Australian Government

Private Health Insurance Ombudsman

# Annual Report 2004

# contact details

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

**STREET AND POSTAL ADDRESS**

Private Health Insurance Ombudsman
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**TELEPHONE, FAX AND E-MAIL**

Inquiries and complaints
1800 640 695 Free Call – higher cost from Mobiles

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

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

E-mail info@phio.org.au
Internet http://www.phio.org.au

Administration (02) 8235 8777
Facsimile (02) 8235 8778

Freecall telephone hours of operation
9.00 am – 5.00 pm (Sydney time)
Monday – Friday

Readers with inquiries about the Ombudsman or this report should contact the administration at the above address.

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

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Financials

Australian Government
Private Health Insurance Ombudsman

The Hon Tony Abbott MP
Minister for Health and Ageing
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 2003 to 30 June 2004.

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

Yours sincerely

John Powlay
OMBUDSMAN

30 September 2004

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# ombudsman's overview

## SOME THINGS CHANGE ...

This year has seen some significant changes in the functions, powers and workload of the Private Health Insurance Ombudsman.

The most notable change in function is the requirement for the Ombudsman to produce an annual State of the Health Funds report, providing comparative information on the performance and service delivery of the health funds. I had hoped to produce the first such report in early 2004, to coincide with health fund premium increases. However a delay in the passage of the legislation authorising the report has meant that I will now be producing the first State of the Health Funds in late 2004, reporting on the performance of funds during the 2003/2004 financial year. As well as including additional analysis of complaints, the report will include summary information on financial measures, access to fund services and product features. I expect that the publication of the report will also help to inform the general public and individual fund members of the services available through my office.

Some significant changes to the way in which the actions of health funds are regulated were also legislated this year. From 1 July 2004, funds are no longer required to submit non-premium related rule changes to the Department 60 days before the date of effect, although they are still required to notify the Department of changes to their rules before the changes come into effect. Associated with this change will be a shift in the role of the department from direct regulation (in effect, approval of fund actions) to monitoring fund activities through the use of broader performance indicators. Information provided by the Private Health Insurance Ombudsman on complaint trends and issues will be a key performance indicator. In addition, the Ombudsman has been given more explicit power to report and make recommendations to the Minister or the Department about the findings of investigations into complaints or fund practices. These changes suggest that the Private Health Insurance Ombudsman may have a broader and more important role in the regulation of private health insurance arrangements.

**John Powlay**

In terms of workload, this year has seen a significant reduction in the number of complaints received overall but a slight increase in the more work intensive, level 3 complaints (those requiring a health fund report or investigation). The drop in total complaint numbers is due to a large reduction in complaints about premium increases compared to last year. The average increase for health fund premiums this year was similar to last year (around 7%). I attribute the reduction in complaints mainly to better management and implementation of the premium review process by the funds and the department and earlier advice of the Minister's clearance.

### ...AND SOME THINGS DON'T CHANGE MUCH AT ALL.

In hindsight it was probably a mistake to look at previous Private Health Insurance Ombudsman annual reports in preparing to write this overview. There are a number of key issues for the private health insurance industry that have been raised regularly in the Ombudsman's Overview of past years' reports. They have been as much or more of a concern in 2003/2004 as they have been in virtually all previous years of this office's existence.

### THESE PERENNIAL ISSUES ARE:

- The rights of consumers when changing health funds (portability).
- The impact of hospital/health fund contract negotiations.
- The adequacy of information provided to consumers about what costs their health insurance will and won't cover.
- Reasonable advance notice of the costs of hospital treatment and doctors' charges (Informed Financial Consent).
- Out of pocket costs associated with doctors' services in hospitals (Medical Gaps).
- The application of the pre-existing ailment waiting period provisions.

For the most part, the comments made on these issues in previous Annual Reports remain relevant now. However there have been some developments on these issues that are worth noting.

### PORTABILITY AND HEALTH FUND/HOSPITAL CONTRACTING

In August 2003, the BUPA health funds (HBA, Mutual Community and Territory Community) advised the Healthscope hospital group that it intended to withdraw from the contracted arrangements with Healthscope hospitals from 1 October 2003 because the parties had been unable to agree on prices.

This contracting dispute was very significant because of the size and strong position of the fund and hospital group in particular markets (especially Victoria, South Australia and the Northern Territory). There was therefore a significant risk that large numbers of health fund contributors may choose to take advantage of the portability provisions to transfer to other funds, leading to large unplanned and unfunded costs for those other funds.

While I acknowledged the financial risk to other funds resulting from the transfer of BUPA members requiring treatment at Healthscope hospitals, I insisted that all other funds comply with the portability policy position and allow transfers without imposing any waiting periods for equivalent hospital benefits.

Both the hospital group and the health fund agreed to implement the transitional arrangements previously recommended by the Ombudsman in the "Review of Portability Arrangements for Private health Insurance" as well as other protections for affected members. These arrangements should have provided sufficient assurance for BUPA members and reduced the incidence of fund transfers. However, other actions and decisions by the hospital group and the fund as well as extensive media coverage led to a high incidence of fund transfers, including (apparently) by many people who would have been protected by the agreed transitional arrangements.

A small number of health insurance providers in both South Australia and Victoria, who, under the portability policy, provided immediate access to full hospital benefits, were required to fund several million dollars of additional unexpected claim costs.





Those costs were not offset to any significant extent by extra premium payments. Many of the costs will be ongoing and will place additional pressure on premium levels for all members of those funds. It is fortunate that on this occasion the funds most affected held sufficient reserves to meet the extra, unexpected claim costs without impacting on the financial viability of the funds.

The factors that contributed significantly to the problems experienced in this situation included:

- the actions of the hospital group, which embarked on a very active (unprecedented) public campaign to encourage transfer to funds that still had a contract with them;
- the size of the potential out-of-contract gap because of the hospital group's actions in substantially increasing its prices and the fund's decision to substantially reduce benefits for some types of treatment; and
- the practice adopted by the hospital of requiring BUPA members to pay the full cost of the hospitalisation prior to admission (rather than just the out of pocket gap).

This experience has led a number of funds to question the application of the portability policy in situations arising from the cessation of contracts between hospitals and health funds.

The issues raised by this situation are complex. They involve the need to balance the interests of individual members directly affected by such contract disputes, with the interests of other funds and their members as well as balancing the commercial interests of particular hospitals and funds with their industry and social responsibilities. This is currently the subject of discussion and consultation between funds and hospitals, with the aim of developing an agreed approach that will avoid such problems in future.

My view is that any agreed approach needs to include commitments from all parties about the conduct of hospitals and health funds in such situations (particularly regarding public statements and advice to affected patients) and these commitments need to be included in a strengthened industry Code of Conduct. If this can be achieved by agreement across the industry it should not be necessary for any fund to limit consumer portability rights in such situations.

### INFORMATION ABOUT WHAT'S COVERED (AND WHAT'S NOT)

Nearly all funds offer hospital products that include restrictions (or exclusions) on some types of treatment. Where a treatment is identified as "restricted" the fund will pay a very limited benefit (usually the minimum amount allowable under the National Health Act), leaving patients with a large gap to pay themselves if they choose to be treated as a private patient. If a treatment is "excluded" the fund will not pay any benefit for that treatment. The patient must then meet any and all charges for that treatment (other than the amount covered by any Medicare rebate).

The types of treatments that are typically restricted (or excluded) under such arrangements include cardiac procedures, joint replacements and eye surgery. Such treatments can be very expensive, leaving patients with very large bills to pay if they decide to proceed with private treatment, not understanding the implications of these restrictions on their policy.

