2010

PRIVATE HEALTH INSURANCE OMBUDSMAN

ANNUAL REPORT

Private Health Insurance
OMBUDSMAN

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1800 640 695 Free Call - higher cost from Mobiles

Consumers requiring translators
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Deaf, hearing or speech impaired
13 36 77 (National Relay Service)

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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 2000 to 30 June 2001.

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

Yours sincerely

Norman W Branson
OMBUDSMAN

28 August 2001

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OMBUDSMAN'S OVERVIEW

Norman Branson
Private Health Insurance Ombudsman

I commenced my overview last year with the statement "This year has been one where the private health insurance industry has received considerable public focus." It is difficult to begin this one with any different words. If anything the public focus has been greater and scrutiny of the industry from a range of sources has increased. The ability of the industry to respond has been varied. There have been some very positive outcomes but on some issues there is still a long way to go.

It was obvious there would be a greater number of complaints flowing from the increase of around thirty percent in the insured population following the lifetime health cover campaign. The final quarter last year had produced an increase of 42% in complaints over previous quarters, so the pattern was there. We had not expected the increase of complaints to be 80% for the year, nor that the complexity of complaints would be so significant. I am pleased to report that with a small increase in staff numbers and no increase in budget, the office was able to provide a high level of service to the consumers and the industry. This is evidenced not only by reference to the numbers appearing in the body of this report, but also from the client survey conducted during the period of peak workload. I commend my staff for their efforts.

Scrutiny of the industry was bound to be intense. Not only was my office required to report periodically the large increase in complaint numbers, but other bodies such as the ACCC raised concerns over certain practices which did not on the surface meet the required standards. This office was asked to provide details of complaints supporting the actions by the ACCC and also had to refer matters to them which were outside our jurisdiction or more appropriately handled by that body. The ACCC has reported in detail on the issues in question and this overview will not canvass the issues further.

Media attention focussed mainly on the negatives as they related to individuals and the system generally and it was difficult in this climate to provide a balanced view to the broader public. There was a great deal of positive work being carried out by concerned groups and this tended not to be as widely reported even though media outlets were informed and some talk back radio commentators did allow coverage along with the negatives. If these positive inputs could have received equal prominence to the negatives it is possible there may have been a better outcome for some aggrieved consumers. They would have been better informed.

None-the-less, my office, the industry, consumer groups and the Government, together progressed with trying to solve many of the underlying fundamental problems, which were present. In some of the areas of concern, there has been good progress which bodes well for the future. In others, while the process to bring about change continues and the commitment appears to be there, the effort does not seem to be matched by any marked reduction in complaint numbers or complexity. The adoption of these changes needs to progress throughout the private health industry much quicker.

The major fundamental issues which faced the industry for some time, and have been the focus of all previous reports from this office have been:

- The interpretation of the pre-existing ailment provisions of the National Health Act.
- Portability of membership between health insurance products and funds.
- The provision of timely and accurate information enabling informed financial consent.
- The gap consumers are required to pay between the charges of the medical practitioner and the rebates available from Medicare and the health funds.
- Difficulties faced by consumers when hospitals and insurers ceased to have a preferred provider arrangement.
- Poor quality information on health insurance products.

PRE-EXISTING AILMENTS

The largest single complaint issue facing consumers this year has been the application of the pre-existing ailment provisions to their hospitalisation or intended hospitalisation. Pre-existing ailment complaints are generally the most costly for consumers compared to other issues.

The incidence of complaints in this category was very high. 775 complaints representing 23% of all lodged complaints related directly to pre-existing ailments. This was an increase of 266% of this complaint issue over the previous year. It should not have been this high. It was a direct result of poorly handled marketing by some funds during the lifetime health cover campaign, advertising that suggested to many that all waiting periods were waived and welcoming letters that failed to clearly indicate what the waiver specifically covered. This was compounded by a poor understanding by some medical practitioners of where the authority lies for determining pre-existing ailments. They, along with their patients, were under the false impression that if the condition had not been diagnosed prior to joining a health fund then it could not be deemed pre-existing. The only person with the authority to determine if an ailment is pre-existing under the provisions of the National Health Act, is the medical practitioner appointed by the fund for that purpose.

The varied application and interpretation of the pre-existing ailment provisions of the National Health Act have always created difficulties for consumers and as a consequence the Government commissioned a detailed report in 1999. (Dreher, Fogarty & Lipscombe, 2000). In November 2000 they adopted the report and its 16 recommendations. Although the best practice principles provided for in the report are yet to be finalised and distributed, health insurance funds which had previously adopted a different view of the provisions have generally now varied their practice in line with the report outcome.

It is indeed unfortunate that the measures outlined in the Dreher et al. report had not been in place much earlier. This would have alleviated some of the hardship faced by new

consumers who entered health insurance this year believing the product they were buying was free from waiting periods. The more accurate information requirements and best practices flowing from the report implementation would have defused many of the problems faced recently by new consumers.

The educative program following the finalisation of the best practice principles should allow for a consistent approach to be followed by all private health participants and reduce the incidence of complaints in this area.

PORTABILITY

A second area where consumers have consistently faced difficulty is in the area of product portability. The National Health Act as it relates to portability is extremely complex and again it is an area where the interpretation and subsequent application of the provisions by funds has been inconsistent.

There is growing evidence that many new members are reviewing their original purchase and seeing a need to change. Around 100 complaints this year involved problems associated with portability.

The Ombudsman's office, in liaison with officers of the Department of Health and Aged Care, together with health fund industry representatives combined to produce a set of twenty seven recommendations in a comprehensive review of portability arrangements. The review was completed and published in December 2000.

The basic principle underpinning all of the recommendations is that any member transferring from one product to another, either within a fund or between funds, will never be placed in a more adverse position than a new member entering that product for the first time. Although outwardly this principle seems so evident as to not need stating, it was not the position universally adopted and as a consequence aberrant practices led to significant disputes.

The Ombudsman has produced a new brochure for consumers *"The Right to Change"* and distributed it to all health funds in quantities sufficient to be provided to any member who expresses a desire to change product or fund.

The acceptance of the recommendations by health funds, and the consequent change to their administrative practices should lead to more consumer certainty and see a significant lessening of complaints in this area.

INFORMED FINANCIAL CONSENT

Prior to a patient undergoing a procedure within the private health sector, they should be fully informed of any costs that will not be met either by their health fund or by Medicare. Unfortunately this still does not occur routinely.

With the majority of health funds now having electronic verification systems in place, there is no excuse with elective surgery for not disclosing the cost implications of the episode in time for the consumer to give informed financial consent to the procedure. There is likewise

little excuse for patients not to be informed even in emergency situations.

A large proportion of complaints about pre-existing ailments, and product exclusions or limitations come about because the patient was not informed prior to the procedure that there was an impediment to their cover. They proceed without knowledge that they face significant costs because their product does not at the time cover their procedure. In a lot of instances, this lack of notification is caused by administrative oversight or in the worst instances neglect, on the part of health funds, medical practitioners or hospitals. It should not occur.

This office has long been an advocate of using electronic systems with a 24-hour direct interface to information on patient eligibility as the answer to this long-standing problem. Given the continuing reluctance of some participants to interface with these new systems, my office will take a firm stance in future where it can be shown that the consumer has been disadvantaged by not having a clear and unambiguous statement as to the likely cost implications of their procedure.

MEDICAL GAP

Even when the patient is aware they are covered for the procedure they are about to undergo, there is a strong desire by most consumers of private health not to be out of pocket after paying for the highest levels of hospital cover. The gap between the practitioner's charges and the combined Medicare and fund benefits has long been a concern to the privately insured.

In 1995 the Federal Parliament allowed for the Gap to be paid by health funds on the proviso that a contract existed either between the fund and the practitioner or between the fund, hospital and practitioner. There was staunch opposition from the medical profession to enter into contracts binding them to a third party. They contended their relationship was one between themselves and the patient only. As a consequence the gap continued to be a major impediment to full cover by consumers.

In 2000, the Federal Parliament again legislated to allow for gap payments by health funds; this time using the medium of approved schemes of arrangement not involving direct contracting with practitioners. Funds now have approved arrangements and there is an increasing tendency for practitioners in certain branches of the medical profession to participate. However there is still entrenched opposition from peak industry bodies such as the AMA. While this opposition continues consumers will suffer. The costs to individual consumers can be very significant. The body of this report will detail situations where consumers have faced significant out of pocket practitioner fees.

My office is well aware of the differences in opinion, which exist between insurers on one hand and sections of the medical profession on the other, relating to the question of the establishment and promulgation of lists of participating gap practitioners. We are also aware there are real concerns that the establishment of lists may introduce a quasi price/quality selection criteria, which is seen by some as not being in the best interests of the patient. It is very difficult in the combatant environment that exists with this whole

question of gap arrangements, to sort out the rhetoric from reality. Consumer rights dictate that the private patient has a right to know which specialists are participants in gap schemes. It is the responsibility of the referring practitioner to look to the maintenance of the quality referral criteria they would normally use and price then just becomes another factor to be considered with regards to the desires of the individual patient.

