities	8	159,845	352,409
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		90,024	18,401
Purchase of intangibles		239,272	345,672
Total cash used		329,296	364,073
Net cash from (used by) investing activities		(329,296)	(364,073)
FINANCING ACTIVITIES			
Cash received			
Contributed equity		138,000	-
Total cash received		138,000	-
Net increase (decrease) in cash held		(31,451)	(11,664)
Cash and cash equivalents at the beginning of the reporting period		54,193	65,857
Cash and cash equivalents at the end of the reporting period	4A	22,742	54,193

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

Private Health Insurance Ombudsman Schedule of Commitments

AS AT 30 JUNE 2011

	2011 $	2010 $
BY TYPE		
Commitments receivable		
Net GST recoverable on commitments	146,703	21,335
Total commitments receivable	146,703	21,335
Commitments payable		
Other commitments		
Operating leases	1,336,750	73,115
Other	276,980	161,571
Total other commitments	1,613,730	234,686
Net commitments by type	1,467,027	213,351
BY MATURITY		
Commitments receivable		
One year or less	34,987	21,335
From one to five years	111,716	-
Total other commitments receivable	146,703	21,335
Commitments payable		
Operating lease commitments		
One year or less	269,450	73,115
From one to five years	1,067,300	-
Total operating lease commitments	1,336,750	73,115
Other Commitments		
One year or less	115,408	161,571
From one to five years	161,572	-
Total other commitments	276,980	161,571
Net commitments by maturity	1,467,027	213,351

NB: Commitments are GST inclusive where relevant.

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

Other commitments comprise of a contract for maintenance and development of the www.privatehealth.gov.au website. Payments are per the contract agreement. The contract will expire after 31 May 2013.

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

Private Health Insurance Ombudsman Schedule of Contingencies

AS AT 30 JUNE 2011

There were no contingent assets and liabilities as at 30 June 2011.

Private Health Insurance Ombudsman Schedule of Asset Additions

FOR THE PERIOD ENDED 30 JUNE 2011

The following non-financial non-current assets were added in 2010-11:

	LEASEHOLD IMPROVEMENTS $	PROPERTY, PLANT & EQUIPMENT $	INTANGIBLES $	TOTAL $
Additions funded in the current year				
By purchase - appropriation ordinary annual services				
Departmental capital budget	47,899	42,125	47,976	138,000
Ordinary operating costs	-	-	191,296	191,296
Total funded additions funded in the current year	47,899	42,125	239,272	329,296
Additions recognised in 2010-11 - to be funded in future years				
Make-good	33,175	-	-	33,175
Total future years/unfunded additions	33,175	-	-	33,175
Total additions	81,074	42,125	239,272	362,471

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

	Leasehold Improvements $	Property, Plant & Equipment $	Intangibles $	Total $
Additions funded in the current year				
By purchase - appropriation ordinary annual services				
Ordinary operating costs	-	18,401	345,672	364,073
Total funded additions funded in the current year	-	18,401	345,672	364,073
Total additions	-	18,401	345,672	364,073

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

Private Health Insurance Ombudsman Financial Statement Notes

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Objectives of the entity

The Private Health Insurance Ombudsman is an Australian Government controlled 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*.

The financial statements have been prepared in accordance with:

- Finance Minister's Orders (FMOs) for reporting periods ending on or after 1 July 2010; and
- Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

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

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

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. No new accounting standards, amendments to standards and interpretations issued by the AASB that are applicable in the current reporting period have had a material financial affect on the Private Health Insurance Ombudsman.

Future Australian Accounting Standard Requirements

New standards, amendments to standards, and interpretations issued by the AASB and are applicable to future reporting periods are not expected to have a financial impact on the Private Health Insurance Ombudsman.

1.5 Revenue

Revenue from the sale of goods is recognised when:

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

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

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

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

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any impairment allowance account. Collectability of debts is reviewed at end of 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 1.7).

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 2010-11, 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 twelve months of the end of reporting period are measured at their nominal amounts.

