Private Health Insurance
OMBUDSMAN

1999
ANNUAL REPORT

Contact Details

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

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1800 640 695 (Free Call)

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

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13 25 44 (National Relay Service)

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Hours of operation

8.30 am - 5.00 pm (Sydney time) Monday - Friday

Readers with inquiries about the Ombudsman or this report should contact the Director, Corporate Services at the above address.

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

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Private Health Insurance
OMBUDSMAN

The Hon Dr Michael Wooldridge MP
Minister for Health and Aged Care
Parliament House
CANBERRA ACT 2600

Dear Minister

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

I have pleasure in submitting to you for presentation to the Parliament the Private Health Insurance Ombudsman's Annual Report, for the period 1 July 1998 to 30 June 1999.

The report has been prepared in accordance with government guidelines for the preparation of annual reports and financial statements.

Yours sincerely

Norman W Branson

OMBUDSMAN

20 August 1999

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Ombudsman's Overview

Norman Branson
Private Health Insurance Ombudsman

In July 1999, I was appointed to the position of Private Health Insurance Ombudsman for a three year term commencing on 2 August 1999.

The office of the Ombudsman is one of the key elements of the Federal Government's commitment to private health insurance reforms and this office will work within the broader private health environment to ensure that the private health insurance industry is more responsive and consumer focussed.

While the principal focus of the office must of necessity continue to be the resolution of individual complaints, the longer-term strategy must be to address the underlying causes of these complaints and seek perpetual solutions from stakeholders.

The core function of the office is the resolution of complaints that fall within the definition contained in Section 82ZS of the National Health Act 1953. Complaints can be in respect of health funds, hospitals, doctors and some dentists. These complaints continue to constitute the greatest call on the resources of the office. There is also considerable workload associated with responding to general consumer inquiries which do not meet the Section 82ZS definition. It is pleasing to note that the Government is seeking a more appropriate avenue to address these general inquiries.

It is reasonable to assume there will always be consumer complaints about the level of benefits, cost of insurance and the coverage supplied by particular products. However, it is the more significant underlying problems which continue to exist that need a fundamental assessment. The issues currently in this category include disputes on the interpretation of pre-existing ailment rules, portability between health funds, informed financial consent and the medical gap. The industry and Government are currently addressing these questions and if resolution can be reached, together with the introduction and acceptance of key features statements within health fund promotional material, this will provide consumers with greater levels of certainty about the product that they purchase.

Although the number of complaints is not small, it needs to be viewed in the context of the nearly one and a half million hospital episodes and the seventy eight million ancillary services that were provided to privately insured patients during the reporting year. The overall number of Section 82ZS complaints received by the office this year is marginally lower than the previous year, but the number of inquiries has significantly increased.

A review of the statistics indicates that greater emphasis is being placed on dispute resolution within the individual health funds and this leads to a lessening of the complaint load for this office. In addition, some of the Government's reforms to the industry, in particular the 30% rebate on premiums, have had a major effect on the level of complaint. The 30% rebate has led to a reduction in complaints about price, from 529 in 1997/98 to 135 in 1998/99.

Although it is pleasing to report a lessening of complaint numbers, complaints within the significant areas detailed above and by some individual funds are still a concern. Every effort is being made to reduce the levels of complaint by modifying fund behaviour and where necessary fund rules. This is an on-going process.

Role and Function

Introduction

The Private Health Insurance Ombudsman is an independent statutory corporation established by the Health Legislation (Private Health Insurance Reform) Amendment Act 1995 which amended certain parts of the National Health Act 1953.

The Ombudsman was originally established in late 1995 as the Private Health Insurance Complaints Commissioner. Following the passage of legislation through the Parliament in 1998, the Ombudsman replaced the former Complaints Commissioner.

The Ombudsman adds value for those who insure privately by providing an independent means of resolving problems about private health insurance.

Functions

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

- deal with complaints and conduct investigations;
- publish aggregate data about complaints;
- make recommendations to the Minister or Department of Health and Aged Care;
- make available and publicise the existence of the Private Patients' Hospital Charter; and
- promote an understanding of the Ombudsman's functions.

In 1997, the Ombudsman was also given jurisdiction to deal with complaints concerning health funds' management of the Federal Government's new Private Health Insurance Incentives Scheme.

In 1998, by Ministerial Determination under Schedule 1 of the National Health Act 1953, the Ombudsman was given jurisdiction to arbitrate disputes between private hospitals and health funds regarding second tier default benefits payable in respect of health fund members.

Legislative amendments to the National Health Act 1953 currently before the Parliament will give the Ombudsman explicit jurisdiction to deal with complaints about the 30% Rebate for private health insurance which was introduced on 1 January 1999.

Who can make a complaint?

Complaints may be made in writing, by telephone, fax, e-mail or in person by:

- health fund members;
- doctors and some dentists;
- hospitals and day hospital facilities;
- health funds; and
- persons acting on behalf of any of the above, including a family member, lawyer or friend.

What can the Ombudsman do with a complaint?

The Ombudsman is able to deal with complaints by:

- mediation;
- referring the complaint to the health fund 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 fund's explanation or proposed action, the Ombudsman may investigate the complaint;
- referring the complaint to the Australian Competition and Consumer Commission; and
- referring the complaint to any other appropriate body.

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

Staff of the Ombudsman
Rear Left to Right: Roger Gimblett, Norman Branson, Samantha Gavel, Anthony Fisk,
Front Left to Right: Jacqueline Power, Sasha Andrews, Alia Williams

What happens at the end of a complaint or investigation?

The Ombudsman is able to recommend that:

- health funds, hospitals, doctors and dentists take a specific course of action in relation to a complaint; and
- a health fund changes its rules.

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

Section 82ZSG of the National Health Act 1953 provides various grounds for the Ombudsman to decide not to deal with a complaint.

These include if the complaint is trivial, vexatious or frivolous, if the complainant has not taken reasonable steps to negotiate a settlement, if the complainant does not have a sufficient interest in the subject matter of the complaint, or if another organisation is dealing adequately with the complaint.

How staff resolve complaints

The Ombudsman deals with most complaints by telephone and fax. Where complainants have not attempted to resolve their complaint with their health fund, staff will usually refer complainants back to the fund in the first instance.

Where complaints are complex or where informal contact with the health fund is unable to resolve the problem, the Ombudsman will write to the health fund seeking further information.

Staff of the Ombudsman's office keep complainants regularly informed of developments about their complaint, usually by telephone.

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

Performance

Introduction

The Ombudsman received 1812 complaints in the reporting period 1 July 1998 to 30 June 1999, slightly lower than the 1997/98 high of 1966 complaints. This was made up of 940 disputes, 529 grievances and 343 problems. The office also recorded 2261 inquiries which do not fall within the definition of a complaint under Section 82ZS of the National Health Act 1953. Figure 1 shows the number of approaches to the Ombudsman during the financial year.

Recording complaints

An approach to the Ombudsman's office is recorded as a complaint when it meets the criteria contained in the National Health Act 1953. A complaint must be:

- an expression of dissatisfaction with any matter arising out of or connected with a private health insurance arrangement;
- made by a health fund member, hospital, doctor (including some dentists), a health fund or someone acting on their behalf; or be
- made about a health fund, hospital, doctor (including some dentists).

Complaints are categorised by the degree of effort needed for their solution. Currently this categorisation is:

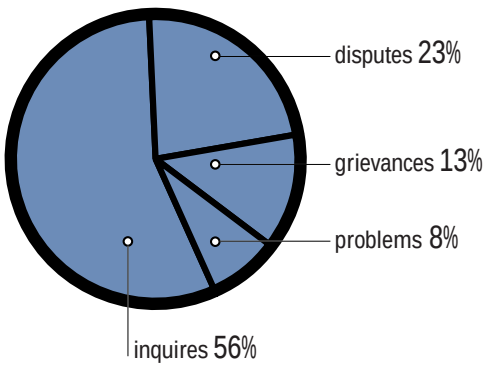
- **Disputes: Highest level of complaint where significant intervention is required**

  Disputes are dealt with by contacting the health fund, hospital, doctor or dentist about the matter. Issues in this category will have previously been the subject of dispute between the complainant and the respondent and have not been resolved. The Ombudsman attempts resolution through conciliation by telephone or in writing.

- **Grievances: Moderate level of complaint where mediation is required**

  Grievances are dealt with by staff of the Ombudsman investigating the complainant's grievance directly and providing additional information or a clearer explanation.