CONTRACT DISPUTES

It is disappointing to record that on a number of occasions during this year vulnerable consumers were placed in a position of heightened anxiety when hospitals and health funds were in dispute concerning the outcome of contract negotiations. My office was called upon to placate very frightened elderly, pregnant and sick consumers who were informed by hospitals, that they were no longer covered by their health fund. This unacceptable behavior was occurring right at the time the peak bodies representing the funds and the private hospitals were signing off on a voluntary code of conduct.

Hospitals, which were unable to negotiate benefits they considered appropriate, contacted past and prospective patients directly, informing them that their health fund would not honour previous levels of benefit and as a consequence the patient would be better off changing funds. Local newspapers carried similar messages causing considerable consternation to vulnerable members of the community. This office issued a warning to both hospitals and health funds, that we would not stand idly by while consumers were held to ransom to facilitate the commercial aspirations of the disputant parties. This practice of engaging the patients in the dispute, or placing derogatory statements in the local press is prohibited under the terms of the voluntary code of conduct.

It is important that non-signatory hospitals commit to the code, which their industry association successfully negotiated. The Code contains provisions which when combined with the industry portability principles, gives protection to all consumers wanting certainty of cover and access to treatment at their preferred hospital.

INADEQUATE INFORMATION

An area where a lot of detailed work needs to be done is in the provision and dissemination of quality information that fully informs all consumers of the scope of benefits within their product. My office has been openly critical of product brochures, which may be very successful as marketing tools but which ultimately fail to properly inform members. Far too often the bright and glossy brochures are difficult to navigate and lack information of substance. The ACCC is also concerned with this problem.

We have also been critical of information flows between consumers and funds, which fail to adequately inform participants of vital pieces of information. I will illustrate this problem by reference to probably the worst case of its kind brought to our attention during the year.

A Tasmanian family joined a major health fund during the lifetime health cover campaign period. In September their son was diagnosed with SV Tachycardia.

They sought information from the fund as to whether the procedure was a pre-existing ailment. Their practitioner had told them that the procedure necessary to alleviate the problem would need to be carried out in Melbourne.

In February the family received two written responses from the fund.

"This letter is to confirm that L's Tachycardia is not a pre-existing condition and therefore we will pay benefits for the hospital claim."

And then the next day,

"Based on the information supplied by Dr S, I advise that the above mentioned rule (PEA) will not be applied for the ailment illness or condition. Therefore, benefit will be payable on your current level of cover".

Unfortunately only very limited benefits were payable on their current level of cover. The family had purchased a cover, which had a benefit limitation on cardiac surgery, certainly not enough for private hospitalisation for such a procedure at a private hospital. They learned this after they had transported the patient and mother to Melbourne at considerable personal expense and inconvenience. They had to return to Tasmania without the procedure being carried out. When the Ombudsman's office intervened, the health fund accepted it had not adequately informed the member and agreed to pay benefits at the higher level. The correct information should have been properly conveyed at the very beginning of the process, not after a lengthy and unnecessary pre-existing ailment enquiry. If the fund had properly interrogated the database for the family and informed them early of the specific limitation, they would not have been subjected to the cost and added inconvenience of a trip to Melbourne.

This is not the only case where essential detail is lacking in information provided to consumers. It occurs quite regularly. To the credit of some of the major players in the industry, where this office has highlighted faulty literature there has been considerable effort to modify the information. Given the significant resources of these companies this sort of mishap should not occur, at least not as frequently as it does. Unfortunately on the other hand, some funds resolutely defend poorly constructed information even when it is shown to misinform some consumers. Consumers are too often left to carry the burden created by inaccurate and sometimes misleading information.

SUMMATION

As can be seen from my overview, there has been a large increase in consumer complaints during the reporting period. There is some evidence that this is abating but it is still too high. There is also considerable evidence of industry participants conscientiously working to install systems within their own work environment and within the broader industry environment to solve the underlying fundamental problems. Unfortunately others are still in denial with respect to the existence of a problem. It is fortunate for the industry and consumers that the former group is succeeding and there is significant progress becoming evident.

ROLE & FUNCTION

The Private Health Insurance Ombudsman is an independent statutory corporation established by the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995.* 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 is an independent body which resolves problems about private health insurance, and acts as the umpire in dispute resolution at all levels within the private health industry.

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 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.

The Ombudsman has jurisdiction to deal with complaints about the 30% Rebate for private health insurance.

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, a 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.

Private Health Insurance Ombudsman Staff: (L-R) Roger Gimblett, Hillary Stirrat, John Basso, Ursula Schappi, Ginette Bulmer, Norman Branson, Samantha Gavel, David McGregor, Sasha Andrews.

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

The Ombudsman received 3357 complaints in the reporting period 1 July 2000 to 30 June 2001, compared to 1875 for the corresponding period of the last report, an increase of some 79%. It is worthy of note that approximately 50% of the complaints were received from members with less than 12 months membership, although this group only made up around 30% of the insured group.

Figure 1 shows the distribution of these complaints through the four quarters of the year.

The 3357 complaints recorded consisted of 1081 disputes, 648 grievances and 1628 problems. Figure 2 is a representation of these ratios.

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 not have been resolved.

FIGURE 1: TOTAL COMPLAINTS RECEIVED BY QUARTER

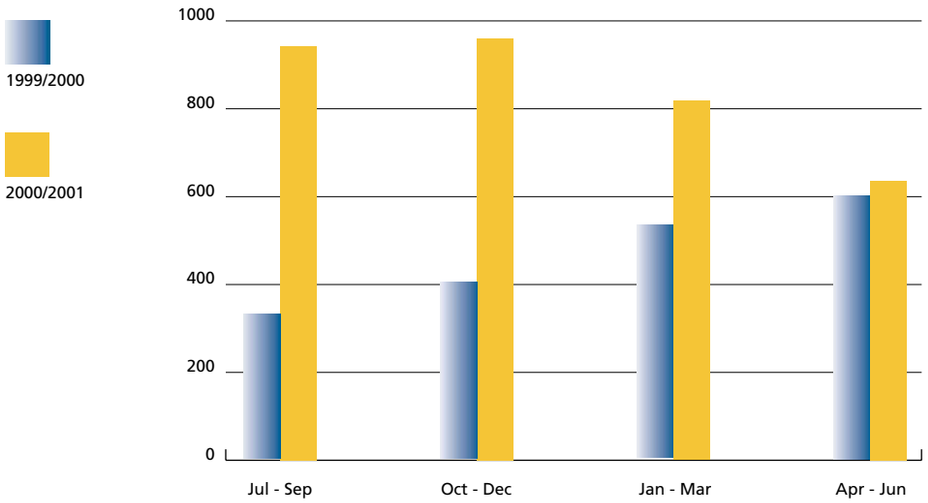
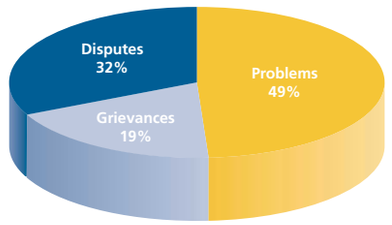


FIGURE 2: PERCENTAGE OF COMPLAINTS BY CATEGORY 2000/2001



The Ombudsman attempts resolution through conciliation by telephone or in writing. Common complaints in this category would include pre-existing ailments, informed financial consent, benefits available on portability of membership, benefits not in accordance with brochure descriptions and contribution errors.

- **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. Complaints within this category generally result from misunderstanding by the consumer of their rights under the product they have purchased, concerns with service levels provided by the fund or provider, price increase, 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.
- **Problems: Moderate 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. Issues within this category can be across the whole complaint range of product description, benefits paid, informed financial consent, pre existing ailments and service quality. The Ombudsman's staff empower the consumer to try and resolve the complaint directly and if they are not successful, they return and reactivate the complaint as a dispute.

The process and timeframes for handling these issues are depicted in Figure 3.

The majority of complaints handled are from fund members about their own fund. In a large number of instances this year, however complaints were recorded against the health fund and the provider, particularly when the complaint concerned pre-existing ailments and more than one party was involved in less than appropriate management of the issue. Fund members also lodge complaints about their hospital, (generally about inadequate information regarding out of pocket fees) doctor (almost always relating to either the gap between charges and benefits paid through Medicare and the fund, and the failure to inform of the discrepancy before proceeding) or other practitioners (generally about the gap between the charges and the benefit paid through ancillary tables). Overall complaints against these provider groups are small in

number when compared with complaints against health funds. Hospitals and some providers can also lodge complaints against health funds. These are also numerically small but generally of a complex nature. Issues surrounding selective contracting and second tier benefit payments constitute the majority of complaints from this group.