Products that include such restrictions can be attractive to consumers because they are considerably cheaper than products that provide a more comprehensive cover. However, such arrangements have been,

and remain, a major cause of complaint to my office.

While there has been some improvement in the way these matters are explained in fund brochures and other general information products, inevitably our complainants say they were either unaware of the restriction on their cover or at least had no understanding of the implications of those restrictions.

Given our complaints experience and the considerable disadvantage experienced by fund members who do not understand the implications of such restrictions, my view is that funds need to take more action to explicitly disclose such restrictions and exclusions to consumers. This should include providing separate, clear and explicit information about the implications of any product restrictions (a "product disclosure statement") and ensuring that, on joining, members acknowledge that they are aware of the restrictions (or exclusions) and their implications.

## INFORMED FINANCIAL CONSENT

Most complaints received by this office about the actions of hospitals or medical practitioners involve the issue of informed financial consent (adequate disclosure, in advance of treatment, of the costs a patient may be required to meet).

The total number of complaints received is not large but is still sufficient to suggest that some hospitals and medical practitioners give insufficient attention to ensuring that patients are adequately informed of the financial implications of their treatment.

This year I was also approached by the Australasian Council of Health Complaints Commissioners about the issue. Virtually all State and Territory health complaints bodies reported that the lack of adequate advance notice of fees was a significant issue in complaints they receive about health costs. The Council has since undertaken an examination of the issue and resolved to work with a number of professional bodies to develop or improve policies and practices.

During the year The Minister for Health and Ageing established a taskforce of industry and professional representatives to develop and implement a strategy to improve the incidence of genuine informed financial consent. I am a member of the Taskforce, which is chaired by Professor John Hunn of Tasmania. The taskforce will present a strategy to the Minister before the end of this calendar year.

## MEDICAL GAPS

This year my office conducted an investigation into the operation of health fund gap cover schemes. The key issue examined was the adequacy of fund information for consumers about the operation of these schemes. The operation and requirements of these schemes vary considerably between funds. Based on our complaints experience, it would appear that many consumers are not aware of how the schemes operate and have developed unreal expectations based on the general promotion and marketing of gap cover arrangements. Many doctors seem unaware of the requirements of particular gap cover arrangements and as a result are unable to correctly advise their patients of how much of their fees the patient will be liable to pay. This is contributing to the problems of providing for informed financial consent, referred to above.

## PRE-EXISTING AILMENT WAITING PERIOD

In his 2000/2001 Annual Report the then Ombudsman reported that the application of the pre-existing ailment provisions was the largest single complaint issue for consumers that year. The number of complaints about this issue reduced considerably following



the distribution of best practice guidelines by the Department in late 2001 and their general adoption by funds. However this year has seen a resurgence in complaints on this issue. Some new issues associated with these complaints are the application of the pre-existing ailment provisions to overseas visitor policies and in the case of hospital admissions for new-born babies.

## AMBULANCE BILL LOTTO

Obtaining a health insurance product to cover the cost of ambulance services can be a confusing undertaking. Health funds take a variety of approaches to insuring the costs of ambulance services. In some cases funds offer coverage only for "emergency situations" or do not cover ambulance bills when the person is not transported to hospital. Some funds offer more comprehensive coverage but require patient co-payments in non-emergency situations. Some funds offer a full or partial refund of payments to an ambulance subscription scheme. Depending on the fund, ambulance cover may be included with hospital cover, with ancillary (extras) cover, as a standalone product or in any combination. In states where ambulance services are government or levy funded funds do not offer ambulance cover as an option.

This confusing situation arises in large part because of the different charging policies and funding arrangements for ambulance services established by various state governments. Health funds tend to design their ambulance cover arrangements to suit the state in which they originated or have their largest market share. It is therefore important that consumers check with their fund exactly what ambulance costs are covered by the policy they purchase and understand what ambulance services they may be charged for. This is made more difficult in some states because of a lack of transparency in ambulance charging arrangements. It is virtually impossible in some states to ascertain the charging policies of ambulance services (let alone how much a charge might be).

An even more difficult situation arises in some states if you require ambulance services when visiting from interstate. Until relatively recently an informal agreement applied between the various State and Territory ambulance services that provided for reciprocal coverage of ambulance subscription schemes. Interstate visitors would not be billed. This arrangement operated reasonably well for consumers but the costs for the smaller states and "holiday destination" states was relatively high. At least two states (South Australia and Queensland) have unilaterally withdrawn from this informal agreement, leaving a very confused situation for the other states. The failure of the State and Territory authorities to agree or settle these interstate arrangements has led to a large amount of unnecessary and costly administrative effort by some state ambulance services and made it virtually impossible for health insurers to identify what ambulance cover should be provided in various states. Our complaints indicate that it has also exposed some patients (including pensioners) to large, unexpected ambulance bills.

## THE OMBUDSMAN'S JURISDICTION

The National Health Act defines the grounds for complaint to (and therefore the jurisdiction of) the Private Health Insurance Ombudsman reasonably broadly as " any matter arising out of or connected with a private health insurance arrangement". It has been suggested that this may not include arrangements for providing health insurance for visitors to Australia (commonly known as "Overseas Visitor Cover"), which is not otherwise covered by the provisions of the National Health Act relating to the regulation of health funds. My office

# ombudsman's overview

regularly receives complaints about these arrangements. The issues and fund rules applying to these arrangements are the same or very similar to general private health insurance. There is no other complaint body with a remit to deal with such complaints. I have therefore taken the view that the jurisdiction should not be interpreted so narrowly as to preclude my involvement in these issues. However, there is a case for clarifying this issue within the legislation to ensure that visitors, taking out health insurance within Australia, can continue to have access to an appropriate, independent complaints body.

The Private Health Insurance Ombudsman's jurisdiction is also defined in terms of who may complain. This is limited, under the Act, to health fund members, health funds, hospitals and medical practitioners. The Ombudsman cannot, therefore, deal with complaints from other individuals or organisations unless the complaint is on behalf of one of those prescribed groups. This precludes complaints from a wide range of allied health services providers; most dentists, optometrists, physiotherapists as well as suppliers of prostheses and medical devices all of whom have some direct interest in health insurance arrangements. At present my office will take enquiries from these groups and provide general information about health insurance matters but is unable to deal with or investigate complaints. However, if the matters raised are particularly serious or significant the Ombudsman can use the "own initiative" power available under the Act to investigate the practices or procedures of health funds.

## PUBLICATION OF HEALTH FUND RULES

All health funds operate according to detailed rules setting out the conditions under which benefits are paid. Fund brochures usually indicate in the terms and conditions section that the brochures and other fund publications provide only a summary of key fund rules and procedures; that the full range of conditions applying to a particular policy are set out in the fund rules; and that the rules may be examined on request. In practice it can be difficult for members to access a full current set of fund rules. Even if they are able to do so, it has been very difficult for an untrained person to locate particular details within the rules.

The department has recently introduced a system for recording fund rules electronically that includes a standardised template for organising and presenting the rules. All funds have rewritten their rules to fit this standardised format. This should make fund rules more understandable and accessible for consumers.

This year Medibank Private took advantage of this improvement and made its rules readily available on its website. This is an excellent initiative that should be followed by all funds.