Figure 1: Approaches to the Ombudsman 98-99



- **Problems: Lower level of complaint**

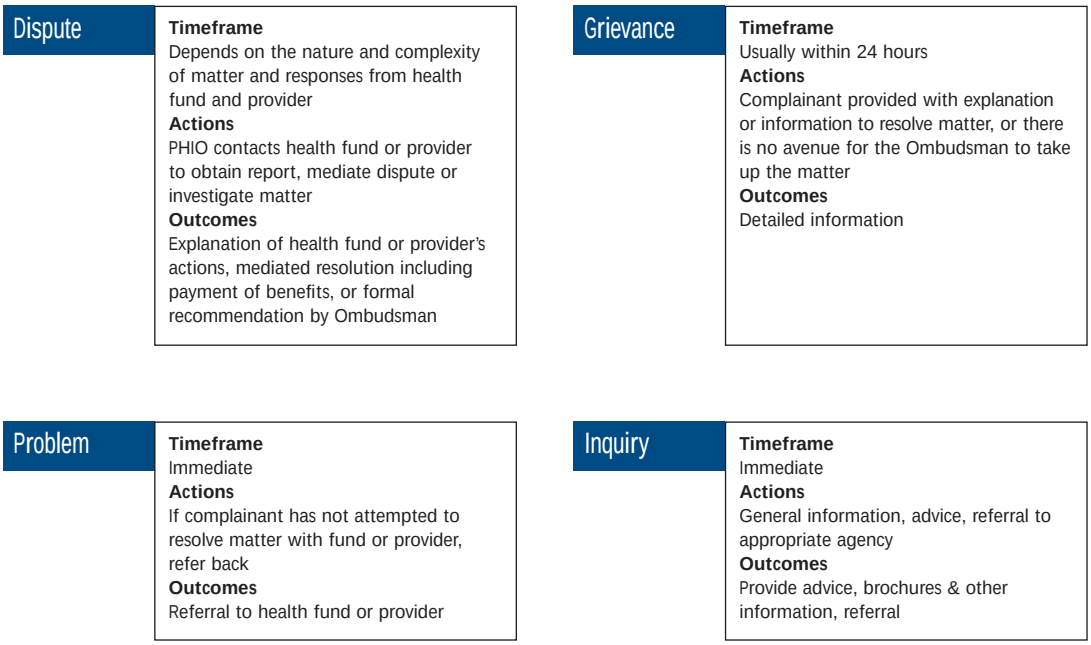
  Problems are dealt with by referring the complainant back to the health fund, hospital, doctor or dentist. This occurs where, in the view of the Ombudsman, the complainant has not made an adequate attempt to resolve the problem, or the Ombudsman is able to suggest to the complainant other ways to approach the problem with the health fund, hospital, doctor or dentist.

The process and timeframes for handling these issues are shown in Figure 2.

The majority of complaints handled are from fund members about their own fund.

Fund members can also lodge complaints about their hospital, doctor or other practitioner but these are small in number. Hospitals and providers can also lodge complaints about health funds. These are also numerically small but generally of a complex nature.

Figure 2: Steps in handling approaches to the Ombudsman



Performance

- **Workload**

  The office received 1812 complaints (problems, grievances and disputes) in 1998/99, an average of 151 complaints per month. This figure is slightly down compared with an average of 164 complaints received per month in the previous year. The office attributes much of this reduction to the sharp decline in the number of complaints about cost of premiums following the introduction of the 30% Federal Government Rebate.

The office finalised 1806 complaints during the year (an average of 150 per month), compared with an average 164 complaints finalised per month in the previous year. Comparative Statistics are depicted in Figure 3.

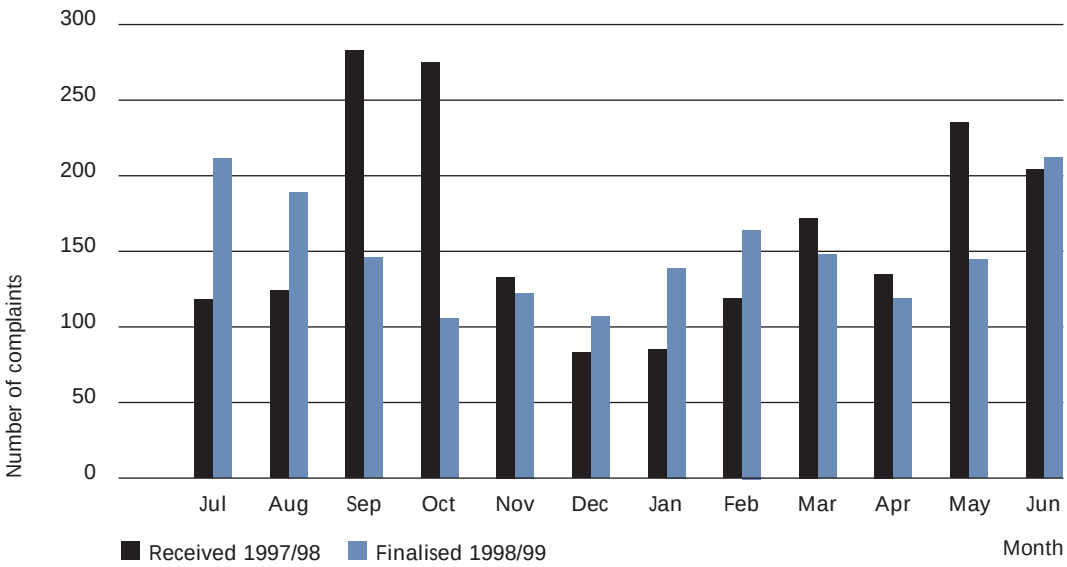
In a slight departure from past reporting, this report will concentrate in the main on complaints and will only provide passing reference to general inquiries. There is further emphasis within the complaints on the category of disputes. This is in line with the decision of the office to provide data and information that will assist in determining a long term solution to the underlying fundamental problems facing consumers.

Complaint Issues

The highest number of complaints this year concerned benefits, accounting for 30% of all complaints received. Benefit sub issues include the extent of cover, amount of benefit, gap payments, excess, limits, compensation, payment delays, and out of pocket expenditure.

14% of complaints received by the Ombudsman during the financial year related to the issue of 'Waiting Periods'; this category includes complaints about the application of waiting periods for pre-existing ailments and obstetric services. Waiting periods and the determination of pre-existing ailments

Figure 3: Complaints (Problems, Grievances and Disputes) Recieved



constitute the single most vexed issue for consumers. There are still inconsistencies between funds on the interpretation and application of the pre-existing ailment rule which makes it difficult to apply a standard approach to consumer complaints in this area. A level of consistency is required both in the interpretation of the rule, and in the dissemination of information to members.

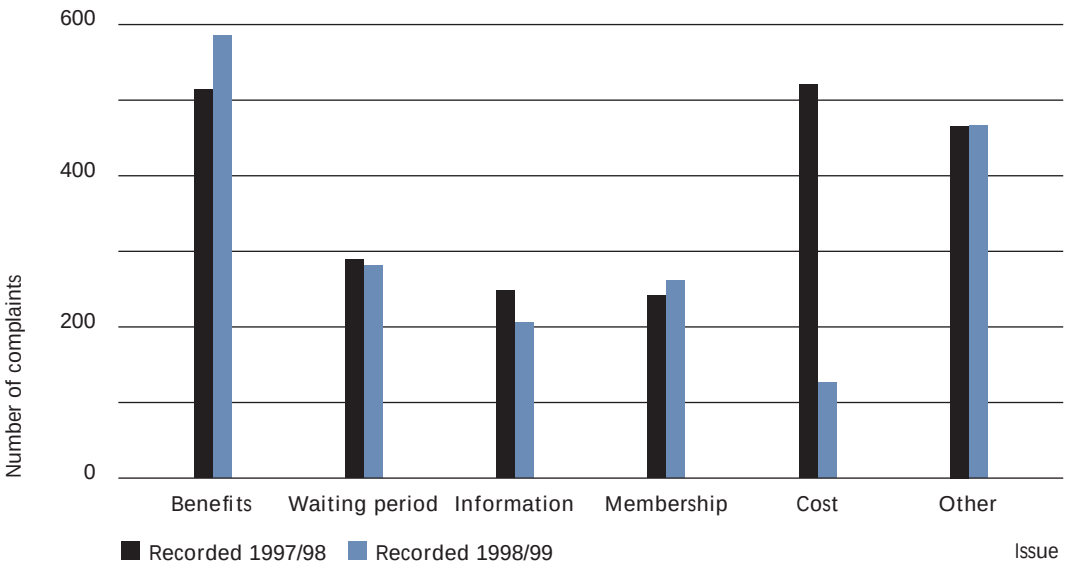
Complaints about 'Membership' accounted for 14% of complaints received and included concerns about the cancellation or suspension of a health fund membership.

Complaints about 'Information' accounted for 11% of all complaints received and these complaints concerned issues such as misleading information, inadequate information and the lack of appropriate information.

Complaints in which 'Cost' was the issue were down significantly from the previous year (7% compared to 23% in 1997/98). The decrease in the number of complaints about cost can be correlated to the Federal Government's 30% Rebate reforms. Complaints relating to cost concern the price of health fund premiums, differential charging of privately insured patients by some health providers and alleged lack of informed financial consent to health providers' fees and charges.

The remaining 24% of complaints dealt with a wide variety of other issues including health fund rule changes, the quality of customer service from a health fund, premium payment difficulties, private patient elections in public hospitals, the Private Health Insurance Incentives Scheme and health fund and hospital contracting arrangements. These are shown in Figure 4.

Figure 4: Complaint (Problems, Grievances and Disputes) Issues



Performance

Complaints by State/Territory

Figure 5 identifies on a state by state basis where complaints originate. This data is shown against the percentage of people who have private health insurance coverage in each state.

The data suggests that outside of the Eastern Seaboard States, the existence of the Ombudsman and the responsibilities of the office may not be as widely known.

Time taken to resolve Complaints

Figure 6 provides information on the time taken to resolve complaints and shows a marginal increase in resolution time. This variation is indicative of the fact that the mix of complaint type is changing, with the more complex disputes having a higher profile. Figure 7 shows this trend.

Response from funds on complaint handling is continuing to improve and most health funds respond to informal telephone requests for information by the Ombudsman's staff, which explains why many complaints are resolved in less than one week.