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

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

Leave

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

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

Separation and Redundancy

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

Superannuation

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

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

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

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:

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

1.11 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 not virtually certain

and contingent liabilities are disclosed when settlement is greater than remote.

1.14 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 price

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

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

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

Depreciation

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

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

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

	2011	2010
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 2011. 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.

1.15 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 years (2009-10: 5 years).

All software assets were assessed for indications of impairment as at 30 June 2011.

1.16 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:

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

NOTE 2: EXPENSES

	2011	2010
	$	$
NOTE 2A: EMPLOYEE BENEFITS		
Wages and salaries	967,473	826,257
Superannuation:		
Defined contribution plans	45,852	38,249
Defined benefit plans	97,862	83,640
Leave and other entitlements	37,326	62,036
Other employee expenses	5,723	6,160
Total employee benefits	1,154,236	1,016,342
NOTE 2B: SUPPLIERS		
Goods and services		
Accounting and audit	41,380	44,040
Brochures and printing	53,905	53,553
Consultants	24,597	16,329
Insurance	10,505	15,095
Legal	20,896	8,682
Media and advertising	45,708	22,583
Mediation	5,807	37,986
Recruitment	5,862	2,004
Stationery	2,878	1,699
Staff development	35,084	53,497
Travel and accommodation	56,067	73,501
Website	118,523	147,748
Other	161,184	120,963
Total goods and services	582,396	597,680
Goods and services are made up of:		
Rendering of services – related entities	-	59,851
Rendering of services – external parties	582,396	537,829
Total goods and services	582,396	597,680
Other supplier expenses		
Operating lease rentals – external parties:		
Minimum lease payments	260,039	70,835
Workers compensation expenses	4,335	4,989
Total other supplier expenses	264,374	75,824
Total supplier expenses	846,770	673,504

	2011	2010
	$	$
NOTE 2C: DEPRECIATION AND AMORTISATION		
Depreciation:		
Property, plant and equipment	27,387	24,373
Leasehold improvements	42,404	9,176
Total depreciation	69,791	33,549
Amortisation:		
Web development	237,765	219,046
Intangibles	6,139	2,990
Total amortisation	243,904	222,036
Total depreciation and amortisation	313,695	255,585
NOTE 2D: FINANCE COSTS		
Unwinding of discount	1,676	-
Total finance costs	1,676	-
NOTE 2E: WRITE-DOWN AND IMPAIRMENT OF ASSETS		
Asset write-downs and impairments from:		
Revaluation decrement - Leasehold improvements	-	40,969
Revaluation decrement - property, plant & equipment	-	9,982
Disposal of assets	8,489	2,245
Total write-down and impairment of assets	8,489	53,196

NOTE 3: INCOME

	2011	2010
OWN-SOURCE REVENUE	$	$
NOTE 3A: SALE OF GOODS AND RENDERING OF SERVICES		
Rendering of services - external parties	24,591	-
Total sale of goods and rendering of services	24,591	-
NOTE 3B: OTHER REVENUE		
MoU for website improvements	29,818	100,000
Other income	15,368	390
Total other revenue	45,186	100,390
NOTE 3C: OTHER GAINS		
Resources received free of charge	16,000	15,690
Total other gains	16,000	15,690

	2011	2010
REVENUE FROM GOVERNMENT	$	$

NOTE 3D: REVENUE FROM GOVERNMENT

Appropriations:		
Departmental appropriation	1,826,000	1,964,000
Total revenue from Government	1,826,000	1,964,000

NOTE 4: FINANCIAL ASSETS

	2011	2010
	$	$
NOTE 4A: CASH AND CASH EQUIVALENTS		
Cash on hand or on deposit	22,742	54,193
Total cash and cash equivalents	22,742	54,193
NOTE 4B: TRADE AND OTHER RECEIVABLES		
Goods and Services:		
Goods and services - related entities	200,000	-
Total goods and services	200,000	-
Appropriations receivable:		
For existing programs	2,116,722	2,355,722
Total appropriations receivable	2,116,722	2,355,722
Total trade and other receivables (net)	2,316,722	2,355,722
Receivables are expected to be recovered in:		
No more than 12 months	200,000	-
More than 12 months	2,116,722	2,355,722
Total trade and other receivables (net)	2,316,722	2,355,722
Receivables are aged as follows:		
Not overdue	2,316,722	2,355,722
Total receivables (gross)	2,316,722	2,355,722