I have appreciated the positive, constructive approach adopted by health funds, hospitals and medical practitioners in dealing with complaints during the year. The industry has generally been very open and responsive to the consumer feedback and suggestions provided through my office. Industry representatives and professional groups within the private health industry have also demonstrated their commitment to improving services through their participation, this year, in a range of seminars, working groups and reference groups aimed at addressing important consumer issues.

John Powlay

*Private Health Insurance Ombudsman*



# role and function

## INTRODUCTION

The Private Health Insurance Ombudsman is a statutory corporation under the National Health Act 1953.

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;
- Publish the State of the Health Funds Report
- Make recommendations to the Minister or Department of Health and Ageing;
- Make available and publicise the existence of the Private Patients' Hospital Charter; and
- Promote an understanding of the Ombudsman's functions.

## 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, hospital or provider, with a request to report to the Ombudsman with its findings and any action it proposes to take. If the Ombudsman is not satisfied with the explanation or proposed action, the Ombudsman may further investigate the complaint and make a formal recommendation;
- 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.

# role and function

## 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 or practices.

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, fax and e-mail. Where complainants have not made a sufficient attempt to resolve their complaint with their health fund or provider, staff will usually refer complainants back to these parties in the first instance.

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

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

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

**Staff Names**
**Left to Right are:**

**Back Row: Ramy Bakhos, Richard Van Der Male, Jacqueline Power, Ursula Schappi, Ruth Brown, David McGregor.**

**Front Row: Samantha Gavel, John Powlay, Hilary Bassingthwaighte.**



# performance

## OUTPUT PERFORMANCE MEASURES

The 2003/2004 Portfolio Budget Statement for the Health and Ageing Portfolio includes both quality and quantity measures for the Private Health Insurance Ombudsman's two output groups. The following is a summary of performance outcomes against these formal performance indicators during 2003/2004.

## OUTPUT GROUP 1 - ADVICE AND RECOMMENDATIONS ABOUT THE PRIVATE HEALTH INSURANCE INDUSTRY

***Quality indicator:*** High level of satisfaction with the relevance, quality and timeliness of advice and submissions.

***Measurement:*** No formal mechanism has been established to assess the satisfaction of key stakeholders. Reporting relies on informal discussion.

***Performance result:*** Overall high level of satisfaction achieved. Some concerns raised about the timeliness of advice on some issues.

***Quantity indicator:*** Advisory services commensurate with the funds allocated to produce a range of products, including 11-15 submissions and public presentations.

***Measurement:*** Count of submissions, other written advice and public presentations.

***Performance result:*** 7 submissions, 15 items of written advice, 12 public presentations. (Further details are provided in the *General Issues* section of this report.)

## OUTPUT GROUP 2 - DIRECT DELIVERY OF SERVICES (INFORMATION AND DISPUTE RESOLUTION SERVICE

***Quality indicator:*** Information provided and complaints dealt with accurately and in a timely manner.

***Measurement:*** Analysis of PHIO complaints recording database, client satisfaction survey.

***Performance result:*** Quality meets the standard indicated. (Further details are provided in the following discussion of complaints performance and in the report of the client satisfaction survey included in the General Issues section of this report.)

***Quantity indicator:*** 75% of complaints resolved within one month. Measurement:

***Measurement:*** Analysis of PHIO complaints recording database.

***Performance result:*** 86% of complaints resolved within one month.

***Quantity indicator:*** 3000 complaints received.

***Measurement:*** Analysis of PHIO complaints recording database

***Performance result:*** 2992 complaints received.

## DECREASE OVERALL IN COMPLAINTS RECEIVED

This year has seen a significant reduction (16.1%) in the number of complaints received by my office. The main reason for the drop in complaints has been a large reduction in complaints associated with premium rises. There are a number of factors that contributed to this reduction in premium complaints. However, in my view, it is mostly attributable to a significant improvement in the management and implementation of the premium review process. Although the average level of premium increases was similar to last year, this year we did not see the incidence of very high levels of increase for some products which has been a feature of the premium increase process in the past. The quality and timeliness of advice from funds to members about the new premiums was also much improved. This was assisted greatly by earlier communication to the funds of Ministerial clearance of premium proposals.

Despite the overall drop in complaints received, the number of level 3 complaints (those requiring a health fund report or investigation) increased slightly compared to the previous year. The issues contributing most to this increase included medical gaps, hospital/fund contracting, restrictions on benefits for some treatments, problems with transferring between funds and the application of the pre-existing ailment rule. These issues are discussed in the Ombudsman's Overview and/or the Complaint Issues section of this report.

Figure 1 shows the distribution of complaints through the four quarters of the 2003/2004 financial year.

Figure 1
Total Complaints Received By Quarter

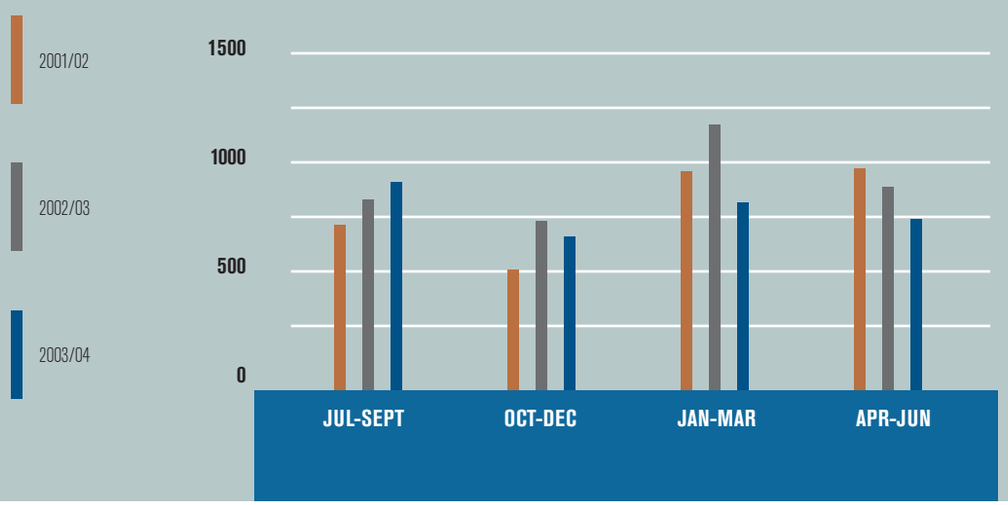





Figure 2
Complaints Received by Year

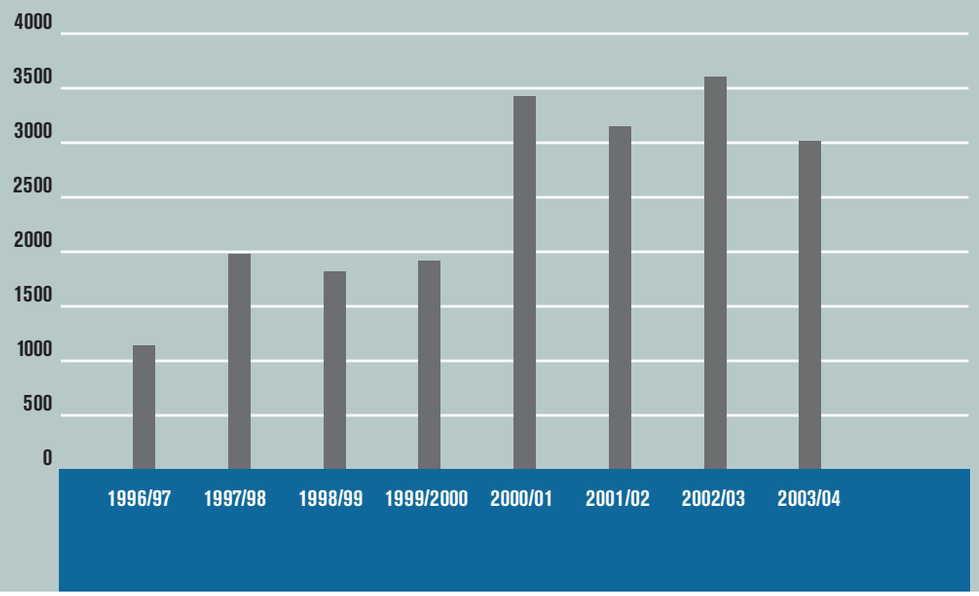



Figure 2 shows the total number of complaints received per year for the last 8 years. The jump in the number of complaints in the 2000/2001 year was associated with the large rise in health fund membership, following the introduction of the 30% rebate and lifetime health cover requirements.