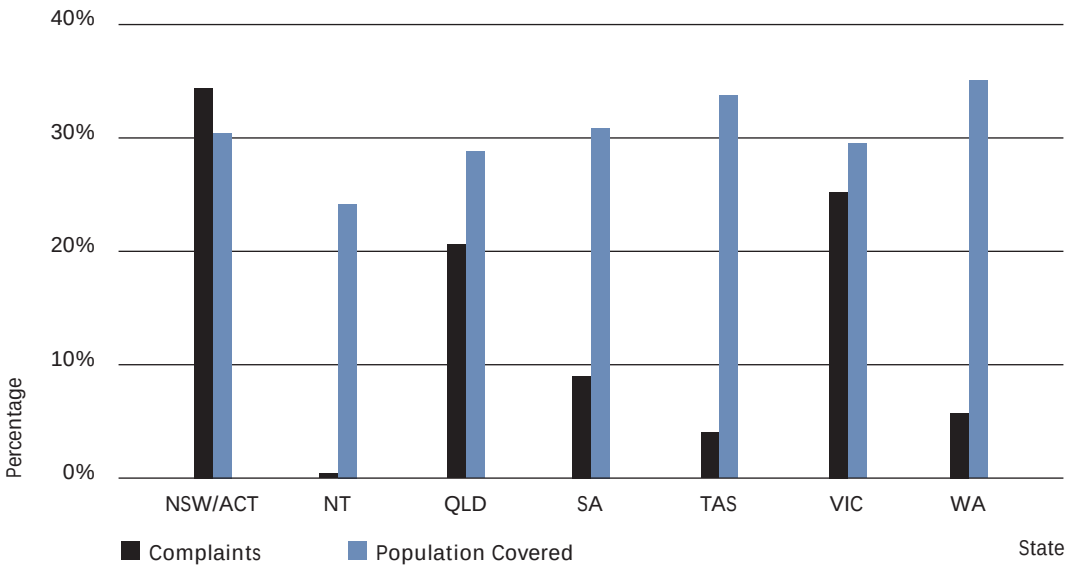
Who was complained about

Most complaints were made about health funds (1749), followed by hospitals (88) and doctors and dentists (49). Because some complaints concern a health fund as well as a hospital, doctor or dentist, the total number of organisations or people being complained about (1886) adds up to more than the total number of complaints (1812).

The number of complaints received each month against health funds, hospitals and doctors is provided at Figure 8.

Figure 5: Complaints (Problems, Grievances & Disputes) by Population Covered by Private Health Insurance

Source: Population Covered, Private Health Insurance Administration Council, June 99 Quarterly Statistics.



The information has been further broken up into problems, grievances and disputes which make up the three-tiered complaint resolution process.

Complaints about health funds

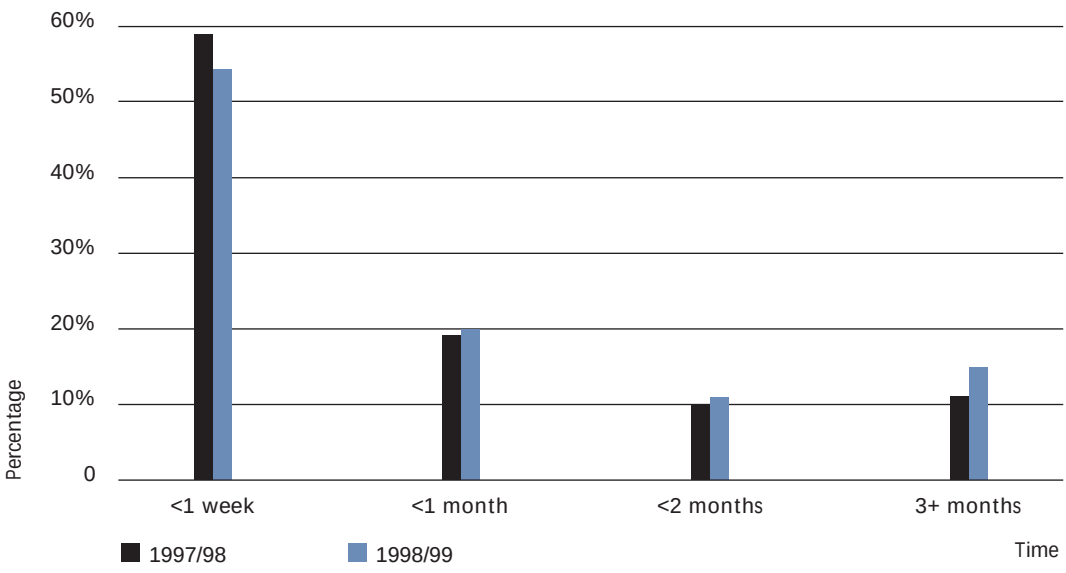
Figure 9 provides a summary of all complaints (problems, grievances and disputes) for individual health funds compared with their market share. This data is further dissected with respect to the higher category "disputes", again by market share. Analysing the information at this further level of detail provides a more realistic picture of the way funds respond to their members' complaints in general and to the higher level issues included in the dispute category.

Complaints about hospitals

Complaints about hospitals usually concern unexpected out of pocket expenses, due to incomplete or misleading advice provided around the time of admission, or as a result of confusion by the health fund member about the extent of their health insurance cover. The National Health Act 1953 requires a hospital which has an agreement with a health fund to inform a potential patient of any out of pocket expenses associated with a hospital episode. In quite a number of instances this is not occurring.

There is insufficient data to enable analysis of the complaints with respect to their geographic distribution, hospital speciality or ownership.

Figure 6: Time to finalise compaints (Problems, Grievances & Disputes)



Performance

Complaints about doctors and dentists

Most complaints about doctors concern the lack of informed financial consent. As with the hospitals, there is insufficient data available to enable analysis with respect to their geographic distribution or medical speciality.

Resolving complaints

51% of complaints are resolved by the Ombudsman's office providing an independent and impartial explanation of the health fund member's problem, or by providing additional information.

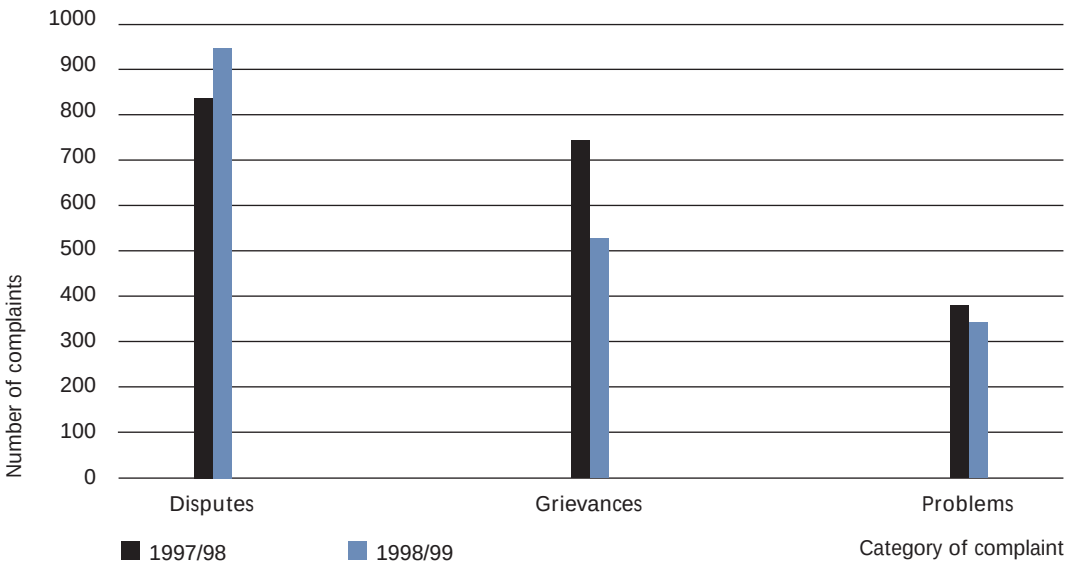
Payments made by health funds or accounts written off by hospitals resolved a further 13% of complaints. Payments by health funds may have resulted from a health fund agreeing with the Ombudsman that the fund member was entitled to payment of a benefit under the terms of the member's level of private health insurance cover, or the payment was made on an ex-gratia basis to a loyal member.

An additional 12% of complaints were resolved by taking other remedial action, such as reinstating a membership or allowing the back payment of contributions where a membership had lapsed.

18% of complaints were referred directly back to the health fund. In these circumstances the Ombudsman was able to suggest ways for the complainant to pursue the matter with the health fund.

Finally, 5% of complaints were withdrawn or required no further action. Information about the resolution of complaints is provided in Figure 10.

Figure 7: Complaints Received



Type of complainant

The law provides that health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf can lodge complaints. Overwhelmingly, complaints were made by health fund members (98.95%), followed by doctors (0.44%), hospitals/day hospitals (0.39%),and health funds (0.22%).

How complaints were made

89.85% of all problems, grievances and disputes were made by telephone. 8.28% were received by letter. The remaining 1.87% were made by fax, personal visit, e-mail or by Parliamentary Representation.

Investigations into health fund practices and procedures

There were no investigations conducted under Section 82ZT of the National Health Act 1953 during the reporting period.

In addition, there were no investigations conducted under Section 82ZTA of the National Health Act 1953.

Inquiries

Any approach to the Ombudsman's office that does not meet the statutory definition of a complaint contained in the National Health Act 1953 is recorded as an inquiry.