NOTE 5: NON-FINANCIAL ASSETS

	2011	2010
	$	$
NOTE 5A: LEASEHOLD IMPROVEMENTS		
Leasehold improvements:		
Fair value	171,175	37,000
Accumulated depreciation	(5,695)	-
Total leasehold improvements	165,480	37,000

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 5B: PROPERTY, PLANT AND EQUIPMENT		
Property, Plant and Equipment:		
Fair value	100,645	69,052
Accumulated depreciation	(24,601)	(9,427)
Total property, plant and equipment	76,044	59,625

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. On 30 June 2011, an independent valuer conducted the revaluations.

A revaluation increment of $96,537 for leasehold improvements (2010: decrement of $40,969) and an increment of $3,444 for plant and equipment (2010: decrement of $9,981), totalling $99,981 were credited to the asset revaluation reserve by asset class and included in the equity section of the balance sheet; no decrements were expensed (2010: $50,950 expensed).

NOTE 5C: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT (2010-11)

	LEASEHOLD IMPROVEMENTS	PROPERTY, PLANT & EQUIPMENT	TOTAL
	$	$	$
As at 1 July 2010			
Gross book value	37,000	69,051	106,051
Accumulated depreciation and impairment	-	(9,427)	(9,427)
Net book value 1 July 2010	37,000	59,624	96,624
Additions*	81,074	42,125	123,199
Revaluations and impairments recognised in other comprehensive income	96,537	3,444	99,981
Depreciation expense	(42,404)	(27,387)	(69,791)
Disposals:			-
Other	(6,727)	(1,762)	(8,489)
Net book value 30 June 2011	165,480	76,044	241,524
Net book value as of 30 June 2011 represented by:			
Gross book value	171,175	100,645	271,820
Accumulated depreciation and impairment	(5,695)	(24,601)	(30,296)
	165,480	76,044	241,524

* Disaggregated additions information are disclosed in the Schedule of Asset Additions.

NOTE 5C (CONT'D): RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT (2009-10)

	LEASEHOLD IMPROVEMENTS	PROPERTY, PLANT & EQUIPMENT	TOTAL
	$	$	$
As at 1 July 2009			
Gross book value	90,986	120,197	211,183
Accumulated depreciation and impairment	(3,841)	(42,374)	(46,215)
Net book value 1 July 2009	87,145	77,823	164,968
Additions*	-	18,401	18,401
Revaluations and impairments recognised in the operating result	(40,969)	(9,981)	(50,950)
Depreciation expense	(9,176)	(24,373)	(33,549)
Disposals:			
Other	-	(2,245)	(2,245)
Net book value 30 June 2010	37,000	59,624	96,625
Net book value as of 30 June 2010 represented by:			
Gross book value	37,000	69,051	106,051
Accumulated depreciation and impairment	-	(9,427)	(9,427)
	37,000	59,624	96,624

* Disaggregated additions information are disclosed in the Schedule of Asset Additions.

	2011	2010
	$	$
NOTE 5D: INTANGIBLES		
Computer software:		
Purchased	1,560,409	1,344,656
Accumulated amortisation	(786,756)	(548,990)
Total computer software	773,653	795,666
Other intangibles:		
Purchased	67,922	44,402
Accumulated amortisation	(9,129)	(2,990)
Total other intangibles	58,793	41,412
Total intangibles	832,446	837,078

No indicators of impairment were found for intangible assets.