## RECORDING AND CATEGORISATION OF COMPLAINTS

An approach to the Ombudsman's office is recorded as a complaint when it meets the criteria contained in the 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; and
- Made by a health fund member, hospital, doctor (including some dentists), a health fund or someone acting on their behalf;

Complaints are categorised by the degree of effort needed for their resolution.

Currently this categorisation is:

**Complaint level 1 (Problems): Moderate level of complaint**

Level 1 complaints 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.

**Complaint level 2 (Grievances): Moderate level of complaint where mediation is required**

Level 2 complaints 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 a misunderstanding by consumers of their rights under the product they have purchased, concerns with service levels provided by the fund or provider, price increases, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

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

Level 3 compliants 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. 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.

The 2992 complaints recorded in 2003/2004 consisted of 612 Level 3 complaints, 1288 Level 2 complaints and 1092 Level 1 complaints. Figures 3 and 4 show these ratios and indicate a significant reduction in the number of Level 1 and 2 complaints. There was a slight increase in Level 3 Complaints, from 609 in 2002/2003 to 612 in 2003/2004.

Figure 3
Complaints Received per Year by Category

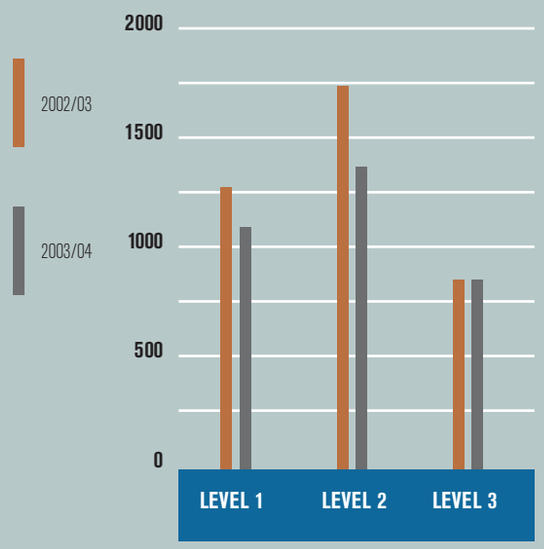
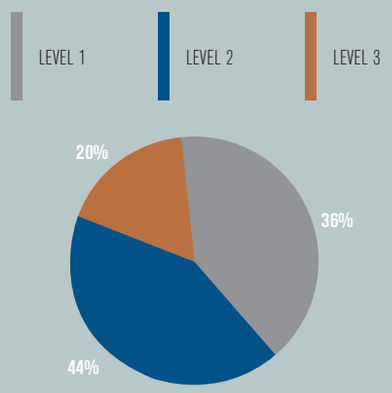



Figure 4
Complaints Category, Percentage






## COMPLAINTS HANDLING PROCEDURES

The process and timeframes for handling the different categories of complaint are depicted in Figure 5.

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

Fund members also lodge complaints about their;

- Hospital, (generally about inadequate information to enable informed financial consent);
- 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).

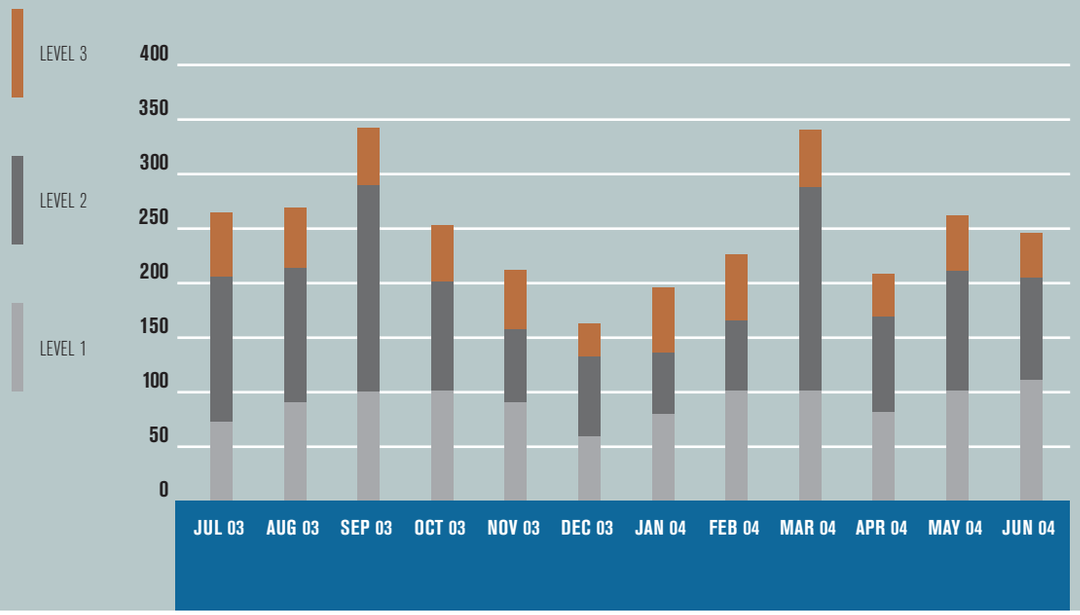
Overall, complaints against provider groups are small in number when compared with complaints against health funds.

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

Figure 5
Steps in Handling Approaches to the Ombudsman

| LEVEL 3 [DISPUTE] | LEVEL 2 [GRIEVANCE] | LEVEL 1 [PROBLEM] |
|---|---|---|
| **TIMEFRAME**<br>Depends on the nature and complexity of matter and responses from health fund and provider | **TIMEFRAME**<br>Usually within 24 Hours | **TIMEFRAME**<br>Immediate |
| **ACTIONS**<br>PHIO contacts health fund or provider to obtain a report, then mediate the dispute between the parties or investigate the matter further | **ACTIONS**<br>Complainant provided with explanation or information to resolve matter, or if there is no avenue for the Ombudsman to take up the matter | **ACTIONS**<br>If complainant has made insufficient effort to resolve the matter with fund or provider, empower them with detail enabling them to take up the issue at an appropriate level |
| **OUTCOMES**<br>Explanation of health fund or provider's actions, mediated resolution including payment of benefits, or formal recommendation by Ombudsman | **OUTCOMES**<br>Detailed information provided which appropriately resolves the issue | **OUTCOMES**<br>Referral to health fund or provider |

Figure 6
Total Complaints Received by Month




## WORKLOAD

The office received 2992 complaints (Levels 1, 2 & 3) in 2003/2004, an average of 249 per month compared with 297 complaints per month in the previous year.