Figure 8: Complaints by object by month

Month 1998-99	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Type of Complaint													
Fund													
Problem	43	38	21	10	16	15	29	24	21	19	32	49	317
Grievance	67	47	36	23	43	13	36	63	45	23	32	76	504
Dispute	92	94	85	70	62	72	62	79	76	72	79	85	928
													1749
Hospital													
Problem	3	0	0	2	1	1	3	2	1	0	3	3	19
Grievance	0	1	2	0	1	0	1	1	1	0	1	3	11
Dispute	5	6	2	5	5	6	8	1	2	7	6	5	58
													88
Practitioner													
Problem	2	1	1	1	1	0	1	0	1	1	5	1	15
Grievance	2	4	1	0	4	1	2	1	1	2	1	1	20
Dispute	0	2	3	2	2	0	0	0	0	1	2	2	14
													49
Total	**214**	**193**	**151**	**113**	**135**	**108**	**142**	**171**	**148**	**125**	**161**	**225**	**1886**

Performance

Figure 9: Complaints (Problems, Grievances and Disputes) by Health Fund

Name of fund	No. of complaints	% of total complaints	No. of disputes	% of total disputes	Health Fund market share
ACA Health Benefits Fund	0	-	0	-	0.1
AMA Health Fund Ltd	0	-	0	-	0.1
Australian Health Management	57	3.3	36	3.9	2.3
Australian Unity Health Fund	41	2.3	26	2.8	2.8
CBHS Friendly Society	1	0.1	1	0.1	0.9
CDH Benefits Fund	0	-	0	-	0.0
CUA Members Benefits Friendly Society	10	0.6	4	0.4	0.5
Defence Health Benefits Society	22	1.3	7	0.8	1.2
Geelong Medical & Hospital Benefits Association	4	0.2	2	0.2	1.0
Goldfields Medical Fund Inc	1	0.1	1	0.1	0.2
Grand United Corporate Health Ltd	7	0.4	4	0.4	0.3
Grand United Friendly Society	29	1.7	9	1.0	0.5
Health Care Insurance Ltd	3	0.2	2	0.2	0.1
Health Insurance Fund of WA	2	0.1	2	0.2	0.3
Health-Partners	7	0.4	4	0.4	0.6
Healthguard Health Benefits Fund Ltd	0	-	0	-	0.1
Hospital Benefits Fund of WA Inc	58	3.3	28	3.0	11.4
Hospitals Contribution Fund of Australia Ltd	98	5.6	50	5.4	8.4
IOOF Friendly Society of Victoria	3	0.2	2	0.2	0.2
IOR Australia Pty Ltd	10	0.6	5	0.5	0.7
Latrobe Health Services (VIC)	8	0.5	6	0.6	0.4
Lysaght	1	0.1	1	0.1	0.2
Manchester Unity Friendly Society in NSW	34	1.9	18	1.9	1.0
Medibank Private	481	27.6	268	29.0	27.1
Medical Benefits Fund of Australia Pty Ltd	419	24.0	162	17.5	18.2
Mildura District Hospital Fund	1	0.1	0	-	0.3
National Mutual Health Insurance Pty Ltd	264	15.1	171	18.5	10.5
Naval Health Benefits Society	5	0.3	1	0.1	0.3
NIB Health Funds Ltd	84	4.8	56	6.1	4.6
NSW Teachers Federation Health Society	23	1.3	15	1.6	1.5
Phoenix Welfare Association Ltd	2	0.1	2	0.2	0.2
Queensland Country Health	5	0.3	4	0.4	0.2
Queensland Teachers Union Health Society	2	0.1	1	0.1	0.4
Railway & Transport Employees Friendly Society	7	0.4	5	0.5	0.4
Reserve Bank Health Fund Friendly Society	0	-	0	-	0.1
SA Police Employees Health Fund Inc	0	-	0	-	0.1
SGIO Health Pty Ltd	19	1.1	11	1.2	1.2
St Luke's Medical & Hospital Benefits Association	12	0.7	9	1.0	0.5
Transition Benefits Fund	1	0.1	1	0.1	0.2
Transport Friendly Society	3	0.2	1	0.1	0.1
United Ancient Order of Druids Victoria	1	0.1	0	-	0.1
United Ancient Order of Druids Grand Lodge NSW	0	-	0	-	0.1
Western District Health Fund Ltd	19	1.1	10	1.1	0.4
Yallourn Medical & Hospital Society	1	0.1	0	-	0.1
Total for Registered Funds	**1745**	**100.0**	**925**	**100.0**	**100.0**

1. Complaints = problems, grievances and disputes
2. Disputes require intervention by the Ombudsman
3. Proportion of people covered by health fund as at 30 June 1998 reported in the PHIAC Annual Report

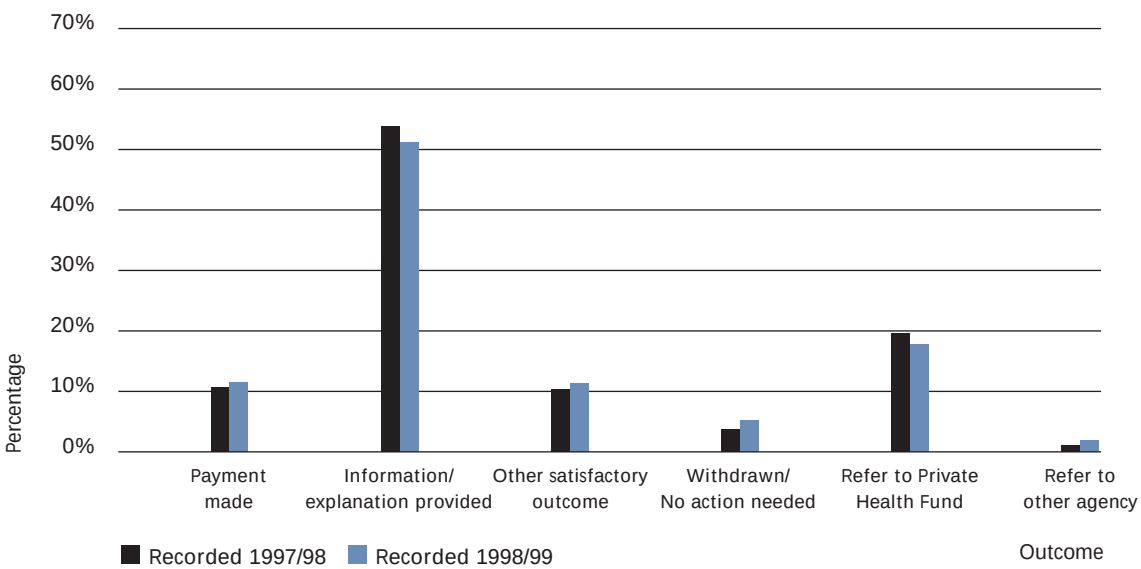
Examples of inquiries include calls and letters seeking general information about private health insurance, requests for brochures, explanations about waiting periods and referring callers to other, more appropriate agencies.

In response to questions about the merits of joining a specific fund, the Ombudsman does not recommend specific funds but provides the booklet Insure? Not Sure? which explains some of the health insurance terminology that consumers often find difficult to understand. This booklet also contains a list of all private health insurance funds in Australia and their telephone numbers. The Ombudsman also provides a brochure titled The Ten Golden Rules of Private Health Insurance. Other general health insurance inquiries were dealt with by providing telephone advice and a copy of the Private Patients' Hospital Charter.

Response to inquiries

Most inquiries were dealt with by providing information, an explanation or brochure. Some inquiries received by the Ombudsman were more appropriately dealt with by another organisation and were referred elsewhere.

Figure 10: Complaint (Problems, Grievances & Disputes) Outcome



Complaint Issues

Introduction

Because complaints to the Ombudsman must be connected to a health insurance arrangement, unsurprisingly, the great majority of them are about health insurance funds. Matters involving hospitals and doctors are invariably about fees and accounts that fund members have been asked to pay. Complaints about the service that doctors or hospitals provide to health fund members are referred to the various state-based health complaints bodies.

During the reporting period, the issue of cost declined dramatically on the previous financial year, when it was the largest single issue complained about. However, issues such as pre-existing ailments, informed financial consent and transfers between health funds continue to present problems for consumers and for the Ombudsman in trying to find acceptable resolutions to such complaints.

Pre-existing ailments

The principles governing the application of waiting periods for ailments, illnesses and conditions existing at the time a member joins a fund or upgrades their cover continue to cause the type of problems described in previous annual reports.

The test to be applied is set out in the National Health Act 1953. The rule requires that a medical practitioner appointed by the health fund must be satisfied that signs or symptoms of an ailment, illness or condition were in existence at any time in the six months before the member joined or upgraded their cover. Benefits are not payable for treatment in relation to this ailment, injury or condition for the first twelve months after joining or upgrading.

Application of the pre-existing ailment rule does not depend on the awareness of the ailment or on the need for treatment, but purely on the existence of signs or symptoms.

The question of pre-existing ailments does, to a certain extent, rely on the interpretation of the intent of the legislation. Differences of view between some health funds and the Ombudsman center on what constitutes a sign of an ailment or illness.

The Ombudsman believes that in the context of the relevant provisions of the National Health Act 1953, before a fund's medical adviser can say there was a sign (or symptom), there must be some manifestation of the ailment, illness or condition at some time in the preceding six months. While it is not necessary for the member to have known they had a medical problem, there must have been something which would have prompted a reasonable person to seek medical advice or a reasonably competent General Practitioner to have detected an abnormality during a routine visit.

Ms Sapphire joined a health fund on the recommendation of her doctor, after suffering a miscarriage. Two weeks later, she sustained an accidental blow to her hand and was taken to a nearby accident and emergency department for x-rays. After the x-ray, she was asked to come back, because the x-ray had picked up a cyst, which turned out to be a tumour in the bone. She subsequently required a number of procedures for this condition, including a bone graft.