WORKLOAD

The office received 3357 complaints (problems, grievances and disputes) in 2000/2001, an average of 280 per month compared with 156 complaints per month in the previous year.

The office finalised 3284 complaints during the year; an average of 274 per month, compared with an average 154 complaints finalised per month in the previous year.

TIME TAKEN TO RESOLVE COMPLAINTS

Figures 4 and 5 provide information on the time taken to resolve complaints and shows a decrease in resolution time. To some extent this is attributable to the fact that a much larger number of complaints fell into the category of problem. This category has complaints which the Ombudsman's office considers it more appropriate for the complainant to take further action personally with the fund. These complaints are generally closed on the day of referral.

Response from funds on complaint handling is continuing to improve and most health funds respond to informal telephone and e-mail requests for information by the Ombudsman's staff assisting with the speedy resolution of complaints.

FIGURE 3: STEPS IN HANDLING APPROACHES TO THE OMBUDSMAN

DISPUTE	GRIEVANCE	PROBLEM
Timeframe Depends on the nature and complexity of matter and responses from health fund and provider	**Timeframe** Usually within 24 hours	**Timeframe** Immediate
Actions PHIO contacts health fund or provider to obtain report, mediate dispute or investigate matter	**Actions** Complainant provided with explanation or information to resolve matter, or there is no avenue for the Ombudsman to take up the matter	**Actions** If complainant has not attempted to resolve matter with fund or provider, refer back
Outcomes Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal recommendation by Ombudsman	**Outcomes** Detailed information	**Outcomes** Referral to health fund or provider

FIGURE 4: TIME TAKEN TO FINALISE COMPLAINTS (PROBLEMS, GRIEVANCES, DISPUTES)

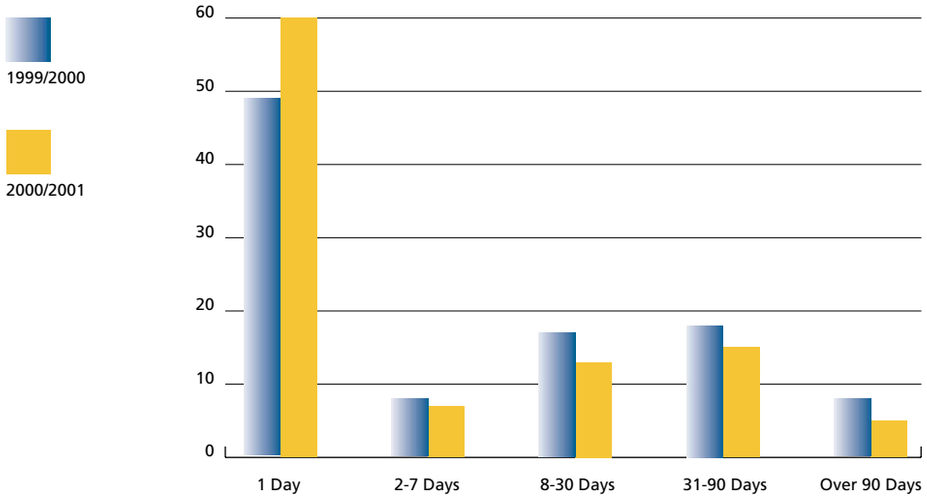
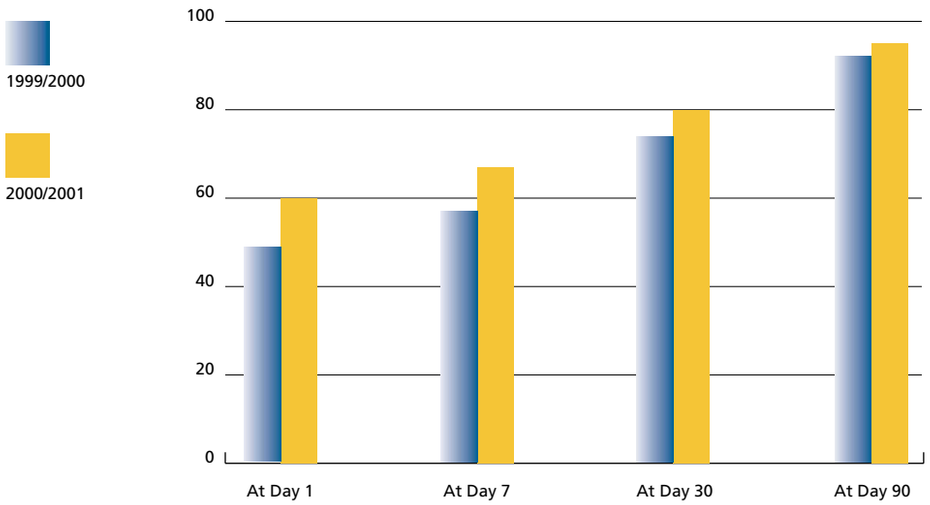


FIGURE 5: COMPLAINTS COMPLETED SINCE DAY OF LODGEMENT



WHO WAS COMPLAINED ABOUT

Most complaints were made about health funds (3148), followed by practitioners, doctors and dentists (135) and hospitals (65). 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 (3348) adds up to more than the total number of complaints (3284).

COMPLAINTS ABOUT HEALTH FUNDS

Figure 6 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. Higher dispute to market share ratios, are a pointer to a less than adequate internal disputes resolution process for complex issues within the fund.

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* provides for a hospital which has an agreement with a health fund to inform a potential patient of any out of pocket expense associated with a hospital episode. It is unfortunate this still does not routinely occur, with some major hospitals considering this as unnecessary in many instances. This inaction by the hospitals often causes great financial hardship to clients.

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

COMPLAINTS ABOUT DOCTORS

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. This Office has worked with the Department and the AMA to devise simple administrative procedures and documentation to facilitate the routine provision of information to inform patients.

RESOLVING COMPLAINTS

31% 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.

46% of complaints were referred directly back to the health fund, generally through the complainant. In these circumstances the Ombudsman was able to suggest ways for the complainant to pursue the matter with the health fund. Only in a relatively small number of instances was it subsequently necessary for the complaint to be re-opened as a dispute and actioned by the office direct with the fund on behalf of the contributor.

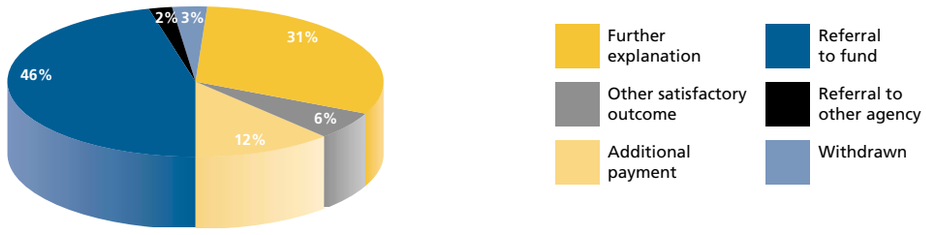
Payments made by health funds or accounts written off by hospitals resolved a further 12% of complaints. Payments by health funds may have resulted from a health fund

FIGURE 6: COMPLAINTS BY HEALTH FUND MARKET SHARE

Name of Fund	Total number complaints (Note 1)	% of total complaints	Total number of disputes (Note 2)	% of total disputes	% Health fund of market share (Note 3)
ACA Health Benefits Fund	2	0.1	1	0.1	0.1
AMA Health Fund Ltd	0	0.0	0	0.0	0.1
Australian Health Management Group	83	2.6	31	2.9	2.6
Australian Unity Health Limited	147	4.7	56	5.2	2.8
AXA Australia Health Insurance	353	11.2	151	14.0	10.3
CBHS Friendly Society Limited	13	0.4	4	0.4	0.9
Cessnock District Health Benefits Fund	0	0.0	0	0.0	0
Credicare Health Fund	6	0.2	1	0.1	0.5
Defence Health Benefits Society	37	1.2	12	1.1	1.1
Federation Health	3	0.1	1	0.1	0.2
Geelong Medical & Hospital Benefits Association Limited	19	0.6	4	0.4	1.0
Goldfields Medical Fund (Inc.)	18	0.6	3	0.3	0.5
Grand United Corporate Health Limited	8	0.3	1	0.1	0.2
Grand United Health Fund Pty Ltd	22	0.7	9	0.8	0.5
Health Care Insurance Limited	3	0.1	3	0.3	0.1
Health Insurance Fund of WA	11	0.3	2	0.2	0.4
Health-Partners Inc.	6	0.2	3	0.3	0.5
Healthguard Health Benefits Fund Ltd	1	0.0	0	0.0	0.1
HBF Health Funds Inc.	90	2.9	25	2.3	8.9
Hospitals Contribution Fund of Australia Limited	144	4.6	58	5.4	7.8
IOOF Health Services Limited	15	0.5	9	0.8	0.2
IOR Australia Pty Ltd	47	1.5	16	1.5	0.8
Latrobe Health Services Inc.	9	0.3	4	0.4	0.5
Lysaght Hospital and Medical Club	1	0.0	1	0.1	0.2
Manchester Unity Friendly Society in NSW	105	3.3	43	4.0	1.3
Medibank Private	1075	34.1	336	31.2	29.7
Medical Benefits Fund of Australia Ltd	671	21.3	214	19.9	17.3
Mildura District Hospital Fund Limited	1	0.0	1	0.1	0.3
Navy Health Limited	2	0.1	0	0.0	0.3
NIB Health Funds Limited	152	4.8	61	5.7	5.4
NRMA Health Pty Ltd	34	1.1	8	0.7	1.5
Phoenix Welfare Association Ltd	0	0.0	0	0.0	0.1
Queensland Country Health Limited	3	0.1	0	0.0	0.2
Railway & Transport Employees Friendly Society Health Fund Ltd	4	0.1	1	0.1	0.3
Reserve Bank Health Society	0	0.0	0	0.0	0.1
SA Police Employees' Health Fund Inc	2	0.1	0	0.0	0.1
St Luke's Medical & Hospital Benefits Association Limited	6	0.2	3	0.3	0.4
Teachers Federation Health Limited	14	0.4	2	0.2	1.4
Transition Benefits Fund Pty Ltd	0	0.0	0	0.0	0.1
Queensland Teacher's Union Health Fund Ltd	8	0.3	3	0.3	0.4
Transport Friendly Society Limited	4	0.1	1	0.1	0.1
United Ancient Order of Druids Victoria	0	0.0	0	0.0	0.1
United Ancient Order of Druids G/L NSW	3	0.1	1	0.1	0.0
Western District Health Fund Ltd	26	0.8	9	0.8	0.7
Total for Registered Funds	**3148**	**100.0**	**1078**	**100.0**	**100.0**