The office finalised 3008 complaints during the year; an average of 251 per month, compared with an average 298 complaints finalised per month in the previous year.

Figure 6 shows the number of complaints received in each month of the year, indicating changes in workload over the year in the various complaint categories. The workload peak in September 2003 was due to complaints associated with the Healthscope /BUPA hospital contract dispute, referred to in the Ombudsman's overview.

The workload peak in March 2004 was associated with health fund premium

increases, though this peak was only half that which occurred following 2003's health fund premium increases.

## TIME TAKEN TO RESOLVE COMPLAINTS

Figures 7 and 8 provide information on the time taken to resolve complaints this year compared to last year. There has been a marginal decline in the timeliness of complaints processing. This is attributable to the increase in the more complex and work intensive Level 3 complaints.



Figure 7
Time Taken to Finalise Complaints

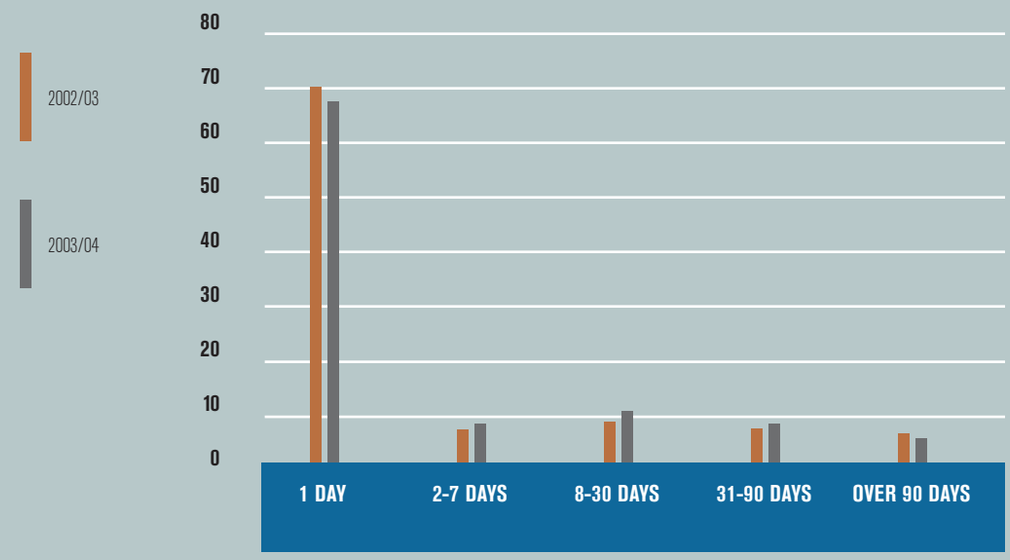
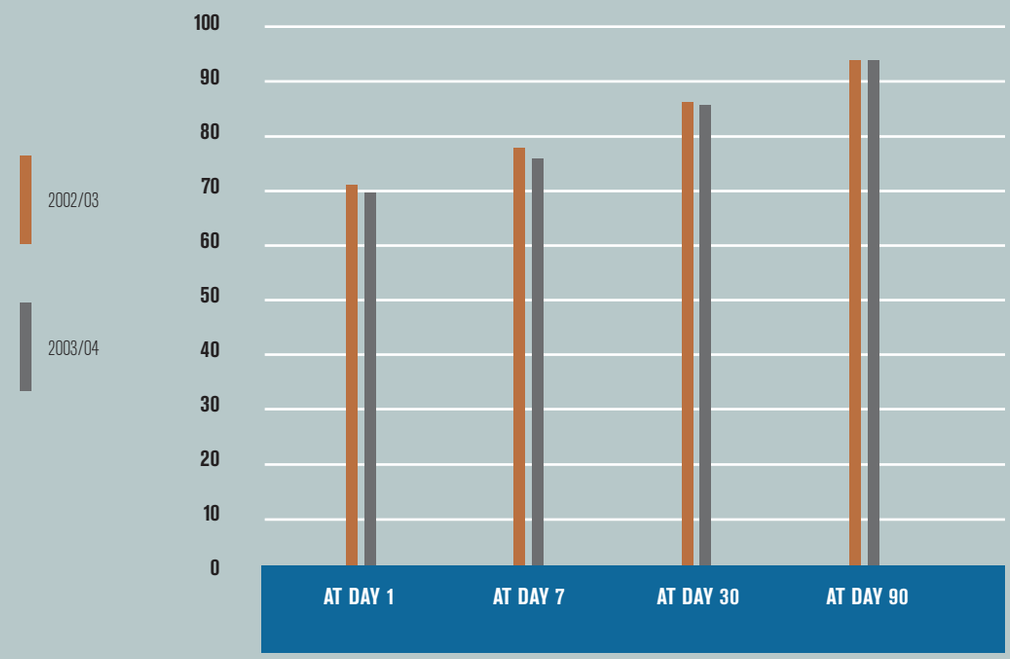



Figure 8
Complaints Completed Since Day of Lodgement



## WHO WAS COMPLAINED ABOUT

Most complaints were made about health funds (2861) followed by hospitals (277) and practitioners (doctors and dentists), 177. Some complaints concern one or more health funds, or a health fund as well as a hospital, doctor or dentist. Consequently, the total number of organisations or people being complained about (3315) adds up to more than the total number of complaints, 2992.

## COMPLAINTS ABOUT HEALTH FUNDS

Figure 9 provides a summary of all complaints (Levels 1, 2 & 3) for individual health funds compared with their market share. This data is also presented for the higher category "Level 3" complaints. Analysing the information at this further level of detail provides a more realistic picture of the way funds respond to their members' complaints. Higher Level 3 complaint 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

During the year, there were 277 complaints registered against hospitals. Of these complaints 72 were Level 1, 99 were Level 2 and 106 were Level 3 complaints. Those Level 3 complaints, which required investigation, were most likely to result in a hospital accepting a reduced payment for an outstanding hospital account because of shortcomings in financial consent been sought on admission.

Complaints to the Ombudsman about hospitals are mostly related to a failure to provide adequate advance notice of likely out-of-pocket costs. This is generally associated with a failure to verify fund membership details or ineffective communication between hospital and health fund staff. A high proportion of these complaints involve situations where a Hospital Purchaser-Provider Agreement (HPPA) is in place. In effect the hospital and health fund have a contractual relationship, with the HPPA setting the basis of their contract. All such agreements are required to include a requirement that the hospital provide, wherever possible, adequate advance notice to the health fund member of likely out of pocket costs.

In effect, when dealing with many of these complaints we are engaged in requiring either the hospital or fund to comply with their own contractual obligations. This should not be necessary.

Again this year, the office also received a number of complaints that arose out of the actions of hospitals during or after the breakdown of negotiations between hospitals and funds about Hospital Purchaser-Provider Agreements (HPPA). The office also received complaints from health funds about the actions of hospitals during or after HPPA negotiations (and from hospitals about the actions of funds in these situations). The situation that arose between BUPA Australia and Healthscope, referred to in the Ombudsman's Overview, accounted for a significant proportion of these complaints this year.

## COMPLAINTS ABOUT PRACTITIONERS

Most complaints about doctors and practitioners concerned medical gap issues and/or the lack of informed financial consent. During 2003/2004 the office received 197 complaints about medical gap issues and 177 complaints registered against practitioners.

In many cases these problems were associated with patient and/or doctor misunderstandings about the requirements of particular gap schemes. We again received a small number of complaints about practitioners charging additional fees (often labelled booking or administration fees).