When she submitted her bills to the fund, they refused to pay benefits, on the grounds that the tumour was a pre-existing ailment. Ms Sapphire then approached the Ombudsman for assistance. The Ombudsman investigated the case and examined a copy of Ms Sapphire's medical records, as well as the opinion on her case supplied by the fund's medical adviser.

The Ombudsman took the view that no signs or symptoms of the condition were in existence in the six months before Ms Sapphire joined the fund. The tumour was discovered by accident only when Ms Sapphire underwent an x-ray for an unrelated condition. However, the fund maintained that it was entitled to apply the pre-existing ailment rule in this case, because the condition would have been in existence when Ms Sapphire joined the fund, regardless of whether there were any signs or symptoms.

The Ombudsman disagreed with the fund's interpretation of the pre-existing ailment rule, but was unable to persuade the fund to pay benefits. The Ombudsman therefore suggested to Ms Sapphire that her only option was to pursue the matter through the Victorian Civil and Administrative Tribunal (previously known as the Small Claims Tribunal).

Ms Sapphire indicated to the fund that she was considering this option. The fund subsequently reversed its previous stance and paid benefits for her hospitalisation.

Transfers between health funds

The right to transfer between health funds without having to re-serve waiting periods is a basic consumer protection measure which has been available to health fund members for many years. However, the issue has become increasingly complex in recent years, due to a number of factors, including the difficulties of comparing different tables of cover and the introduction of selective contracting with hospitals.

Complaints about portability (the ability to transfer between health funds without penalty), like those involving pre-existing ailments, are invariably complex and difficult to solve, as the following case study illustrates:

Mrs Amethyst had been a long serving member of her health fund who paid her premiums twelve months in advance. When her fund introduced a hospital co-payment to her level of cover, she indicated to the fund that she intended to transfer to another fund once the period for which she had paid in advance expired. Fund staff assured her that as long as she transferred before her date paid to, she would get continuity at her present level of cover.

She transferred to another fund two weeks before her date paid to expired. Just prior to transferring to the new fund, she was hospitalised. The old fund did not impose the co-payment on her hospitalisation. After the transfer, she was hospitalised several times. On each occasion, she was told by the new fund that a $600 co-payment would apply. When she queried this with the fund, she was told that her old fund had sent a clearance certificate to her new fund, which only gave her continuity at the new lower rate which included the co-payment.

Mrs Amethyst attempted to resolve the problem with her new fund, but when this proved unsuccessful, she sought the Ombudsman's assistance. The Ombudsman investigated her complaint and sought further information from both funds. The old fund wrote to the Ombudsman indicating that Mrs Amethyst had rate and benefit protection until the expiration of her date paid to. However, the new fund argued that they were within their rights to apply the co-payment to any hospitalisations which Mrs Amethyst had in her first year with them.

Because the Ombudsman was unable to resolve the issue, a legal opinion was sought as to whether Mrs Amethyst's new fund was correct in its interpretation of the portability provisions of the National Health Act 1953. The legal opinion supported the Ombudsman's view that the new fund was incorrect in applying the co-payment to Mrs Amethyst's hospitalisations.

At the time of going to print, the Ombudsman was still attempting to resolve the complaint with Mrs Amethyst's new fund.

Complaint Issues

Problems with direct debit of premiums from bank accounts

With the rise of electronic banking in recent years, many funds are actively encouraging members to pay their premiums through automatic deduction from their bank accounts, often by offering the member a discount if they agree to pay this way. While direct debit offers members a convenient method of payment, members need to check their bank statements regularly, to ensure that payments are being debited, as the following case study shows:

Mrs Pearl had been a long term member of her health fund, when she fell at home and was not found until several days later by a neighbour. She was immediately sent by ambulance to a major teaching hospital, where she elected to be admitted as a private patient, on the basis of her long standing membership of a private health insurance fund. She stayed at this hospital for several weeks and then spent several more weeks convalescing at a smaller private facility.

When Mrs Pearl's nephew, who was acting on her behalf, submitted the bills to her health fund, the fund refused to pay benefits on the grounds that no payment had been received on her membership for nearly six months. Mrs Pearl was surprised to hear this, because six months earlier she had organised for her premium to be debited each month from her bank account to take advantage of a special discount offer by the fund for using this payment option.

After she had organised for the direct debit through her bank, the fund had sent her a letter confirming the arrangement and she assumed that her premiums were coming out automatically. Because Mrs Pearl was an elderly lady and not in good health, she had not been checking her bank statements as regularly as in the past and had asked her nephew to manage most of her affairs on her behalf.

Following the fund's refusal to pay benefits for her hospitalisation, Mrs Pearl's nephew contacted her bank and was told that a digit had been incorrectly recorded on Mrs Pearl's direct debit form, which was why payments were not being deducted from her account. He contacted the fund with this information, but the fund maintained its stance that benefits were not payable for Mrs Pearl's hospitalisation.

Mrs Pearl's nephew subsequently contacted the Ombudsman, who investigated the complaint and contacted the fund on Mrs Pearl's behalf. The fund reconsidered the case and agreed to pay benefits for Mrs Pearl's hospitalisation, as long as the arrears on the account were paid. The fact that Mrs Pearl was a long standing member of the fund who had not previously been in arrears, helped persuade the fund to reverse its decision.

Informed Financial Consent

During the reporting period, the Ombudsman received a number of complaints about the issue of informed financial consent. Both the Ombudsman and health funds recommend that members check their entitlements with the fund before they are admitted to hospital. Where a health fund has a purchaser-provider agreement with a hospital, the hospital is required to advise the member of what their out-of-pocket expenses will be for their hospitalisation. Sometimes, in spite of seeking information about what their costs will be, members receive unexpected bills, as the following case study shows:

When Mrs Ruby's daughter required hospitalisation, she contacted her health fund to check that she would be covered. Fund staff advised her that the hospital would give her a written estimate after they contacted the fund.

The hospital duly provided Mrs Ruby with a written estimate, suggesting that her out-of-pocket expenses would be $500, the amount of her excess. Mrs Ruby paid this amount when her daughter was discharged from the hospital.

Some weeks later, Mrs Ruby was surprised to receive an account for over $5000 from the

hospital. She immediately contacted the hospital to query the account. Hospital staff informed her that the fund had correctly advised them of her level of cover, but hospital staff had transcribed it incorrectly. The hospital indicated that there was little it could do to help her and that she would have to take responsibility for the account.

Mrs Ruby contacted the Ombudsman to seek assistance in resolving the matter. After investigating the complaint, the Ombudsman formed the view that Mrs Ruby had done everything possible to find out how much the operation was going to cost. Had she been informed of the large out-of-pocket costs she was facing, she would have had the option of determining whether other less expensive options were available to her.

The Ombudsman considered it was reasonable that Mrs Ruby be able to rely on a written estimate given by the hospital after contact with the fund. While it was understandable that an estimate could vary somewhat from the final cost of the hospitalisation due to complications in the treatment of the patient, the Ombudsman believed that the discrepancy between the $500 originally quoted and the final bill of over $5000 was unreasonable.

The Ombudsman wrote to the hospital outlining these concerns. In its response, hospital staff indicated that the incorrect assessment of Mrs Ruby's costs was an honest mistake on the part of its staff, and that it would not press for recovery of the outstanding amount.

Problems for members travelling overseas

During the reporting period, the Ombudsman received a number of complaints from people with overseas visitors' cover. This cover is designed for overseas visitors to Australia who are not eligible to reclaim any of their costs from Medicare. A number of these complaints came from people with overseas visitors' cover who had been asked to re-serve waiting periods because they left the country for a short period of time.

Mr Topaz, who lived in the United States but made frequent visits to Australia, had held overseas visitors' cover with an Australian health fund for six years, when he was hospitalised for several weeks, incurring a bill of around $15,000.

When he submitted the hospital bills to the fund, the fund refused to pay benefits and informed him that he should have cancelled his policy with them each time he returned to the United States and re-served waiting periods when he returned to Australia. He was also informed that his health insurance policy had recently been cancelled because he had returned to the United States.

Mr Topaz contacted the Ombudsman, who investigated his complaint. When the Ombudsman contacted the health fund, fund staff indicated that the current brochure advised that the fund could cancel policies and refuse to pay benefits if a member left the country.

The Ombudsman pointed out that this provision was not included in the health fund brochure which Mr Topaz had received when he joined the fund. Nor had Mr Topaz been informed of the change at a later date. The Ombudsman therefore recommended that the fund reverse its decision not to pay benefits in this instance. After considering the Ombudsman's views, the fund agreed to change its stance and pay benefits.

General Issues

Establishment of the Private Health Insurance Ombudsman

Under the Health Legislation Amendment Act (No. 2) 1998 which came into effect on 24 April 1998, the Private Health Insurance Complaints Commissioner became the Private Health Insurance Ombudsman. The move to an Ombudsman is a key element of the Federal Government's ongoing commitment to the private health insurance reform process and is designed to encourage a more responsive and consumer focussed health insurance industry.

The 1998 amendments also:

- gave the Ombudsman power to make recommendations directly to hospitals and doctors;
- gave the Ombudsman power to take complaints from partners and dependents of fund contributors;
- extended the Ombudsman's powers to decline to take action on complaints in certain situations;
- extended the Ombudsman's powers to mediate complaints;
- gave people the right to apply to the Minister requesting that the Minister direct the Ombudsman to investigate, or not investigate, their complaint; and
- made other changes of a practical administrative nature.

Dr Brendan Nelson MP at the Ombudsman's launch.