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

NOTE 5E: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF INTANGIBLES (2010-11)

	COMPUTER SOFTWARE PURCHASED	OTHER INTANGIBLES PURCHASED	TOTAL
	$	$	$
As at 1 July 2010			
Gross book value	1,344,656	44,402	1,389,058
Accumulated amortisation and impairment	(548,990)	(2,990)	(551,980)
Net book value 1 July 2010	795,666	41,412	837,078
Additions*	215,752	23,520	239,272
Amortisation	(237,765)	(6,139)	(243,904)
Net book value 30 June 2011	773,653	58,793	832,446
Net book value as of 30 June 2011 represented by:			
Gross book value	1,560,409	67,922	1,628,331
Accumulated amortisation and impairment	(786,756)	(9,129)	(795,885)
	773,653	58,793	832,446

* Disaggregated additions information are disclosed in the Schedule of Asset Additions.

NOTE 5E (CONT'D): RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF INTANGIBLES (2009-10)

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

* Disaggregated additions information are disclosed in the Schedule of Asset Additions.

	2011	2010
	$	$
NOTE 5F: OTHER NON-FINANCIAL ASSETS		
Prepayments	7,482	13,200
Total other non-financial assets	7,482	13,200
Total other non-financial assets - are expected to be recovered in:		
No more than 12 months	7,482	13,200
Total other non-financial assets	7,482	13,200

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

NOTE 6: PAYABLES

NOTE 6A: SUPPLIERS		
Trade creditors and accruals	33,285	142,490
Total supplier payables	33,285	142,490
Supplier payables expected to be settled within 12 months:		
External parties	33,285	142,490
Total	33,285	142,490
Total supplier payables	33,285	142,490

Settlement was usually made within 30 days.

NOTE 6B: OTHER PAYABLES		
GST payable to ATO	1,625	-
Unearned income	152,000	-
Lease liabilities	106,216	-
Other	19,859	3,467
Total other payables	279,700	3,467

NOTE 7: PROVISIONS

	2011	2010
	$	$
NOTE 7A: EMPLOYEE PROVISIONS		
Leave	293,955	256,628
Total employee provisions	293,955	256,628
Employee provisions are expected to be settled in:		
No more than 12 months	264,952	214,738
More than 12 months	29,003	41,890
Total employee provisions	293,955	256,628

NOTE 7B: OTHER PROVISIONS		
Provision for restoration obligations	34,851	-
Total other provisions	34,851	-
Other provisions are expected to be settled in:		
No more than 12 months	-	-
More than 12 months	34,851	-
Total other provisions	34,851	-

	PROVISION FOR RESTORATION	TOTAL
	$	$
Carrying amount 1 July 2010	-	-
Additional provisions made	33,176	33,176
Unwinding of discount	1,675	1,675
Closing balance 2011	34,851	34,851

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 8: CASH FLOW RECONCILIATION

	2011	2010
	$	$
Reconciliation of cash and cash equivalents as per Balance Sheet to Cash Flow Statement		
Cash and cash equivalents as per:		
Cash flow statement	22,742	54,193
Balance sheet	22,742	54,193
Difference	-	-
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	(2,239,089)	(1,882,547)
Add revenue from Government	1,826,000	1,964,000
Adjustments for non-cash items		
Depreciation / amortisation	313,695	255,585
Net write down of non-financial assets	8,489	53,196
Finance cost	1,676	-
Changes in assets / liabilities		
(Increase) / decrease in net receivables	39,000	(102,709)
(Increase) / decrease in prepayments	5,718	(11,240)
Increase / (decrease) in employee provisions	37,327	62,036
Increase / (decrease) in supplier payables	(109,204)	14,169
Increase / (decrease) in other payables	276,233	-
Net cash from (used by) operating activities	159,845	352,490

NOTE 9: SENIOR EXECUTIVE REMUNERATION

NOTE 9A: SENIOR EXECUTIVE REMUNERATION EXPENSE FOR THE REPORTING PERIOD

	2011	2010
	$	$
Short-term employee benefits:		
Salary	204,325	198,400
Annual leave accrued	15,708	15,088
Total short-term employee benefits	220,033	213,488
Post-employment benefits:		
Superannuation	30,673	27,107
Total post-employment benefits	30,673	27,107
Other long-term benefits:		
Long-service leave	7,068	6,790
Total other long-term benefits	7,068	6,790
Total	257,774	247,385

Notes:

1. Note 9A was prepared on an accrual basis.

2. Note 9A excludes acting arrangements and part-year service where remuneration expensed for a senior executive was less than $150,000.