**Figure 9**
**Complaints by Health Fund Market Share**

| NAME OF FUND | TOTAL NUMBER OF COMPLAINTS (1) | % OF TOTAL COMPLAINTS | TOTAL NUMBER OF LEVEL 3 COMPLAINTS (2) | % OF TOTAL LEVEL 3 COMPLAINTS | MARKET SHARE (3) |
|---|---|---|---|---|---|
| ACA Health Benefits | 0 | 0.0 | 0 | 0.0 | 0.1 |
| AMA Health Fund | 0 | 0.0 | 0 | 0.0 | 0.1 |
| Australian Health Management Group | 105 | 3.2 | 22 | 3.8 | 2.4 |
| Australian Unity | 90 | 2.6 | 23 | 4.0 | 3.1 |
| BUPA Australia Health | 387 | 13.7 | 79 | 13.8 | 9.8 |
| CBHS | 32 | 1.1 | 5 | 0.9 | 1.1 |
| CDH (Cessnock District Health) | 1 | 0.0 | 0 | 0.0 | <0.1 |
| Credicare | 7 | 0.2 | 2 | 0.3 | 0.4 |
| Defence Health | 34 | 1.2 | 4 | 0.7 | 1.3 |
| Druids NSW | 2 | 0.1 | 0 | 0.0 | <0.1 |
| Druids Victoria | 4 | 0.1 | 1 | 0.2 | 0.1 |
| Federation Health | 7 | 0.2 | 1 | 0.2 | 0.2 |
| GMHBA | 32 | 1.1 | 7 | 1.2 | 1.4 |
| Grand United Corporate Health | 14 | 0.5 | 3 | 0.5 | 0.3 |
| Grand United Health | 22 | 0.8 | 4 | 0.7 | 0.4 |
| HBF Health | 101 | 3.6 | 21 | 3.7 | 8.6 |
| HCF(Hospitals Contribution Fund) | 172 | 6.1 | 28 | 4.9 | 7.7 |
| Health Care Insurance | 1 | 0.0 | 0 | 0.0 | 0.1 |
| Health Insurance Fund of W.A. | 15 | 0.5 | 3 | 0.5 | 0.4 |
| Healthguard | 14 | 0.5 | 1 | 0.2 | 0.6 |
| Health-Partners | 14 | 0.5 | 2 | 0.3 | 0.6 |
| I.O.R. Australia | 53 | 1.9 | 13 | 2.3 | 0.9 |
| Latrobe Health | 7 | 0.2 | 0 | 0.0 | 0.4 |
| Lysaght Peoplecare | 7 | 0.2 | 0 | 0.0 | 0.3 |
| Manchester Unity | 59 | 2.1 | 19 | 3.3 | 1.3 |
| MBF Australia Limited | 422 | 15.0 | 58 | 10.1 | 16.6 |
| Medibank Private | 869 | 30.8 | 185 | 32.2 | 29.1 |
| Mildura District Hospital Fund | 2 | 0.1 | 1 | 0.2 | 0.3 |
| N.I.B. Health | 198 | 7.0 | 62 | 10.8 | 6.0 |
| Navy Health | 5 | 0.2 | 0 | 0.0 | 0.3 |
| NRMA Health (Prov.d by MBF Health Pty Limited) | 51 | 1.8 | 9 | 1.6 | 2.1 |
| Phoenix Health Fund | 1 | 0.0 | 0 | 0.0 | 0.1 |
| Police Health (SA) | 1 | 0.0 | 0 | 0.0 | 0.2 |
| Queensland Country Health | 10 | 0.4 | 4 | 0.7 | 0.2 |
| Railway & Transport Health | 6 | 0.2 | 1 | 0.2 | 0.3 |
| Reserve Bank Health | 0 | 0.0 | 0 | 0.0 | <0.1 |
| St Lukes Health | 10 | 0.4 | 1 | 0.2 | 0.4 |
| Teacher Federation Health (NSW) | 21 | 0.7 | 3 | 0.5 | 1.6 |
| Teachers Union Health (QLD) | 25 | 0.9 | 6 | 1.0 | 0.4 |
| Transport Health | 2 | 0.1 | 0 | 0.0 | 0.1 |
| Westfund | 16 | 0.6 | 6 | 1.0 | 0.7 |
| **TOTAL FOR REGISTERED FUNDS** | **2819** | **100.0** | **574** | **100.0** | **100.0** |

Note 1. Complaints (Levels 1,2 & 3) from those holding registered health fund policies.
Note 2. Level 3 Complaints required the intervention of the Ombudsman and the health fund.
Note 3. Market share data provided by PHIAC as at 30 June 2004.

## RESOLVING COMPLAINTS

49% of complaints were resolved by the Ombudsman's office providing an independent and impartial explanation of the health fund member's grievance.

36% of complaints were referred directly back to the health fund through the complainant. The Ombudsman was generally able to suggest alternative ways for the complainant to pursue the matter with the health fund. In 2004, responses to our client survey indicated a marked improvement in complainant's satisfaction with their fund's response after being referred in this way (from 30% in 2003 to 57% in 2004).

Five percent of complaints (23% of the Level 3 complaint category) were resolved following payments by health funds or the writing off of accounts by hospitals.

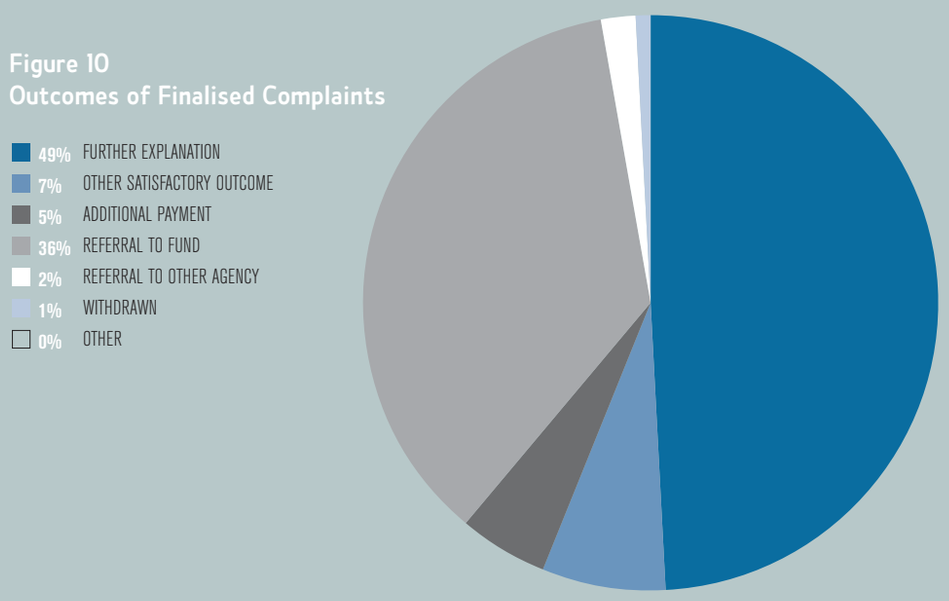
Payments by health funds generally result from a health fund agreeing with the Ombudsman that the fund member was entitled to the payment of a benefit under the terms of the member's private health insurance. In some cases, payment is made on an ex gratia basis, for instance, where the fund accepts that the member relied on incorrect advice from the fund. Accounts written off by hospitals are usually the result of hospitals needing to accept their responsibility after failing initially to adequately inform patients of their costs.