Official Launch

The launch of the Complaints Commissioner as the Ombudsman in July 1998 provided another opportunity to further increase awareness of the service we provide for health insurance members. Dr Brendan Nelson MP officiated at the formal launch which was held on 9th July 1998. Dr Nelson, who is Chairman of the Government Members' Health, Family Services and Veterans' Affairs Committee, was elected to the Federal Parliament in 1996 as the Member for Bradfield.

In launching the office as the Private Health Insurance Ombudsman, Dr Nelson said he was pleased that the new role of Ombudsman would help to increase consumer confidence in the private health insurance industry, in line with the Federal Government's ongoing commitment to private health insurance reforms.

A number of other initiatives were also planned around the launch to raise the profile of the service provided by the Ombudsman. These included press briefings and participation by the Ombudsman in talkback and other radio broadcasts.

Appointment of new Ombudsman

Ms Mary Perrett, who was appointed as the first Private Health Insurance Complaints Commissioner in late 1995 and subsequently the first Private Health Insurance Ombudsman in June 1998, completed her three year term as Ombudsman in November 1998.

In July 1999, Mr Norman Branson was officially appointed to the position of Private Health

Insurance Ombudsman. Mr Branson brings his extensive experience and knowledge of the private health insurance industry to the position. Mr Branson took up his new position at the beginning of August 1999, after the close of the reporting period.

During the intervening period Mr Matthew Blackmore was appointed Acting Ombudsman.

Access and public awareness

Because the Private Health Insurance Ombudsman was established primarily for the benefit of health fund members, it is important that they know about their right to approach the Ombudsman for assistance. Health funds are required to publish the contact details for the Ombudsman in their main product brochures, and many members are being made aware of the Ombudsman's services through this avenue.

To further raise awareness of the service provided by the Ombudsman, the following strategies were also employed:

- advertisements outlining the Ombudsman's services were placed in metropolitan and regional newspapers during the year;
- the Ombudsman gave radio interviews and participated in talkback radio;
- the Ombudsman hosts a World Wide Web site where consumers can access a range of brochures and recent Ombudsman Annual Reports. The site enables consumers to make inquiries, lodge complaints and request printed copies of brochures (including community language). It also provides consumers with links to other useful sites. The Ombudsman's website is located at: http://www.phio.org.au; and
- the Ombudsman and staff spoke at numerous conferences and public/community meetings during the year.

Relations with Stakeholders

The Ombudsman produces a Quarterly Bulletin containing general information about private health insurance and complaint statistics which is sent to members of Parliament, consumer groups, libraries, health funds and hospitals.

The Ombudsman maintains regular contact with relevant health fund, hospital and consumer organisations.

In April 1999, the office carried out a follow up survey to the full client relations survey previously conducted by an external body. The office surveyed 200 persons who had initiated a complaint in the previous 3 months.

The aim of the survey was to find out whether the Ombudsman was meeting its clients' needs and to identify any areas where improvements could be made. Regular consultation with stakeholders through such surveys is now an important element of the Federal Government's program of implementing and reporting on service charters for Commonwealth Government Departments and Statutory Authorities.

The survey found a similar high level of satisfaction among consumers with the Ombudsman's services as was found previously. Among the findings, the study showed that:

- 93% of respondents said it was not difficult to contact the Ombudsman.
- 75% said staff listened very well and 22% said staff were attentive.
- 74% of respondents said they were very satisfied or mostly satisfied with the time it took to resolve their inquiry or complaint.
- 74% found our advice easy to understand all of the time and 14% most of the time.
- 71% found our advice helpful and 14% found it partly helpful.
- 61% were very satisfied with our service and 25% were satisfied.

Statutory Reporting Information

Staffing

As at 30 June 1999, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman	-	-
Acting Ombudsman	-	1
Director, Policy & Customer Service	-	-
Director, Corporate Services	1	-
Dispute Resolution Officers	1	2
Policy & Project Officer	1	-
Administrative Assistant	1	-
Total	**4**	**3**

Statutory positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry Date
Ms M Perrett	Ombudsman	3 years	1 Nov 1998

At the completion of Ms Perrett's term, Mr Matthew Blackmore was appointed Acting Ombudsman.

Mr Norman Branson was appointed as Ombudsman on 12 July 1999 and formally took up the position on 2 August 1999.

Staff development and training

During the 1998-99 financial year, $15,050.00 was spent on PHIO staff attending training courses, conferences and seminars.

During the 1998-99 financial year the Ombudsman implemented a tailored staff development and training program for its Dispute Resolution staff.

Training undertaken by staff during the year is summarised below.

Topic	Provider	Attending
Health & Health Insurance		
Health Billing Conference	IIR Conferences Pty Ltd	1 staff
Dispute Resolution Training Program	Margot Costanzo In-House training	5 staff
Health care Funding Conference	Australian Institute of Actuaries	1 staff
National Medico-Legal Conference	IIR Conferences Pty Ltd	1 staff
General Business Related		
Career Management	Public Sector Development	1 staff
Administration Law Update	Australian Institute of Admin. Law	1 staff
First Aid	St John's Ambulance	1 staff
Complaint Handling Seminar	Society of Consumer Affairs Professionals	1 staff
Privacy Laws in Australia	IIR Conferences Pty Ltd	1 staff
Communication & Negotiation skills	IIR Pty Ltd	1 staff
Consumer Affair Issues Seminar	Society of Consumer Affairs Professionals	1 staff
Dispute Resolution Seminar	Australian Dispute Resolution Association	1 staff
Customer Satisfaction Conference	AMR Quantum Harris	1 staff

Staff also participated in part-time studies at formal educational institutions.

Statutory Reporting Information

Equal employment opportunity

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

The following table shows the number of staff in the EEO target groups who were employed or separated in 1998-99.

Workplace Diversity

The Ombudsman is committed to workplace diversity. Its workplace diversity program meets all the requirements set out in the Public Service Commissioner Guidelines on Managing Workplace Diversity. The program is accessible to all employees, it encourages them to develop their work skills and contribute to their maximum potential. It recognises the diverse skills, cultural values and backgrounds of employees and ensures that the Ombudsman uses these effectively. Workplace structures, systems and procedures are in place to assist employees balance their work and family responsibilities effectively.

Occupational Group	NESB1	NESB2	ATSI	PWD	Women	Total Staff
SES	-	-	-	-	1	1
Other	-	-	-	-	8	11
Total	**-**	**-**	**-**	**-**	**9**	**12***

Note: SES Senior Executive Service
Other All other staff - temporary and permanent
NESB1 Non-English speaking background, 1st Generation
NESB2 Non-English speaking background, 2nd Generation
ATSI Aboriginal and Torres Strait Islander
PWD People with a disability
* Effective full time equivalent staff is 6.4

Performance Appraisal

The Ombudsman has a performance appraisal system in place that is used to measure staff performance. This tool assists the Ombudsman with annual salary reviews. All staff are subject to an annual performance appraisal.

Occupational Health & Safety

Responsibility for the safety and health of all staff rests with the Ombudsman, who is required to be aware of all dangers to health and safety in the workplace. The Policy and Project Officer is the Ombudsman's First Aid and Occupational Health and Safety Officer.

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

Industrial Democracy

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

Consultants Engaged

During the financial year, the Ombudsman engaged specialist consultants to provide expertise in the areas of legal advice and information technology.

Three consultancies were let at a total cost of $23,313.13. Consultants were appointed using the Ombudsman's purchasing and contracting guidelines, which have regard to value for money, open and effective competition, the promotion of ANZ industry development, ethics and fair dealing.

Details of consultants who were paid more than $2,000.00 are set out below.

Consultant	Project	Total Cost of Consultancy $	1997/98 Payments $
K Burns*	The preparation of a briefing paper on Workers Compensation and Private Health Insurance.	2769.10	2769.10
Banki Haddok Fiora*	Legal Research - Various Health Insurance Issues	14544.03	14544.03
Axis Technologies†	Year 2000 Compliance program. Consultancy to provide expertise in scoping and planning PHIO's Y2K compliance program.	6000.00	6000.00

* Need for access to the latest experience in application

† Lack of inhouse resources

Statutory Reporting Information

Advertising and Market Research

The Ombudsman expended $61379 during the 1998/99 financial year on advertising and market research.

Provider	Service	Amount $
Telstra White Pages	Advertising - print media	41237.00
Yellow Pages Australia	Advertising - print media	19927.00
David Syme & Co.	Advertising - print media	215.00

Information Systems

The Ombudsman's information system is based upon a Windows NT network using ASI personal computers. Software used consists of the Microsoft Office 97 suite, which includes word processing, spreadsheet, desktop publishing, mail and database facilities. Accounting software used is Mind Your Own Business Accounting and Asset Manager. Additionally the Ombudsman has a purpose built Complaints Management and Reporting System on-site.

Accounting services

The Ombudsman has engaged Hall Chadwick Chartered Accountants to assist it with its accounting functions.

Payroll services

The Ombudsman has engaged Australian Payroll Management Services to provide a payroll processing service.

Fraud control

Staff are trained in fraud awareness. Procedures are in place to notify the Australian Federal Police and/or the Director of Public Prosecutions if loss occurs as a result of fraud. No cases of fraud were detected during the 1998/99 financial year.

Social justice, access and equity

The Private Health Insurance Ombudsman is committed to the principles of access, equity, communication, responsiveness, effectiveness, efficiency and accountability as set out in the Government's Charter of Public Service in a Culturally Diverse Society.

Access and equity policies aim to ensure that government services meet the needs of people from diverse linguistic and cultural backgrounds so that they can participate fully in economic, social and cultural life.

To this end, the Ombudsman provides a speedy and informal complaints and inquiry service which is free of charge. Complaints and inquires can be made from anywhere in Australia on the Ombudsman's free-call Hotline 1800 640 695. Complaints may be lodged by telephone, fax and e-mail.