Note 1. Complaints = problems, grievances and disputes
Note 2. Disputes require intervention by the Ombudsman with the fund
Note 3. Derived using 2000 PHIAC Annual Report

FIGURE 7: OUTCOMES OF FINALISED COMPLAINTS



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. Accounts written off by hospitals would have been as a direct result of a hospital failing in their obligation to adequately inform patients of their costs.

An additional 6% of complaints were resolved by taking other remedial action, such as re-instating a membership or allowing the back payment of contributions where a membership had lapsed.

3% of complaints were withdrawn or required no further action.

Finally, 2% of complaints which met the criteria for complaint contained in the National Health Act were referred to another agency.

Information about the resolution of complaints is provided in Figure 7.

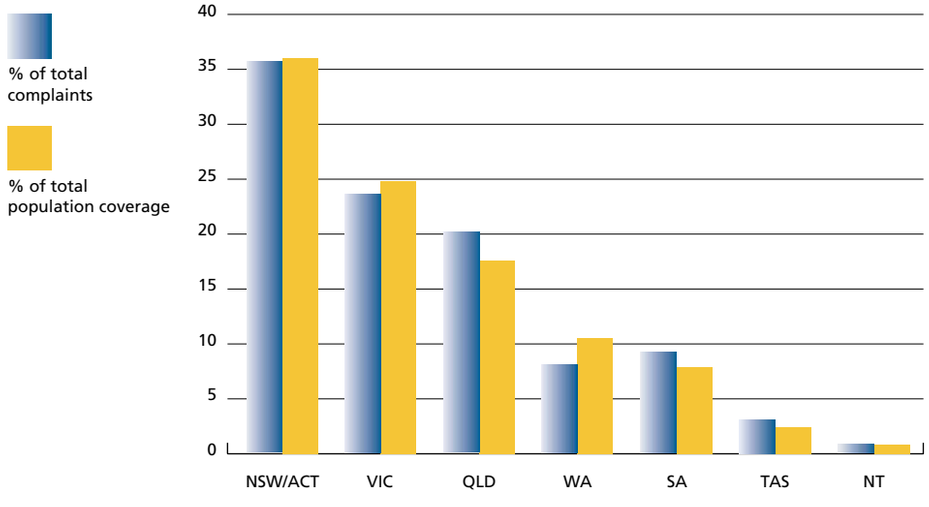
TYPE OF COMPLAINANT

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 (99%), followed by hospitals/day hospitals, practitioners, and health funds.

HOW COMPLAINTS WERE MADE

89% of all problems, grievances and disputes were made by telephone. 8% were received by letter. The remaining 3% were made by fax, personal visit, e-mail or by Parliamentary Representation.

FIGURE 8: COMPLAINTS BY POPULATION COVERED BY STATE & TERRITORY



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.

There were no investigations conducted under Section 82ZTA of the *National Health Act 1953*.

COMPLAINTS BY STATE/TERRITORY

Figure 8 identifies, on a state by state basis, where complaints originate. This data is shown by State, against the percentage of people who have private health insurance coverage.

COMPLAINT ISSUES

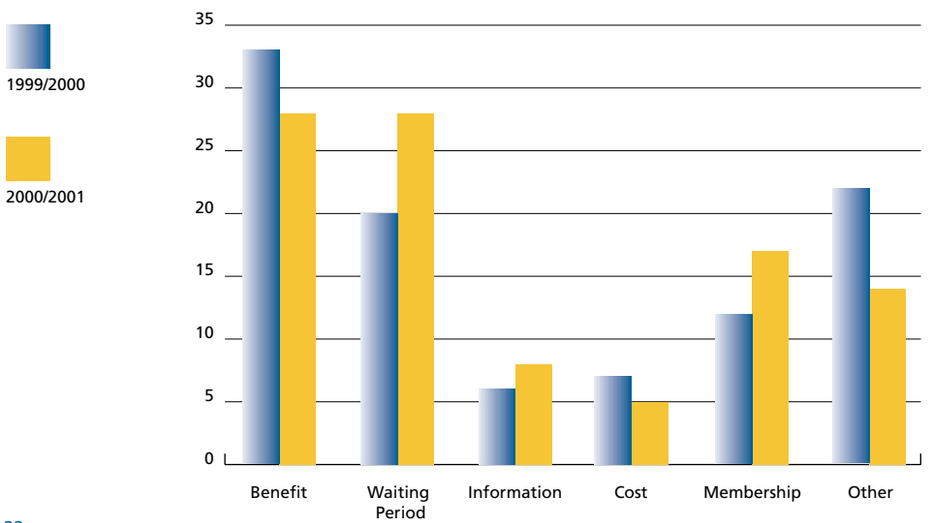
Complaints to the Ombudsman must first meet the requirements of the Section 82Z of the National Health Act. Embodied in that section is the requirement that a complaint be about a health insurance arrangement. Given this criteria, it is not surprising the great majority of complaints are from consumers about their health insurer. From a consumer's perspective, matters involving hospitals and doctors are generally about fees and accounts that fund members have been asked to pay. On the other hand, there are quite a number of complaints registered by practitioners and hospitals with respect to preferred provider conditions and conditions of contract. Complaints about the service that doctors or hospitals provide to health fund members do not come within the bailiwick of this office and are referred to the various state-based health complaints bodies.

The highest category of complaint this year was shared between Waiting Periods and Benefits, each accounting for 28% of all complaints received. 20% of complaints were registered as Membership related, Information represented 8% and various Cost issues accounted for a further 5%. The remaining 11% of complaints dealt with a wide variety of other issues including health fund rule changes, the quality of customer service from a health fund, private patient elections in public hospitals, health fund and hospital contracting arrangements.

WAITING PERIODS

28% of complaints received by the Ombudsman during the financial year related to the issue of Waiting Periods; this is significantly higher than the 20% recorded last year and has risen from 14% to its current 28% over a two year period.

FIGURE 9: COMPLAINT ISSUES



This category includes the application of waiting periods for pre-existing ailments and obstetric services.

PRE-EXISTING AILMENTS

Pre-existing ailment complaints rose dramatically during this reporting period. To some extent this was anticipated, given that at the commencement of the period some funds were still inappropriately applying the rule and marketing campaigns for new members offered waivers of waiting periods, but failed to adequately inform consumers regarding pre-existing ailments. 775 pre-existing ailment complaints were reported.

The pre-existing ailment complaints comprised;

- 104 Grievances, where further information on the issue was provided by the Ombudsman's office. Fortunately in quite a number of instances, clarification was provided prior to the member completing arrangements for their medical procedure. The consumer was questioning the application of the rule to their particular circumstance.
- 264 complaints in this area were problems, where the Ombudsman considered the health fund had not addressed the issue at an appropriate level. The consumer was provided with assistance and advised to take up their complaint at a more senior level with the health fund. These complaints were then resolved at this level, as the member did not subsequently resurrect the complaint as a formal dispute through this office.
- 407 complaints were recorded as disputes where this Office had to intervene in the process to resolve the issue.

The basis of a large number of the complaints was that consumers contended that the fund had waived all waiting periods including pre-existing ailments.