An additional 7% of complaints (29% of the Level 3 complaint category) 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.

2% of complaints, which met the criteria for complaint contained in the National Health Act 1953, were referred to another agency such as the ACCC and 1% of complaints were withdrawn or required no further action.

Information about the resolution of complaints and disputes is provided in Figures 10 and 11.

**Figure 10**
**Outcomes of Finalised Complaints**





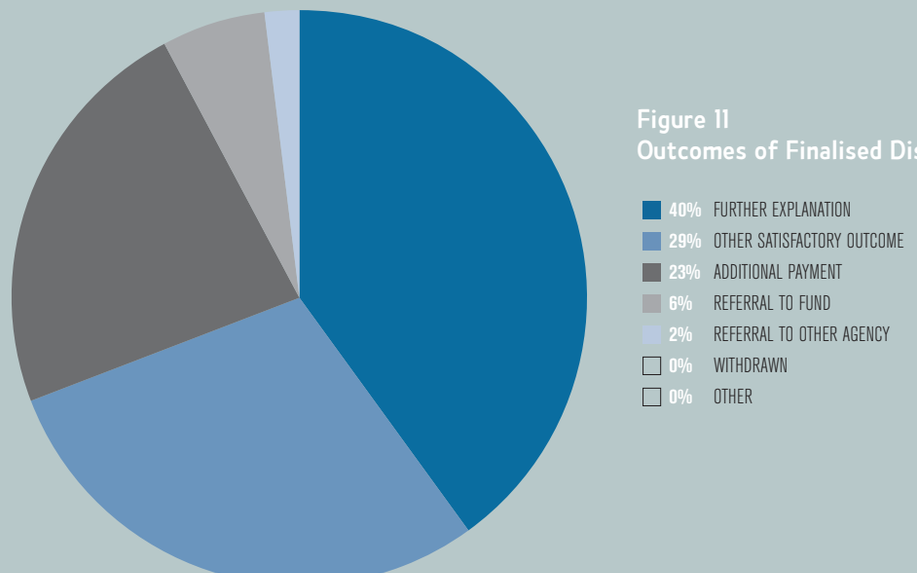



**Figure 11**
**Outcomes of Finalised Disputes**



Our client survey for this year again asked respondents to indicate if they took any other action following having their complaint dealt with by the Ombudsman. Compared to last year, a much smaller percentage dropped out of private health insurance following their complaint (5%) compared to last year (13%) but a higher proportion of respondents changed health funds (21%) in 2003/04 compared to 8% in 2002/03.

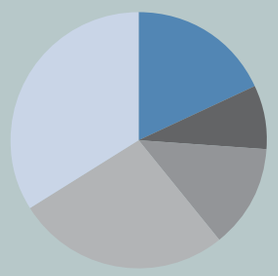


**Figure 12**
**After we closed your complaint did you take any action? 2002/03**



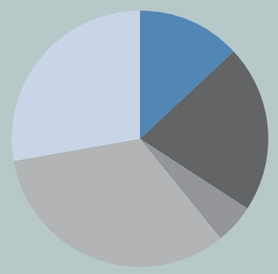


**Figure 12a**
**After we closed your complaint did you take any action? 2003/04**

### WHO COMPLAINED?

The *National Health Act 1953* allows health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf to lodge complaints. Overwhelmingly, complaints were made by health fund members (99%), followed by hospitals/day hospitals, practitioners, and health funds.

### HOW COMPLAINTS WERE MADE

90% of complaints were made initially by telephone. 5% were received by letter, almost 4% were lodged by email. The remainder were made by fax, personal visit, or by Parliamentary Representation.

### COMPLAINTS BY STATE/TERRITORY

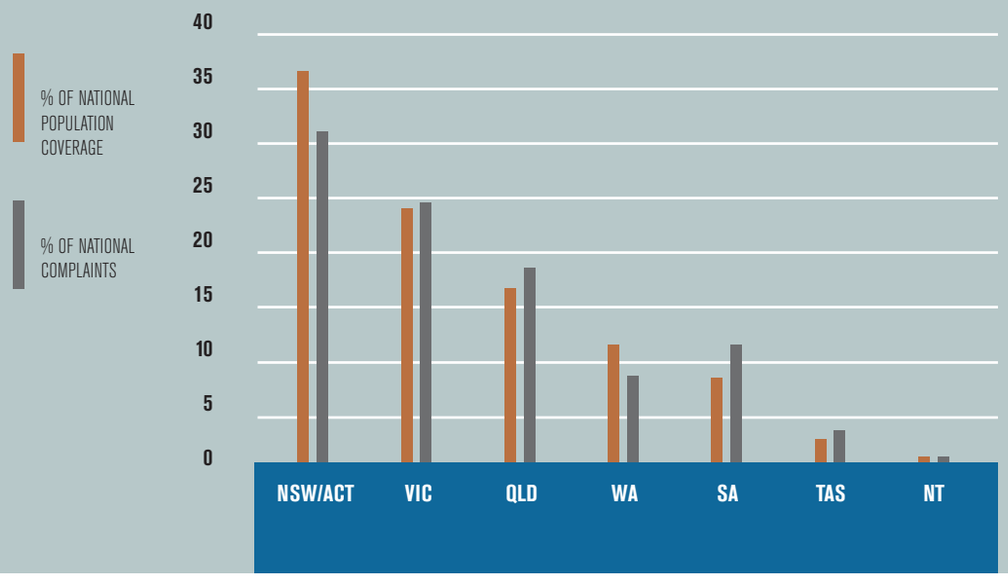
Figure 12 identifies, on a state-by-state basis, where complaints originate. This data is shown by State, against the percentage of people who have private health insurance coverage.

### INVESTIGATIONS INTO HEALTH FUND PRACTICES AND PROCEDURES

During 2003/2004 the Ombudsman conducted three investigations into health fund practices and procedures under section 82ZT of the *National Health Act 1953*.

Two of these investigations related to the matters arising from the BUPA/Healthscope contract dispute.

**Figure 13**
**Complaints by Population Covered by State & Territory**




- The first related to funds' administration of the portability requirements of the *National Health Act* in such situations. This resulted in a recommendation to Australian Unity Health Limited to allow transferring members immediate access to benefits under the fund's HPPA arrangements. Australian Unity did not agree to act on the Ombudsman's recommendation but subsequently altered it's practices to conform to the approach suggested.
- The second related to the billing arrangements for BUPA members attending Healthscope hospitals following the termination of the HPPA between BUPA and Healthscope Limited. This resulted in a recommendation to Healthscope Limited to charge BUPA members, on admission, only the applicable "gap" amount rather than require members to pay the full hospital charge and seek a partial refund from BUPA. Healthscope did not agree to act on the Ombudsman's recommendation but shortly after reached agreement on new HPPA arrangements with BUPA.

A further investigation under section 82ZT involved examination of the administration of health fund gap cover schemes. This is referred to in the *Ombudsman's Overview* section of this report.

There were no investigations undertaken under section 82ZTA of the *National Health Act 1953.*

# complaints issues

## INTRODUCTION

Complaints to the Ombudsman must first meet the requirements of the Section 82Z of the *National Health Act 1953*. Embodied in that section is the requirement that a complaint be about a health insurance arrangement. For reporting purposes complaints are classified in terms of broad issues and sub issues.

Figures 13 and 13a compare the relative complaint issues over the past two years.