People who are deaf, hearing or speech impaired can contact us through the National Relay Service by telephoning 13 25 44.

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

The Ombudsman has also produced a web site on the Internet, which enables people to access information about us via computer.

Access and equity goals underpin the decision making process of the Ombudsman's office. A primary goal is to raise community awareness about the Ombudsman through advertising and through the wide distribution of pamphlets and our annual report to community groups, private hospitals, doctors' surgeries, health funds, Ombudsmans' offices, consumer affairs organisations and Members of Parliament.

Another key goal is to ensure that information about the Ombudsman's role and functions is available to the wider community through the publication of our brochures in six community languages, Arabic, Greek, Italian, Spanish, Chinese and Vietnamese.

Service Charter

The Ombudsman's Service Charter has been in operation since November 1997 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 customers can expect and the steps they can take if these standards are not met. The Charter was developed in consultation with staff and customers.

Copies of the Charter are sent to people who contact the Ombudsman's office with a complaint or inquiry. Copies have also been sent to consumer groups and other stakeholders.

The Charter is currently being reviewed. Further information about the Ombudsman's Service Charter can be found later in this report.

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 1999.

Establishment

The Private Health Insurance Ombudsman is established under the National Health Act 1953 to resolve complaints about any matter arising out of or connected with a private health insurance arrangement. The Ombudsman is an independent statutory corporation.

Legislation enabling the Private Health Insurance Complaints Commissioner (now Ombudsman) commenced on 1 October 1995.

The Health Legislation Amendment Act (No. 2) 1998 came into effect on 24 April 1998, and provided for the renaming of the Private Health Insurance Complaints Commissioner as the Private Health Insurance Ombudsman.

Public Information

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

Requests

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

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

Documents held by the Ombudsman

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

- a brochure "Who We Are"
- a brochure "Making a Complaint"
- a brochure "The Ten Golden Rules of Private Health Insurance"
- a brochure "Service Charter"
- a brochure "When the Doctor's Bill Makes You Ill"
- a booklet and brochure "Private Patients' Hospital Charter"
- a booklet "Insure, Not Sure?"
- Complaints Register and Complaints files
- Correspondence and working papers relating to the administration of the Ombudsman, including personnel and financial papers
- Other guidelines for staff of an administrative nature to assist in the efficient and effective operation of the office.

Documents available free of charge

The following documents are available free of charge upon request:

- a brochure "Who We Are"
- a brochure "Making a Complaint"
- a brochure "The Ten Golden Rules of Private Health Insurance"
- a brochure "Service Charter"
- a brochure "When the Doctor's Bill Makes You Ill"
- a booklet and brochure "Private Patients' Hospital Charter"
- a booklet "Insure, Not Sure?"

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 1201, Level 12, St Martins Tower, 31 Market Street, Sydney, NSW, 2000
- by telephoning (02) 92615855 or 1800 640 695 (freecall)
- by fax on (02) 9261 5937
- 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

Requests under the FOI Act should be made in writing and accompanied by a $35 application fee, as required by the Act, and directed to:

Director, Policy and Customer Service

Private Health Insurance Ombudsman

Suite 1201, Level 12

St Martins Tower

31 Market Street

SYDNEY NSW 2000.

Initial enquires about access to documents may be made in person or by telephone. The office is open for business between 8:30am and 5:00pm on weekdays.

External review and scrutiny

Courts

In June 1998, the Ombudsman was advised that proceedings had been lodged with the Federal Court seeking a review under the Administrative Decisions (Judicial Review) Act 1974, of a decision made by the Ombudsman.

Solicitors acting on behalf of two dentists had previously lodged complaints with the Ombudsman about a registered health fund.

Under the National Health Act 1953, only certain dentists, ones who fall within the definition of "medical practitioners", have the right to lodge a complaint with the Private Health Insurance Ombudsman. As these dentists did not fall within the definition, the Ombudsman declined to act on the complaints, giving reasons for declining to take action.

The dentists then lodged applications in the Federal Court seeking a review of the Ombudsman's decision.

The application by the dentists was dismissed on Monday, 7 June 1999. Costs were awarded against the dentists.

Commonwealth Ombudsman

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

Other

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

Service Charter

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

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

The Charter includes 15 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. In addition, we conduct regular surveys to monitor satisfaction with our service.

During the reporting period, one formal complaint about our service was recorded, out of 4073 approaches to the office. 17 formal compliments about our service were also recorded.

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

In April 1999, the Ombudsman conducted a small in house survey of 200 people who had contacted the office in the previous three months with an inquiry or complaint. This was intended as a follow up on the survey conducted by a market research company during the 1997/98 financial year.

The survey measured the extent to which the Ombudsman met the key performance standards listed in the Charter and produced the following results:

Accessibility

- 93% of respondents said it was not difficult to contact the Ombudsman.

Courtesy and Sensitivity

- 75% said staff listened very well and 22% said staff were attentive.

Timeliness

- 74% of respondents said they were very satisfied or mostly satisfied with the time it took to resolve their inquiry or complaint.

High Quality Advice

- 74% found our advice easy to understand all of the time and 14% most of the time.
- 71% found our advice helpful and 14% found it partly helpful.
- 61% were very satisfied with our service and 25% were satisfied.

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Aged Care

Scope

I have audited the financial statements of Private Health Insurance Ombudsman for the year ended 30 June 1999. The financial statements comprise:

- Statement by Ombudsman;
- Operating Statement;
- Statement of Assets and Liabilities;
- Statement of Cash Flows;
- Schedule of Commitments;
- Schedule of Contingencies; and
- Notes to and forming part of the Financial Statements.

The Ombudsman is responsible for the preparation and presentation of the financial statements and the information they contain. I have conducted an independent audit of the financial statements in order to express an opinion on them to you, the Minister for Health and Aged Care.

The audit has been conducted in accordance with Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards, to provide reasonable assurance as to whether the financial statements are free of material misstatement. Audit procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Australian Accounting Standards, other mandatory professional reporting requirements and statutory requirements so as to present a view of the entity which is consistent with my understanding of its financial position, the results of its operations and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

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

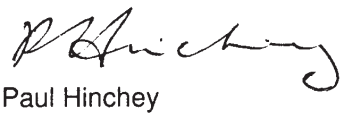
Audit Opinion

In my opinion,

(i) the financial statements have been prepared in accordance with Schedule 2 of the Finance Minister's Orders; and

(ii) the financial statements give a true and fair view, in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and Schedule 2 of the Finance Minister's Orders, of the financial position of the Private Health Insurance Ombudsman as at 30 June 1999 and the results of its operations and its cash flows for the year then ended.

Australian National Audit Office



Paul Hinchey
Senior Director

Delegate of the Auditor-General

Sydney
19 July 1999

Private Health Insurance Ombudsman

Statement by the Ombudsman

In my opinion, the attached financial statements give a true and fair view of the matters required by the Finance Minister's Orders.

Matthew Blackmore
Acting Ombudsman

Dated: 16/7/99

Operating Statement

For the year ended 30th June 1999

	Note	1999 $	1998 $
NET COST OF SERVICES			
Operating expenses			
Suppliers	2A	**409,009**	291,254
Employees	2B	**344,160**	472,343
Depreciation and Amortisation	2C	**74,340**	66,736
Total operating expenses		**827,509**	830,333
Operating revenue from independent sources			
Interest	3A	**7,413**	15,456
Other Income	3B	**10,224**	-
Total operating revenue from independent sources		**17,637**	15,456
Net cost of services		**809,872**	814,877
REVENUES FROM GOVERNMENT			
Parliamentary Appropriations Received	4A	**700,000**	700,000
Total revenues from government		**700,000**	700,000
Surplus (deficit) of revenues from government over net costs of services		**(109,872)**	(114,877)
Surplus (deficit)		**(109,872)**	(114,877)
Accumulated surpluses at beginning of reporting period		**208,864**	323,741
Accumulated surpluses at end of reporting period		**98,992**	208,864

The accompanying notes form part of these financial statements

Statement of Assets and Liabilities

For the year ended 30th June 1999

	Note	1999 $	1998 $
PROVISIONS AND PAYABLES			
Suppliers	5A	**38,395**	91,086
Employees	5B	**45,157**	90,852
Total provisions and payables		**83,552**	181,938
Total liabilities		**83,552**	181,938
EQUITY			
Accumulated Surpluses		**98,992**	208,864
Total liabilities and equity		**182,544**	390,802
FINANCIAL ASSETS			
Cash	6A	**52,788**	147,664
Receivable	6B	**8,466**	-
Total financial assets		**61,254**	147,664
NON FINANCIAL ASSETS			
Infrastructure, plant and equipment	7A	**112,272**	173,387
Other	7B	**9,018**	69,751
Total non-financial assets		**121,290**	243,138
Total assets		**182,544**	390,802
CURRENT LIABILITIES		**68,564**	128,738
NON-CURRENT LIABILITIES		**14,988**	53,200
CURRENT ASSETS		**70,272**	217,415
NON-CURRENT ASSETS		**112,272**	173,387

The accompanying notes form part of these financial statements

Statement of Cashflows

For the year ended 30th June 1999

	Note	1999 $	1998 $
OPERATING ACTIVITIES			
Cash received			
Appropriations		**700,000**	700,000
Interest		**7,413**	15,456
Other		**3,174**	-
Total cash received		**710,587**	715,456
Cash used			
Suppliers		**(412,031)**	(364,976)
Employees		**(378,150)**	(444,658)
		(790,181)	(809,634)
Net cash from operating activities	**14**	**(79,595)**	(94,178)
INVESTING ACTIVITIES			
Cash used			
Purchase of Infrastructure, Plant & Equipment		**(15,281)**	(49,810)
Net cash from investment activities		**(15,281)**	(49,810)
Net increase/(decrease) in cash held		**(94,876)**	(143,988)
add cash at 1 July		**147,664**	291,652
Cash at 30 June		**52,788**	147,664

The accompanying notes form part of these financial statements

Schedule of Commitments

For the year ended 30th June 1999

	1999 $	1998 $
BY TYPE		
OTHER COMMITMENTS		
Operating Lease Commitments	-	64,003
	-	64,003
BY MATURITY		
One Year or Less	-	**64,003**
From one to two years	-	-
One Year or Less	-	**64,003**

Schedule of Contingencies

For the year ended 30th June 1999

CONTINGENT LOSSES	-	-
CONTINGENT GAINS	-	-
Net Contingencies	**0**	0

Notes to and forming part of the Financial Statements

For the year ended 30th June 1999

1.STATEMENT OF ACCOUNTING POLICIES

The financial statements are a general purpose financial report. They have been prepared on an accrual basis from the records of the entity for the year ended 30th June 1999. They are based on historical costs and do not take into account the changing values of money. Cost is based on the fair values of the consideration given in exchange for assets.