Pre-Existing ailment issues are generally extremely costly, many running to thousands of dollars for consumers. The resolution of these issues involves the Office in extensive investigations of the consumer claims and processes of all other parties concerned. The process of resolution can involve investigation of;

- the marketing campaign by the fund,
- information provided to the patient by the medical practitioner;
- checking processes by the admitting hospital and their obligations to the consumer with respect to providing informed financial consent to the procedure;
- the response by the health fund to all parties (member, practitioner, hospital), with respect to timeliness, accuracy and process;
- the consumer's own actions with respect to the process.

Investigations revealed deficiencies to a varying extent throughout the process including;

- poorly handled marketing by some funds;
- advertising that suggested to many that all waiting periods were waived;
- welcoming letters that failed to clearly indicate what the waiver specifically covered;
- a poor understanding by some medical practitioners of where the authority lies for determining pre existing ailments;
- failure by some hospitals to carry out the

necessary checks to verify patient eligibility for the particular procedure;
- failure by some health funds to clearly specify to treating practitioners and hospitals the extent of the coverage for the individual consumer;
- failure by some health funds to properly notify their members when there was an impediment to their cover;
- failure by some health funds to properly assess the procedure in accordance with the provisions of the Act;
- Failure by some consumers to understand the extent of the pre-existing ailment rule;
- Failure by some consumers to accept the responsibility they have for checking that their policy actually covered the procedure they were about to undergo.

Recognising the varied application and interpretation of the pre-existing ailment provisions of the National Health Act the Government commissioned a detailed independent eminent persons review in 1999. In November 2000 they received the report by Dreher, Fogarty and Lipscombe and adopted its 16 recommendations.

It is unfortunate the review was not completed and implemented earlier. If it had been, the impact on the new consumers entering the system could have been markedly different.

It is though pleasing to report that once the review was finalised, those funds which operated in a way inconsistent with the findings, varied their practice in line with the principles.

Mrs Adelaide, joined her health fund in February and suffered a gallstone attack in late June. Her health fund denied benefits on the basis that a gallstone of that size must have exhibited signs or symptoms.

The Ombudsman's Office took up the case on the basis that proper process had not been followed, in that the medical practitioner appointed by the fund, did not point to any evidence of signs or symptoms specifically relating to the patient but relied on his medical understanding that gallstones of that size would have been in existence at the time of joining the fund.

Following an inconclusive report from the fund's medical officer, the Ombudsman's Office obtained Medicare records which failed to provide evidence that Mrs Adelaide exhibited signs or symptoms of gallstones in the six months preceding joining the fund.

The Ombudsman was asked to speak specifically on this case on local radio and indicated obliquely that the position adopted by the fund with respect to certain categories of pre-existing ailments was inconsistent with the practice of the industry generally.

Four and a half months after the seventy five year old Mrs Adelaide had her surgery the health fund paid the hospital account.

The health fund practices are now in line with the recommendations of the Dreher et al. report with respect to determination of signs and symptoms.

OBSTETRIC WAITING PERIODS

Obstetric waiting period complaints fell into two main categories:

- those associated with the 12 month restriction on benefits allowed for under the legislation, and
- those which resulted from the incorrect application, by some funds, of the 12 months waiting period to all forms of maternity related procedures.

The first range of complaints related to those who once again contended they had purchased a product when the waiting periods were waived, or who upgraded their product to include maternity provisions without recognising the twelve month waiting period applied.

The other significant area of complaint related to an inconsistent application of the provisions of the defined waiting periods and what procedures were covered under the Act. It was necessary for this office to ask the Department of Health and Aged Care to clarify the bounds of the obstetrics restriction allowed for in the Act. They clearly defined the provision, which allows for the waiting period to be applied only to those items in the obstetrics category of the medical benefits schedule and not gynaecological items. Funds were required to modify their rules and brochures to strictly comply with the provisions of the Act.

Mrs Hope joined her health fund in December and was in the process of IVF treatment. She was aware of the waiting periods associated with pregnancy through the program. On the 31st of July, Mrs Hope was diagnosed pregnant by natural means but miscarried only a few weeks later, necessitating a day in hospital and a standard gynaecological procedure.

On the 1st September Mrs Hope contacted the Ombudsman because the health fund had rejected the hospitalisation claim. The rejection was on the basis she had not served twelve months waiting period for maternity related procedures, even though the expected date of birth was in excess of twelve months from joining and the procedure was gynaecological and not obstetric as provided for in the National Health Act 1953.

The fund continued to argue that the Act was meant to allow for a 12 month waiting period for all maternity related procedures and their brochure and rules allowed for this.

The Ombudsman referred the fund interpretation of the Act to the Department for determination. The Department responded, "the clear intention of the Act (sic) is that the 12- month waiting period only be applied to obstetric conditions listed under the Medicare Benefits Schedule. It is not to apply to procedures listed under gynaecological item numbers such as the evacuation of the uterine contents following miscarriage…"

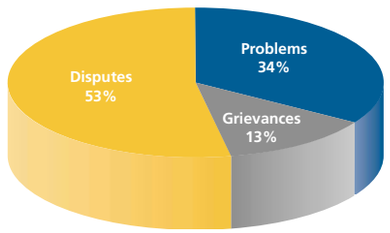
The health fund did not accept this ruling and sought a further review by the Department.

In late December, the Department having considered the objection by the fund, reiterated its earlier advice.

The Ombudsman intervened personally with the CEO of the health fund and arrived at a position where the fund agreed to amend its rules to comply with the Departmental interpretation and to provide for benefits to also be paid where the expected date of birth falls outside the twelve month waiting period, but where medical intervention is needed prior to this period.

The case was resolved on the 16th March, over six months from when it was first referred by Mrs Hope.

FIGURE 10: PRE-EXISTING AILMENT COMPLAINTS



BENEFITS

Complaints where benefits were the concern of members accounted for 28% of all complaints. The significant sub categories include Gap Payments (339 complaints), the benefit amount (254 complaints) and Extent of the Cover (148 complaints).

The issue of Gap payments has always been significant for consumers of private health insurance. Their expectation is that there will be no gap, (because they are paying for top cover) or if there is a gap it will be small enough not to cause concern. Unfortunately their expectations are not always met. Large medical gap payments still exist and consumers, in a number of instances, are not being informed prior to the procedure.

Mr Don Caster had his hospital cover for many years and required an ankle reconstruction. The surgeon charged Don $2500 (250% of the medical benefits scheduled fee). Medicare rebated $750 and the fund $250. Mr Caster was advised by the surgeon that if the balance was forthcoming in 30 days the bill could be reduced to $1250 leaving a balance of $250, otherwise the full $1500 outstanding would need to be paid.

Gaps may also occur with hospital occupancy and with ancillary service provision.

These are generally categorised for statistical purposes under amount of benefit.

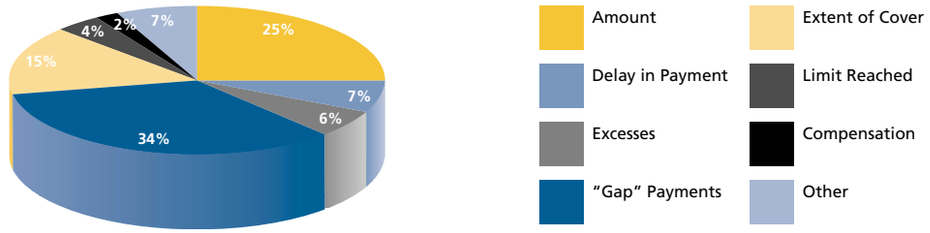
Some consumers have chosen restricted, or excluded benefit products as they offer a lower cost alternative to full cover. They are often unaware of the full implications of the restriction or exclusion. This office is concerned that consumers can find themselves without cover for significant procedures, particularly where the procedure can result from the outcome of otherwise unrestricted services.

The following example, provided by a treating practitioner, is only one of many that can and do occur. There is a need for the industry and Government to establish guidelines for marketing of these products to safeguard consumers.

"This policy states that the patient is not covered for plastic surgery. Whilst it is likely that this product was designed to provide a budget policy for members who felt they would not require cosmetic plastic surgery, it is implemented by the fund to exclude all items from the plastic surgery section of the Medical Benefits Schedule, that is sub group 13.

In effect, this denies patients access to all forms of plastic surgical reconstruction including cancer surgery, burns surgery and even cleft lip and palate surgery. I am currently treating a patient, a member of the fund, who was astonished to discover that she could have a mastectomy for cancer under the terms of her policy, but could not have a breast reconstruction to make her feel feminine once more.

FIGURE 11: BENEFIT COMPLAINTS



Unfortunately the member only discovers the terminology nuances when they are placed in the invidious position of requiring services from a reconstructive plastic surgeon."

Note: The particular product questioned by the surgeon now defines the restriction for "plastic, cosmetic and reconstructive surgery". None-the-less a survey conducted by this office showed scant understanding of the breadth of these restrictions by the general public.