NOTE 9B: AVERAGE ANNUAL REMUNERATION PACKAGES FOR SUBSTANTIVE SENIOR EXECUTIVES AS AT THE END OF THE REPORTING PERIOD

	As at 30 June 2011				As at 30 June 2010			
		FIXED ELEMENTS				FIXED ELEMENTS		
	NO. SES	SALARY $	ALLOWANCES $	TOTAL $	NO. SES	SALARY $	ALLOWANCES $	TOTAL $
Total remuneration (including part-time arrangements):								
$180,000 to $209,999	1	166,240	32,887	199,127	1	159,690	33,943	193,633
Total	1				1			

Variable Elements:

With the exception of bonuses, variable elements were not included in the 'Fixed Elements and Bonus Paid' table above. The following variable elements were a part of senior executives' remuneration package:

- leave entitlements; and
- super contributions.

NOTE 10: REMUNERATION OF AUDITORS

	2011 $	2010 $
Financial statement audit services were provided free of charge to the entity.		
Fair value of the services provided:		
Revenue received free of charge	16,000	15,690
Total	16,000	15,690

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

NOTE 11: FINANCIAL INSTRUMENTS

	2011 $	2010 $
NOTE 11A: CATEGORIES OF FINANCIAL INSTRUMENTS		
Financial Assets		
Cash and cash equivalents	22,742	54,193
Trade and other receivables	200,000	-
Total	222,742	54,193
Carrying amount of financial assets	222,742	54,193
Financial Liabilities		
Trade creditors	33,285	142,490
Total	33,285	142,490
Carrying amount of financial liabilities	33,285	142,490

NOTE 11B: FAIR VALUE OF FINANCIAL INSTRUMENTS

	CARRYING AMOUNT 2011 $	FAIR VALUE 2011 $	CARRYING AMOUNT 2010 $	FAIR VALUE 2010 $
Financial Assets				
Cash and cash equivalent	22,742	22,742	54,193	54,193
Trade and other receivables	200,000	200,000	-	-
Total	222,742	222,742	54,193	54,193
Financial Liabilities				
Trade creditors	33,285	33,285	142,490	142,490
Total	33,285	33,285	142,490	142,490

NOTE 11C: 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 11D: 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 11E: 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 12: APPROPRIATIONS

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

	2011 Appropriations			Appropriation applied in 2011 (current and prior years) $	Variance $
	Appropriation Act Annual Appropriation $	*FMA Act* Section 31 $	Total appropriation $		
DEPARTMENTAL					
Ordinary annual services	1,826,000	69,777	1,895,777	1,928,558	(32,781)
Other services					
Equity	138,000	-	138,000	-	138,000
Total departmental	1,964,000	69,777	2,033,777	1,928,558	105,219

	2010 Appropriations			Appropriation applied in 2010 (current and prior years) $	Variance $
	Appropriation Act Annual Appropriation $	*FMA Act* Section 31 $	Total appropriation $		
DEPARTMENTAL					
Ordinary annual services	1,964,000	100,390	2,064,390	1,609,191	455,199
Total departmental	1,964,000	100,390	2,064,390	1,609,191	455,199

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

Authority	2011 $	2010 $
2005-2006 Appropriation Act 1	1,514,722	1,514,722
2007-2008 Appropriation Act 1	338,000	338,000
2008-2009 Appropriation Act 1	230,000	350,000
2009-2010 Appropriation Act 1	-	119,000
2007-2008 Appropriation Act 3	34,000	34,000
Total	2,116,722	2,355,722

NOTE 13: SPECIAL ACCOUNTS

The Private Health Insurance Ombudsman has a Special Account established with the name Services for Other Enitities and Trust Moneys Special Account (Departmental). This account was abolished in 2011 due to it being inactive and has a nil balance.