The accounts have been prepared in accordance with the Finance Minister's Orders which require compliance with relevant Australian Accounting Standards and related Guidance Releases and have regard to Australian Statements of Accounting Concepts and have been prepared in accordance with Urgent Issues Group consensus views.

The following is a summary of the significant accounting policies adopted in the preparation of the financial statements.

Infrastructure, Plant & Equipment

All assets with a cost of less than $500.00 are expensed in the year of acquisition except where they form a group of similar items which are significant in total.

Infrastructure, plant & equipment are brought to account at cost less, where applicable, any accumulated depreciation or amortisation.

The depreciable amount of fixed assets is depreciated over their useful lives commencing from the time the asset is held ready for use. Leasehold improvements are amortised over the estimated useful lives of the improvements.

Leases

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

Employee Entitlements

The provision for employee entitlements encompasses annual leave and long service leave and the on costs for these provisions. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken by employees is less than the annual entitlement for sick leave.

The provision for annual leave reflects the value of total annual leave entitlements of all employees at 30 June 1999 and is recognised at its nominal value.

The liability for long service leave is recognised and measured at present value of the estimated future cash flows to be made in respect of all employees at 30 June 1999.

Contributions are made by the economic entity to employee superannuation funds and are charged as expenses when incurred.

Taxation

The Ombudsman is exempt from all forms of income tax except fringe benefits tax.

Cash

For the purpose of statement of cash flows, cash includes cash on hand and in at call deposits with banks.

Comparative Figures

Where necessary, comparative figures have been adjusted to conform with changes in presentation in these financial statements.

Notes Continued

For the year ended 30th June 1999

FINANCIAL INSTRUMENTS

(a) Interest rate risk

The Ombudsman's exposure to interest rate risk, which is the risk that a financial instrument's value will fluctuate as a result of changes in the market interest rates and the effective weighted average interest rates on classes of financial assets and financial liabilities, is as follows:

	Weighted average effective interest rate		Floating interest rate	
	1999	1998	1999	1998
Financial Assets	%	%	$	$
Cash	4.75	4.4	52,788	147,664
Debtors			-	-
Total Financial Assets			52,788	147,664

(b) Credit Risk

The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date to recognised financial assets is the carrying amount, net any provisions for doubtful debts, as disclosed in the Statement of Assets and Liabilities and notes to the financial statements.

The Ombudsman does not have any material credit risk exposure to any single debtor or group of debtors under financial instruments entered into by the Ombudsman.

(c) Net Fair Values

For the assets and liabilities the net fair value approximates their carrying value.

Notes Continued

For the year ended 30th June 1999

	1999 $	1998 $
2. GOODS AND SERVICES EXPENSES		
2A. Suppliers expenses		
Supply of Goods and Services	**337,428**	225,186
Operating Lease Rentals	**71,581**	66,068
	409,009	291,254
2B. Employee expenses		
Remuneration for Services Provided	**344,160**	472,343
	344,160	472,343
2C. Depreciation and Amortisation		
Depreciation	**59,984**	52,664
Amortisation - Lease Fitout	**14,356**	14,072
	74,340	66,736
3. REVENUES FROM INDEPENDENT SOURCES		
3A. Interest		
Deposits	**7,413**	15,456
	7,413	15,456
3B. Other income		
Workers compensation insurance	**9,780**	-
Proceeds from sale of plant & equipment	**444**	-
	10,224	-
4. REVENUES FROM GOVERNMENT		
4A. Parliamentary appropriations		
Appropriation Act No. 1	**700,000**	700,284
Offset against receivables as it related to amount owed by Department of Health and Family Services that was taken up as revenue in a prior year.	**-**	(284)
	700,000	700,000

Notes Continued

For the year ended 30th June 1999

	1999 $	1998 $
5. PROVISIONS AND PAYABLES		
5A. Suppliers		
Trade Creditors	**28,179**	87,686
Accruals	**10,216**	3,400
	38,395	91,086
5B. Employees		
Salaries and Wages	**5,974**	5,981
Annual Leave	**24,195**	31,671
Long Service Leave	**14,988**	53,200
	45,157	90,852
6. FINANCIAL ASSETS		
6A. Cash		
Cash on Hand	**250**	250
Cash at Bank	**52,538**	147,414
	52,788	147,664
6B. Receivables		
Other Debtors	**8,466**	-
Other Debtors	**8,466**	-
7. NON FINANCIAL ASSETS		
7A. Infrastructure, plant & equipment		
Leasehold Fitout - at cost	**80,620**	82,420
Less: Accumulated Amortisation	**41,935**	29,379
	38,685	53,041
Plant & Equipment - at cost	**211,096**	218,599
Less: Accumulated Depreciation	**137,509**	98,253
	73,587	120,346
Total Property, Plant & Equipment at Written Down Value	**112,272**	173,387
7B. Other assets		
Other Prepayments	**9,018**	69,751
	9,018	69,751

Notes Continued

For the year ended 30th June 1999

7C. Movement summary 1998-99 for all assets irrespective of valuation base

Item	Leasehold Fitout $	Plant & Equipment $	Total $
Gross value as at 1 July 1998	**82,420**	**218,599**	**301,019**
Additions:	-	24,209	24,209
Revaluations	-	(90)	(90)
Disposals	(1,800)	(22,143)	(23,943)
Other movements	-	(9,478)	(9,478)
Gross Value as at 30 June 1999	**80,620**	**211,097**	**291,717**
Accumulated depreciation / amortisation as at 1 July 1998	**29,379**	**98,253**	**127,632**
Depreciation / amortisation charge for assets held 1 July 1998	13,464	55,095	68,559
Depreciation / amortisation charge for additions	-	4,908	4,908
Adjustment for revaluations	-	(19)	(19)
Adjustment for disposals	(908)	(20,728)	(21,635)
Adjustment for other movements	-	-	-
Accumulated depreciation / amortisation as at 30 June 1999	**41,935**	**137,509**	**179,445**
Net book value as at 30 June 1999	**38,685**	**73,588**	**112,272**
Net book value as at 1 July 1998	**53,041**	**120,346**	**173,387**

Notes Continued

For the year ended 30th June 1999

	1999 $	1998 $

8. REMUNERATION OF OFFICERS

The position of Ombudsman was filled by 2 people during the reporting peiod. Neither received over $100,000 in remuneration

9. REMUNERATION OF AUDITORS

Remuneration to the Auditor-General for Auditing the Financial Statements.	**3,200**	2,900

10. SUPERANNUATION

The Ombudsman's office contributes to the Commonwealth Superannuation (CSS) and the Public Sector Superannuation (PSS) schemes which provide retirement, death and disability benefits to employees. Contributions to the scheme are at rates calculated to cover existing and emerging obligations. Current contribution rates are 20.1% of salary (CSS) and 10.5% of salary (PSS). An additional amount of up to 3% is contributed for employer productivity benefits. Casual staff can choose to be a member of any approved superannuation fund and receive employer benefits at the Superannuation Guarantee Charge rate, currently 7%.

11. ECONOMIC DEPENDENCY

The Ombudsman is dependent on appropriations from Parliament to carry out its normal activities.

12. SEGMENT REPORTING

The Ombudsman operates in a single industry and geographic segment - provision of complaint resolution services in Australia.

13. CASH

Cash on hand	250	250
Cash at bank	52,538	147,414
	52,788	147,664

Notes Continued

For the year ended 30th June 1999

	1999 $	1998 $
14. CASH FLOW RECONCILIATION		
Reconciliation of net cash flows from operating activities to Net Cost of Services		
Net cost of services	**(809,872)**	**(814,877)**
Parliamentary Appropriation	**700,000**	700,000
Operating surplus	**(109,872)**	**(114,877)**
Amortisation - Lease Fitout	**14,356**	14,072
Annual Leave Provision	**(7,476)**	(6,956)
Depreciation	**59,984**	52,664
Long Service Leave	**(36,156)**	3,807
Decrease/(Increase) in Other Debtors	**(8,466)**	4,803
Increase in Trade Creditors	**(59,507)**	2,578
(Decrease)/Increase in Accruals	**6,809**	(1,776)
Increase in Other Prepayments	**60,733**	(48,493)
Net cash provided for by operating activities	**(79,595)**	**(94,178)**

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