MEMBERSHIP

Complaints about 'Membership' accounted for 17% of complaints received and included concerns about the cancellation or suspension of a health fund membership and difficulties reconciling contributions paid with authorities to deduct through electronic processing. They also included concerns related to transferring from one fund to another and the portability provisions available to them when this occurs.

Cancellation and suspension of membership has always been a difficult problem for members, but with the advent of lifetime health cover, it assumes a further dimension. Unacknowledged cancellation or suspension now has the possibility of causing the unwary member to face revised age contribution rates. There is a need for funds to be more alert to the possible problems faced by consumers when they temporarily fall into arrears.

INFORMATION

Complaints about 'Information' accounted for 8% of all complaints received and these complaints concerned issues such as misleading information, inadequate information and the lack of appropriate information.

This Office has informed funds where their printed and oral information lacks clarity. In many instances they respond positively with some funds even availing themselves of assistance by the Office to proof read consumer brochures prior to production. Unfortunately though, some funds still have poorly scripted advice to members both verbally and in writing.

COST

Complaints in which 'Cost' was the issue were marginally lower than the previous low number. This is a reflection on the fact there were no general contribution cost increases during the period.

COMPLAINT ISSUES

FIGURE 12: MEMBERSHIP COMPLAINTS

Complaints relating to cost not only concern the price of health fund premiums, but also differential charging of privately insured patients by some health providers and alleged lack of informed financial consent to health providers' fees and charges.

INFORMED FINANCIAL CONSENT

A patient about to undergo an in-hospital medical procedure should always have enough information about the cost implications of the process to make an informed decision to allow the hospitalisation to proceed. Far too often this does not occur. As a consequence the patient faces large and unexpected accounts. The reasons behind these problems are many and varied. In the main there are systems in place to alleviate the problem. Yet informed financial consent does not routinely occur.

Health insurance is recognised by all in the private health industry as being a complex product. Even for professionals within the industry it is sometimes difficult to immediately determine the exposure an individual patient may have for a procedure. The professionals within the broader health industry have a responsibility to protect their patient/consumers from costs for which they are not covered.

Most private health funds and some private hospitals have set up interfacing electronic systems to allow for the eligibility checking necessary to protect consumers.

Other health funds still rely on a paper-based system but these are becoming more efficient or being phased out. These processes are also available to medical practitioners. Why then are patients still routinely being denied full and accurate information on which they can make an informed decision?

Mr Melbourne was admitted through casualty to a major city private hospital on a Sunday suffering from chest pain. The ward nurse was provided with a fund membership card and informed by the staff member the maximum cost would be the annual excess of $500.

On the Monday afternoon after another attack, Mr Melbourne's cardiologist recommended an angiogram.

On the Tuesday evening after being convinced by another surgeon that the procedure was the appropriate course of

FIGURE 13: INFORMATION COMPLAINTS

action, Mr Melbourne signed the consent forms. He stated at this time "at no stage were financial issues and aspects of this procedure discussed with me and my mind was only concerned with the clinical aspects."

The health fund subsequently advised the Ombudsman that a fund check was carried out by the hospital revealing restricted benefits for cardio thoracic procedures.

When questioned on the hospital's failure to act on the fund advice, they responded in part "Taking into account the patient's history and the reason for admission there was no reason to suggest that his insurance cover was inadequate. ….. It is also reasonable to expect that Mr Melbourne would have been aware of the restrictions to his health cover."

Mr Melbourne has an outstanding account in dispute with the hospital of nearly $9000 after payment of his fund benefit.

This is a classic example where not only did the hospital fail in its obligation to respond appropriately to the patient after verifying eligibility, when they were found wanting on this obligation, they sought to shift the blame to the consumer.

The National Health Act requires that a health fund and hospital contract include an obligation for the hospital to advise a patient of any out of pocket costs they will incur. It is difficult to understand how they can fulfil this legislated obligation without formally establishing the individual's eligibility for the procedure.

Given the availability of membership verification processes, this office needs to adopt a vigorous approach to those hospitals, funds and practitioners who fail in their individual obligation to carry out the necessary checks.

GENERAL ISSUES

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:

- The Ombudsman was able to participate in a considerable number of radio and television interviews during the year, due to the high profile health insurance was given by the mainstream media. Radio interviews and talk-back were conducted in all States.
- The Ombudsman publishes a regular quarterly report which is widely distributed.
- The Ombudsman hosts a World Wide Web site where consumers can access a range of brochures, recent Ombudsman Quarterly Bulletins and 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 web site was extensively upgraded this year making access and linkages easier and allowing for information to be made available more speedily. The Ombudsman's web-site is located at: http://www.phio.org.au During the 00/01 financial year the Ombudsman's website was visited by 27,275 unique users who viewed a total of 33,551 pages. There were 982 complaints and enquiries lodged via the website and 11,677 pdf files were downloaded. These include PHIO's Quarterly Bulletins, Annual Reports and Discussion Papers.
- The Ombudsman and staff spoke at numerous conferences during the year and sponsored a successful national seminar open to the whole private health industry.

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.*

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 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 the office through the National Relay Service by telephoning 13 36 77.

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

A primary goal is to raise community awareness about the Ombudsman through the media and through the wide distribution of pamphlets, bulletins and our annual report to community groups, private hospitals, doctors' surgeries, health funds, Ombudsmans' offices, consumer affairs organisations and Members of Parliament.

Information about the Ombudsman's role and function is also available to the wider community through the publication of our brochures in six community languages, Arabic, Greek, Italian, Spanish, Chinese and Vietnamese.

RELATIONS WITH STAKEHOLDERS

The Ombudsman produces a Quarterly Bulletin containing general information about current problem areas and health insurance 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 February, the Office conducted a seminar in Wollongong, inviting participation from the private health industry. Feedback from participants was excellent and it is intended to conduct further seminars to assist in maintaining an awareness by appropriate personnel of the issues which come before the office and the means adopted to resolve complaints.

In March 2001, the office carried out a mail survey of a randomly selected 300 complainants who had lodged completed complaints during the period 1 September to 31 December, 2000. 128 complainants responded.

The aim of the survey was to gauge the degree to which PHIO 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 complainant 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:

95% reported that staff listened to their concerns, with a similar response to the office explaining their role.

- 92% of respondents said they were satisfied or mostly satisfied with the way staff handled the complaint.
- 84% were satisfied with the time it took to finalise the complaint.
- 92% were of the view that the Ombudsman's staff were independent in dealing with their complaint.
- 92% reported they were satisfied with the Ombudsman's service overall.

It is interesting to note that almost all those clients who recorded dissatisfaction with the office, related to the complaint category of problem, where the office refers the member back to the health fund to resolve the issue without formal intervention by the Ombudsman.

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 presented information to various bodies assisting in the formulation of health policy and the compliance with established rules and laws. Some of the issues of significance were:

GENERAL ISSUES

- Assistance with the development of the Private Health Insurance Key Features Guide.
- Assistance with the development of best practice guidelines to the private health industry on pre existing ailments and conditions.
- Completion in December 2000 of A Review of Portability Arrangements for Private Health Insurance. This included the adoption by the Department of Health and Aged Care of all 27 recommendations.
- Provision of detailed information to the Australian Competition and Consumer Commission to allow it to comply with the provisions of an order from the Australian Senate for six monthly reporting on "any anti competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses".
- Provision of evidence to the Australian Competition and Consumer Commission with respect to certain health fund practices.

APPENDICES

STATUTORY REPORTING INFORMATION

CORPORATE GOVERNANCE

Being a small office with duties specified by the National Health Act 1953, 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. In providing for this, the Ombudsman works with the Director of Policy and Customer Service to define the operational procedures and includes the Director of Corporate Services in determining administrative processes.

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 funds 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 task 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 to bring to the attention of the Ombudsman and the Director of Policy and Customer Service, potential and actual issues, which require broader attention. Dispute resolution staff need to be highly trained and sourced from such disciplines as Law, Commerce or Nursing. The activity of the office is very intense and staff retention as a consequence is a significant problem.

STAFF DETAILS

As at 30 June 2001, the staff employed by the Private Health Insurance Ombudsman comprised:

Permanent & Part-Time Employees	Female	Male
Ombudsman	-	1
Director, Policy & Customer Service	1	-
Director Corporate Services	1	-
Senior Dispute Resolution Officers	1	1
Dispute Resolution Officers	1	2
Administrative Assistant	1	-
Total	**5**	**4**

STATUTORY POSITIONS

The Private Health Insurance Ombudsman comprises one statutory office holder:

Officer	Position	Term	Expiry Date
Mr N Branson	Ombudsman	3 years	1 August 2002

The Ombudsman's remuneration is determined by the Remuneration Tribunal.

STAFF DEVELOPMENT AND TRAINING

During the 2000-2001 financial year $7,440 was spent on PHIO staff attending training courses, conferences and seminars. During the financial year the Ombudsman continued its staff development and training program for Dispute Resolution staff.