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	
	2011 $	2010 $
Expenses		
Departmental	2,324,866	1,998,627
Total	2,324,866	1,998,627
Other own-source income		
Departmental	85,777	116,080
Total	85,777	116,080
Net cost/(contribution) of outcome delivery	2,239,089	1,882,547

NOTE 14B: MAJOR CLASSES OF DEPARTMENTAL EXPENSE, INCOME, ASSETS AND LIABILITIES BY OUTCOME

	Outcome 1	
	2011	2010
	$	$
Departmental Expenses:		
Employee benefits	1,154,236	1,016,342
Supplier expenses	846,770	673,504
Depreciation and amortisation	313,695	255,585
Write-down and impairment of assets	8,489	53,196
Finance cost	1,676	-
Total	2,324,866	1,998,627
Departmental Income:		
Revenue from Government	1,826,000	1,964,000
Other own-source revenue	85,777	116,080
Total	1,911,777	2,080,080
Departmental Assets		
Financial assets	2,339,464	2,409,915
Non-financial assets	1,081,452	946,903
Total	3,420,916	3,356,818
Departmental Liabilities		
Payables	312,985	145,957
Provisions	328,806	256,628
Total	641,791	402,585

NOTE 15: COMPREHENSIVE INCOME (LOSS) ATTRIBUTABLE TO THE ENTITY

	2011	2010
	$	$
Total Comprehensive Income (loss) attributable to the entity		
Total comprehensive income (loss)*	(313,108)	81,453
Plus: non-appropriated expenses		
Depreciation and amortisation expenses	313,695	-
Total comprehensive income (loss) attributable to the entity	587	81,453

* As per the Statement of Comprehensive Income.

Glossary

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

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

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

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

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

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

Fund: Private health insurance provider.

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

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

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

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

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.

Insurer: Private health insurance provider.

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

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

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 students which can be purchased from some Australian private health insurers. It is a requirement to hold this type of insurance under certain visas.

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

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

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

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

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List of Requirements

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A.5		Table of contents	Mandatory	3
A.5		Index	Mandatory	89
A.5		Glossary	Mandatory	88
A.5		Contact officer(s)	Mandatory	1
A.5		Internet home page address and internet address for report	Mandatory	1
9.1	Review by Secretary	Review by departmental secretary	Mandatory	5
9.2		Summary of significant issues and developments	Suggested	5
9.2		Overview of department's performance and financial results	Suggested	Not applicable
9.2		Outlook for following year	Suggested	Not applicable
10	Departmental overview	Overview description of department	Mandatory	12
10.1		Role and function	Mandatory	12
10.1		Organisational structure	Mandatory	46
10.1		Outcome and program structure	Mandatory	14-15, 47
10.2		Where outcome and program structures differ from PB Statements/PAES or other portfolio statements accompanying any other additional appropriation bills (other portfolio statements), details of variation and reasons for change	Mandatory	14-15, 47
10.3		Portfolio structure	Portfolio departments – mandatory	Not applicable
11.1	Report on Performance	Review of performance during the year in relation to programs and contribution to outcomes	Mandatory	14-15
11.1		Actual performance in relation to deliverables and KPIs set out in PB Statements/PAES or other portfolio statements	Mandatory	14-15
		Performance of provider/purchase arrangements	If applicable, suggested	Not applicable
11.1		Narrative discussion and analysis of performance	Mandatory	14-38
11.1		Trend information	Mandatory	14-38
11.1		Significant changes in nature of principal functions/services	Suggested	Not applicable
11.1		Factors, events or trends influencing departmental outcomes	Suggested	Not applicable
11.1		Contribution of risk management in achieving objectives	Suggested	Not applicable
11.1		Social justice and equity impacts	Suggested	Not applicable
11.2		Performance against service charter customer service standards, complaints data and the department's response to complaints	If applicable, mandatory	40-41
11.3		Discussion and analysis of the department's financial performance	Mandatory	57-86
11.3		Discussion of any significant changes from the prior year or from budget.	Suggested	Not applicable
11.4		Agency resource statement and summary resource tables by outcome	Mandatory	84
11.5		Developments since the end of the financial year that have affected or may significantly affect the department's operations or financial results in future	If applicable, mandatory	Not applicable
	Management accountability			
12.1	Corporate governance			
12.1		Statement of the main corporate government in practice	Mandatory	46
12.1		Names of the senior executive and their responsibilities	Suggested	46
12.1		Corporate and operational planning and associated performance reporting and review	Suggested	Not applicable

Ref*	Part of Report	Description	Requirement	Location (page no.)
12.1		Approach adopted to identifying areas of significant financial or operational risk	Suggested	Not applicable
12.1		Agency heads are required to certify that their agency comply with the Commonwealth Fraud Control Guidelines.	Mandatory	48
12.1		Policy and practices on the establishment and maintenance of appropriate ethical standards	Suggested	Not applicable
12.1		How nature and amount of renumeration for SES officers is determined	Suggested	Not applicable
12.2	External scrutiny	Significant developments in external scrutiny	Mandatory	52
12.2		Judicial decisions and decisions of administrative tribunals	Mandatory	52
12.2		Reports by the Auditor-General, a Parliamentary Committee or the Commonwealth Ombudsman	Mandatory	52
12.3	Management of human resources	Assessment of effectiveness in managing and developing human resources to achieve departmental objectives	Mandatory	46
12.3		Workforce planning, staff turnover and retention	Suggested	Not applicable
12.3		Impact and features of enterprise or collective agreements, determinations, common law contracts and AWAs	Suggested	Not applicable
12.3		Training and development undertaken and its impact	Suggested	Not applicable
12.3		Occupational health and safety performance	Suggested	48
12.3		Productivity gains	Suggested	Not applicable
12.3		Statistics on staffing	Mandatory	47
12.3		Enterprise or collective agreements, determinations, common law contracts and AWAs	Mandatory	47
12.3		Performance pay	Mandatory	47
12.4	Assets management	Assessment of effectiveness of assets management	If applicable, mandatory	67-68
12.5	Purchasing	Assessment of purchasing against core policies and principles	Mandatory	Not applicable
12.6	Consultants	The annual report must include a summary statement detailing the number of new consultancy services contracts let during the year; the total actual expenditure on all new consultancy contracts let during the year (inclusive of GST); the number of ongoing consultancy contracts that were active in the reporting year; and the total actual expenditure in the reporting year on the ongoing consultancy contracts (inclusive of GST). The annual report must include a statement noting that information on contracts and consultancies is available through the AusTender website. (Additional information as in Attachment D to be available on the Internet or published as an appendix to the report. Information must be presented in accordance with the pro forma as set out in Attachment D.)	Mandatory	47-48
12.7	Australian National Audit Office Access Clauses	Absence of provisions in contracts allowing access by the Auditor-General	Mandatory	Not applicable
	Mandatory	Not applicable	Mandatory	
12.8	Exempt contracts	Contracts exempt from the AusTender	Mandatory	Not applicable
12.9	Commonwealth Disability Strategy	Report on performance in implementing the Commonwealth Disability Strategy	Mandatory	48
13	Financial Statements	Financial Statements	Mandatory	57-86
14.1		Occupational health and safety (section 74 of the Occupational Health and Safety Act 1991)	Mandatory	48
14.1		Freedom of Information (subsection 8(1) of the Freedom of Information Act 1982)	Mandatory	50-51
14.1		Advertising and Market Research (Section 311A of the Commonwealth Electoral Act 1918) and statement on advertising campaigns	Mandatory	49
14.1		Ecologically sustainable development and environmental performance (Section 516A of the Environment Protection and Biodiversity Conservation Act 1999)	Mandatory	49
14.2	Others	Grant programs	Mandatory	49
14.3		Correction of material errors in previous annual report	If applicable, mandatory	Not applicable
F		List of Requirements	Mandatory	90
F		List of Requirements	Mandatory	90

Notes

Australian Government

Private Health Insurance Ombudsman

Protecting the interests of people covered by private health insurance