In February 2001 the Ombudsman's Office conducted its second annual "Consumer Issues In Private Health" seminar, which is a significant training event attended by customer service and dispute staff associated with the private health insurance funds, together with staff from hospitals and other key industry stakeholders. This seminar is self funding.

With the assistance of the office, staff also participated in part-time studies at formal educational institutions.

STAFF EMPLOYMENT STATUS

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.

The following table shows the numbers and status of staff who are employed on 30 June 2001

Occupational Group	Women	Men	NESB1	Total Staff
SES		1	-	1
Other	5	3	2	8
Total	**5**	**4**	**2**	**9**

Note: SES Senior Executive Service
Other All other staff - temporary and permanent
NESB1 Non-English speaking background, 1st Generation

Workplace structures, systems and procedures are in place to assist employees balance their work and family responsibilities effectively.

PERFORMANCE APPRAISAL

The Ombudsman has a performance appraisal system in place that is used to measure staff performance. This tool is used to assist the Ombudsman with annual salary reviews. All staff are subject to an annual performance appraisal. Salary and promotion advancement is based solely on performance.

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.

ACCOUNTING

The Ombudsman has engaged Hall Chadwick Chartered Accountants to assist it with its accounting functions. The office utilises the MYOB suite of accounting programs internally.

The Ombudsman's Audit Committee, which comprises PHIO's representatives from our office, Hall Chadwick and the National Audit Office met twice during the financial year.

OUTCOMES AND OUTPUTS

The Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Aged Care PBS Outcome Number 8, Choice Through Private Health.

The Ombudsman provides regular advice and makes recommendations about the private health insurance industry. It directly delivers services that contribute to the outcome of a viable private health insurance industry by improving consumer confidence in private health insurance.

CONSULTANTS ENGAGED

The Ombudsman did not engage consultants during the financial year.

ADVERTISING AND MARKET RESEARCH

The Ombudsman only expended $400.00 on advertising during the financial year. Instead we concentrated efforts on increasing our visibility through radio and television interviews. Staff presented papers to industry conferences.

Further information regarding advertising and market research can be found under the sections titled Access and Public Awareness and Relations with Stakeholders provided earlier in this report.

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 2000 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. This system was upgraded during the financial year.

PAYROLL SERVICES

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

FRAUD CONTROL

Staff are trained in fraud awareness and 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. A formal fraud procedure was introduced during the year. No cases of fraud were detected during the year.

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. This year saw us review and upgrade our Service Charter.

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 Service Charter are sent to people who contact the Ombudsman's office with a complaint or inquiry, they can also be downloaded from our internet site. Copies have also been sent to consumer groups and other stakeholders.

OCCUPATIONAL HEALTH AND 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 Director, Policy and Customer Service 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*.

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.

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 2001.

ESTABLISHMENT

The Private Health Insurance Ombudsman (the 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". 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 brochure "The Right to Change - Portability in Health Insurance".
- A booklet and brochure "Private Patients' Hospital Charter"
- Complaints Register and Complaints files
- Guidelines for staff "Dealing with complaints and Inquiries - Policies and Procedures"
- Guideline for staff "Complaints management and Reporting System - User Guide"
- 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 categories of 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 brochure "The Right to Change - Portability in Health Insurance".
- A booklet and brochure "Private Patients' Hospital Charter"

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 (Free-call)
- 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 $30.00 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 9.00am and 4.30pm on weekdays.

EXTERNAL REVIEW & SCRUTINY

The office subjects itself to regular review of its performance by way of the conduct of a survey of complainants. The review of complainants is extensive and was offered to 9% of total complainants.

Details of this review are available 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 Commonwealth Government agencies, the Ombudsman introduced a Service Charter in June 1998 and was reviewed in this period.

The Service Charter covers all of PHIO'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 in place a system for recording complaints, compliments and feedback about our service.

During the reporting period, there were three formal complaints about our service recorded, 34 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.*

FINANCIALS

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Aged Care

Scope

I have audited the financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2001. The financial statements comprise:

- Statement by the Ombudsman;
- Statement of Financial Performance;
- Statement of Financial Position;
- 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 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 in Australia 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.

Audit Opinion

In my opinion,

- the financial statements have been prepared in accordance with Schedule 1 of the Commonwealth Authorities and Companies (Financial Statements 2000-2001) Orders; and
- the financial statements give a true and fair view, in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and Schedule 1 of the Commonwealth Authorities and Companies (Financial Statements 2000-2001) Orders, of the financial position of the Private Health Insurance Ombudsman as at 30 June 2001 and the results of its operations and its cash flows for the year then ended.

Australian National Audit Office

P Hinchey
Senior Director

Delegate of the Auditor-General

Sydney
27 August 2001

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

Private Health Insurance
OMBUDSMAN

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 Schedule 1 of the Commonwealth Authorities and Companies (Financial Statements 2000-2001) Orders made under the *Commonwealth Authorities and Companies Act 1997* for the year ended 30 June 2001.

N Branson
.....
Norman W Branson

15 Aug 2001
.....
Dated

Suite 1201 Level 12
31 Market St Sydney NSW 2000
Telephone (02) 9261 5855
Facsimile (02) 9261 5937
http://www.phicc.org.au
Complaints Hotline 1800 640 695

STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 2001

	Note	2001 $	2000 $
Revenues from ordinary activities			
Revenues from Government	**2A**	**950,000**	950,000
Interest	**3A**	**19,539**	11,328
Other	**3B**	**189**	1,932
Total revenues from ordinary activities		**969,728**	963,260
Expenses from ordinary activities			
Suppliers	**4A**	**340,273**	308,060
Employees	**4B**	**598,504**	443,666
Depreciation and Amortisation	**4C**	**60,704**	57,057
Total expenses from ordinary activities		**999,481**	808,783
Net operating surplus (deficit) from ordinary activities		**(29,753)**	154,477
Total changes in equity other than those resulting from transactions with owners as owners		**(29,753)**	154,477

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 2001

	Note	2001 $	2000 $
ASSETS			
Financial assets			
Cash	5A	**219,020**	191,336
Receivables	5B	**1,294**	477
Total financial assets		**220,314**	191,813
Non-financial assets			
Infrastructure, plant and equipment	6	**69,765**	109,137
Total non-financial assets		**69,765**	109,137
Total assets		**290,079**	300,950
LIABILITIES			
Payables			
Suppliers	7A	**16,519**	9,185
Total payables		**16,519**	9,185
Provisions			
Employees	7B	**49,845**	38,296
Total provisions		**49,845**	38,296
Total liabilities		**66,364**	47,481
EQUITY			
Accumulated surplus (deficit)		**223,715**	253,470
Total equity		**223,715**	253,470
Current liabilities		**52,417**	47,481
Non-current liabilities		**13,947**	0
Current Assets		**220,307**	191,813
Non-current assets		**69,765**	111,913

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

STATEMENT OF CASH FLOWS

For the year ended 30 June 2001

	Note	2001 $	2000 $
OPERATING ACTIVITIES			
Cash Received			
Appropriations		**950,000**	950,000
Interest		**19,539**	11,328
Other		**189**	1,932
Total cash received		**969,728**	963,260
Cash Used			
Suppliers		**(307,906)**	(301,400)
Employees		**(603,565)**	(469,391)
Total cash used		**(911,471)**	(770,791)
Net cash from operating activities	14	**58,257**	192,470
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**(30,573)**	(53,922)
Total cash used		**(30,573)**	(53,922)
Net cash from investing activities		**(30,573)**	(53,922)
Net increase/(decrease) in cash held		**27,684**	138,548
Cash at the beginning of the reporting period		**191,336**	52,788
Cash at the end of the reporting period	13	**219,020**	191,336

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

SCHEDULE OF COMMITMENTS

As at 30 June 2001

	2001 $	2000 $
BY TYPE		
Other Commitments		
Operating Leases	**285,019**	150,981
Total other commitments	**285,019**	150,981
BY MATURITY		
Operating lease commitments		
One year or less	**105,994**	84,835
From one to two years	**97,650**	66,146
From two to five years	**81,375**	0
	285,019	150,981

SCHEDULE OF CONTINGENCIES

As at 30 June 2001

	2001 $	2000 $
CONTINGENT LOSSES	**0**	0
CONTINGENT GAINS	**0**	0
Net Contingencies	**0**	0

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the year ended 30 June 2001

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

1.1 Basis of Accounting

The financial statements are required by Schedule I to the *Commonwealth Authorities and Companies Act 1997* and are a general purpose financial report.

The statements have been prepared in accordance with:

- Schedule 1 of Commonwealth Authorities and Companies (Financial Statements 2000 - 2001) Orders in relation to financial year ending on 30 June 2001;
- Australian Accounting Standards and Accounting Interpretations issued by Australian Accounting - Standards Boards;
- Other authoritative pronouncements of the Boards; and
- Consensus Views of the Urgent Issues Group.

The statements have been prepared having regard to:

- Statements of Accounting Concepts;
- The Explanatory Notes to Schedule 1 issued by the Department of Finance and Administration; and
- Guidance Notes issued by that Department.

The Statements of Financial Performance and Financial Position have been prepared on an accrual basis and are in accordance with historical cost convention, except for certain assets which, as noted, are at valuation. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

1.2 Changes in Accounting Policy

The accounting policies used in the preparation of these Financial statements are consistent with those used in 1999-2000.

1.3 Employee Entitlements

The liability for employee entitlements 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 Authority is estimated to be less than the annual entitlement for sick leave.

The liability for annual leave reflects the value of total annual leave entitlements of all employees at 30 June 2001 and is recognised at its nominal amount.

The non-current portion of the liability for long service leave is recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at 30 June 2001. In determining the present value of the liability, the Authority has taken into account attrition rates and pay increases through promotion and inflation.

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

1.4 Leases
A distinction is made between finance leases, which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of leased non-current assets, and operating leases, under which the lessor effectively retains substantially all such risks and benefits.

Lease payments for operating leases are charged as expenses in the periods in which they are incurred.

The Ombudsman has no finance leases.

1.5 Cash
Cash means notes and coins held and any deposits held at call with a bank or financial institution.

1.6 Financial Instruments
Accounting policies for financial instruments are stated at Note 15.

1.7 Property, Plant and Equipment

Asset Recognition Threshold
Purchases of property, plant and equipment are recognised initially at cost in the Statement of Financial Position, except for purchases costing less than $500, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

Revaluations
Infrastructure, plant and equipment are re-valued every 3 years in accordance with the deprival method of valuation. The last valuation was carried out as at 30 June 2000. Assets acquired after this valuation date are recorded at cost.

Recoverable Amount Test
Schedule 2 requires the application of the recoverable amount test to the Authority's non-current assets in accordance with AAS 10 Recoverable Amount of Non-Current Assets. The carrying amounts of these non-current assets have been reviewed to determine whether they are in excess of their recoverable amounts. In assessing recoverable amounts, the relevant cash flows have been discounted to their present value.

Depreciation and Amortisation
Depreciable property plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Authority using, in all cases, the straight line method of depreciation. Leasehold improvements are amortised on a straight-line basis over the lesser of the estimated useful life of the improvements or the unexpired period of the lease.

Depreciation/amortisation rates (useful lives) and methods are reviewed at each balance date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate. Residual values are re-estimated for a change in prices only when assets are re-valued.

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

	2000-01	1999-2000
Leasehold Fitout	**3 years**	3 years
Plant and Equipment	**3 to 5 years**	3 to 5 years

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 6C.

1.8 Insurance
The Authority has insured for risks through the Government's insurable risk managed fund, called 'Comcover'. Workers compensation is insured through Comcare Australia.

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

	2001 $	2000 $
2 REVENUES FROM GOVERNMENT		
2A Parliamentary appropriations		
Appropriation Act No. 1	**950,000**	950,000
	950,000	950,000
3 REVENUES FROM INDEPENDENT SOURCES		
3A Interest		
Deposits	**19,539**	11,328
	19,539	11,328
3B Other Income		
Other	**150**	0
Employee Reimbursements	**39**	1,933
	189	1,933
4 GOODS AND SERVICES EXPENSES		
4A Suppliers expenses		
Supply of Goods and Services	**238,767**	210,878
Operating Lease Rentals	**101,506**	97,182
	340,273	308,060
4B Employee expenses		
Remuneration for Services Provided	**598,504**	443,666
	598,504	443,666
4C Depreciation and Amortisation		
Depreciation	**46,999**	43,352
Amortisation - Lease Fitout	**13,705**	13,705
	60,704	57,057

	2001 $	2000 $
5 FINANCIAL ASSETS		
5A Cash		
Cash on Hand	**250**	250
Cash at Bank	**218,770**	191,086
	219,020	191,336
5B Receivables		
Other Debtors	**1,294**	477
	1,294	477
6 NON FINANCIAL ASSETS		
6A Land and Buildings		
Leasehold Fitout - at valuation 30 June 2000	**80,620**	80,620
Less: Accumulated Amortisation	**(69,346)**	(55,641)
	11,274	24,979
6B Plant and Equipment		
Plant and Equipment - at valuation 30 June 2000	**265,019**	265,019
Less: Accumulated Depreciation	**(225,071)**	(180,861)
	39,948	84,158
Plant and Equipment - at cost	**21,333**	0
Less: Accumulated Depreciation	**(2,790)**	0
	18,543	0
Total Property, Plant and Equipment at Written Dow	**58,491**	84,158

6C Movement Summary 2000-01 for all assets irrespective of valuation base

Item	Leasehold Fitout $	Plant & Equipment $	Total $
Gross value as at 1 July 2000	80,620	265,019	345,639
Additions	0	21,333	21,333
Disposals	0	0	0
Gross value as at 30 June 2001	**80,620**	**286,352**	**366,972**
Accumulated depreciation/ amortisation as at 1 July 2000	55,640	180,862	236,502
Depreciation/amortisation charge for assets held at 1 July 2000	13,706	44,209	57,915
Depreciation/amortisation charge for additions	0	2,790	2,790
Accumulated depreciation/ amortisation as at 30 June 2001	**69,346**	**227,861**	**297,207**
Net book value as at 30 June 2001	**11,274**	**58,491**	**69,765**
Net book value as at 1 July 2000	24,980	84,157	109,137

	2001 $	2000 $
7 PROVISIONS AND PAYABLES		
7A Suppliers		
Trade creditors	**9,034**	0
Accruals	**7,485**	9,185
	16,519	9,185
7B Employees		
Salaries and Wages	**15,064**	13,300
Annual Leave	**17,731**	24,996
Long Service Leave	**17,050**	0
	49,845	38,296

	2001 $	2000 $
8 REMUNERATION OF OFFICERS		
The position of Ombudsman was filled by 1 person during the reporting period. The remuneration, when at least $100,000 fell within the following bands:		
$160,000 - $169,999	**1**	0
9 REMUNERATION OF AUDITORS		
Remuneration to the Auditor-General for Auditing the Financial Statements	**3,500**	3,200

10 SUPERANNUATION

The Ombudsman's office contributes to the Commonwealth Superannuation (CSS) and the Public Sector (PSS) superannuation 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 23.8% of salary (CSS) and 9.9% 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 8%.

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.

The Ombudsman is structured to meet one outcome, namely, Choice Through Private Health.

Reporting by Outcome for 2000-2001

	Outcome 1	
	Budget	**Actual**
Net Cost to Budget Outcome	**950,000**	979,753
Outcome specific assets	**527,000**	290,079

	2001 $	2000 $
13 CASH		
Cash on Hand	**250**	250
Cash at Bank	**218,770**	191,086
	219,020	191,336
14 CASH FLOW RECONCILIATION		
Operating Surplus (Deficit)	**(29,753)**	154,477
Amortisation - Lease fitout	**13,705**	13,705
Annual Leave Provision	**(4,162)**	801
Depreciation	**46,999**	43,352
Long Service Leave	**13,947**	(14,988)
Decrease/(Increase) in Other Debtors	**(817)**	7,989
(Decrease)/Increase in Trade Creditors	**18,275**	(28,179)
(Decrease)/Increase in Accruals	**63**	6,295
Decrease/(Increase) in Other Prepayment	**0**	9,018
Net Cash provided for by operating activities	**58,257**	192,470

15 FINANCIAL INSTRUMENTS

a) Terms, Conditions and accounting policies

Financial Instruments	Accounting Policies and methods (including recognition criteria and measurement basis)	Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows)
Financial Assets	Financial assets are recognised when control over future economic benefits is established and the amount of the benefits can be reliably measured.	
Other Debtors	These receivables are recognised at the nominal amounts due less any provision for bad and doubtful debts. Provisions are made when collection of the debt is judged to be less rather than more likely.	Credit terms are net 14 days (1999-00: 14 days)
Financial Liabilities	Financial Liabilities are recognised when a present obligation to another party is entered into and the amount of the liability can be reliably measured.	
Trade Creditors	Creditors and accruals are recognised at their nominal amounts, being the amounts at which the liabilities will be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of being invoiced).	Settlement is usually made net 30 days.

b) 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		Carrying amount	
	2001 %	2000 %	2001 $	2000 $
Financial Assets				
Cash	4.5	5.4	**219,020**	191,366
Debtors	N/A	N/A	**1,294**	477
Total Financial Assets			**220,314**	191,843
Financial Liabilities				
Trade Creditors	N/A	N/A	**9,035**	0
Total Financial Liabilities			**9,035**	0

c) 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 Financial Position and notes to the financial statements.

The Ombudsman has no significant concentration of credit risk.

d) Net Fair Values

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

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