**Figure 14**
**Complaints Issues - Percentage of Each Issue**

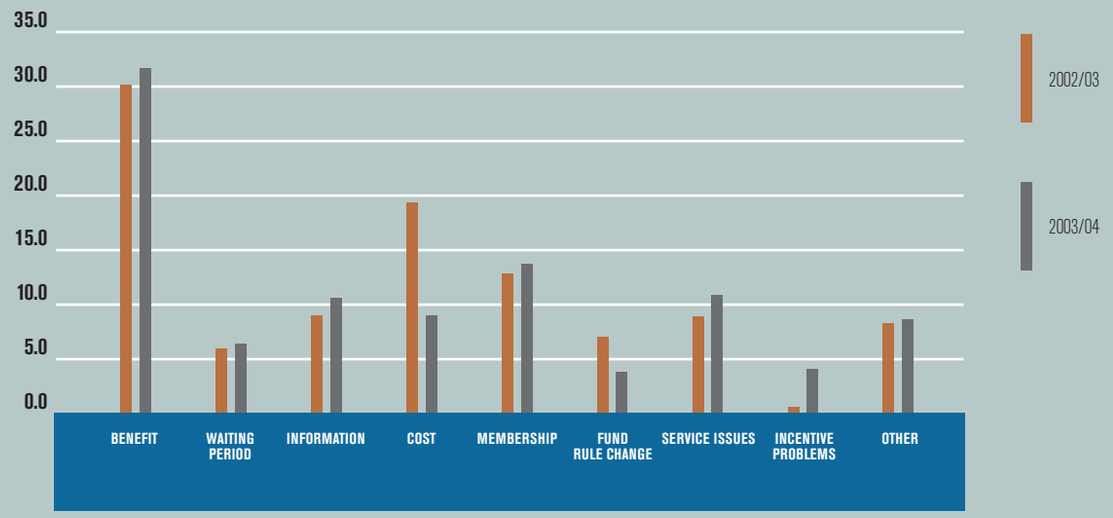
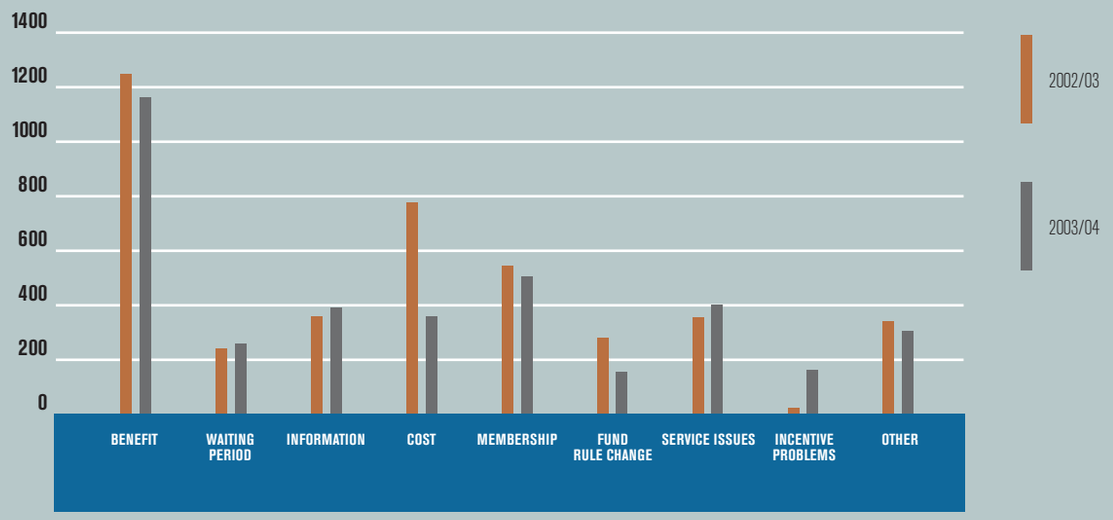



**Figure 14a**
**Complaints Issues - Numbers of Matters Registered**








## CASE STUDIES

### PRE-EXISTING AILMENTS

PHIO received 177 complaints specifically about the pre-existing ailment rule in 2003/04. This was slightly higher than the 162 received last year.

The pre-existing ailment rule is contained in the National Health Act and allows a fund to apply a twelve month waiting period for benefits for any illness, ailment or condition where signs or symptoms were present in the six months prior to joining the fund.

Where a fund has declined to pay benefits on grounds of the pre-existing ailment rule, PHIO can review the matter to ensure the fund is applying the pre-existing ailment rule in accordance with the Act.

The National Health Act stipulates that a medical adviser appointed by the health fund decides whether the ailment is pre-existing. The fund medical adviser is required to consider information from the member's treating doctors in making a decision, but is not bound to agree with them.

In most cases, it is clear that the fund is complying with the Act in applying the pre-existing ailment rule, because the member's treating doctor provides clear information about the length of time signs or symptoms of the illness were present.

Occasionally, PHIO will seek an independent medical opinion if we are not satisfied that the fund is complying with the legislation in refusing benefits based on the pre-existing ailment rule.

Mr Stringybark contacted PHIO on behalf of his mother when her health fund denied benefits for her hospitalisation for a stroke on the grounds of the pre-existing ailment rule. PHIO reviewed the information provided by the fund in support of its decision to deny benefits. It was noted that Mrs Stringybark had a number of risk factors for stroke such as high blood pressure prior to joining the fund and the fund relied on these to deny the claim.

PHIO sought an independent medical opinion, because the legislation requires the existence of signs or symptoms and risk factors are not signs or symptoms as required under the Act. The independent medical adviser examined the medical evidence relating to Mrs Stringybark's hospitalisation. He concluded that the fund was not applying the pre-existing ailment rule correctly, because while there was no doubt the member had a number of risk factors for stroke, there were no signs or symptoms as required under the Act.

The Ombudsman requested the fund to review its stance on the matter. As the fund was not able to provide evidence of signs or symptoms prior to Mrs Stringybark joining the fund, the Ombudsman made a formal recommendation to the fund to pay the outstanding hospital account. The fund agreed to implement the Ombudsman's recommendation.

### INFORMED FINANCIAL CONSENT

Consumers generally do not have a good understanding of how much it costs to be treated in a private hospital. If a health fund member finds they are not fully covered by their health insurance because they are in arrears, have a restricted cover or have not served their waiting periods, they may find themselves responsible for the full cost of the hospitalisation. In most cases, the amount of money involved can come as an unpleasant surprise.

For this reason, the Ombudsman places strong emphasis on hospitals conducting fund eligibility checks and advising members of how much it will cost them if their health

fund, for whatever reason, does not fully cover their episode of care. This enables the member to give informed financial consent to incurring the charges if they proceed with the hospitalisation, or seek alternative treatment options if they cannot afford to do so.

There are now very good systems in place to facilitate fund eligibility checks and in the majority of cases, admission procedures ensure members do not return home to unexpected bills after their hospitalisation.

Unfortunately, as the following case illustrates, even the best administrative systems can be ineffective if hospital admissions staff do not take time to fully comply with them.

Mrs Coolibah held a basic hospital cover that enabled her to be covered as a private patient in a public hospital, but did not provide adequate cover for treatment in a private hospital. When Mrs Coolibah needed surgery, her doctor booked her into a private hospital for the procedure.

One month prior to her hospitalisation, she received a letter from the hospital which advised that the hospital would conduct an eligibility check with her health fund on admission and advise her of any out of pocket costs which she would incur.

The hospital conducted the eligibility check and was advised by the fund that Mrs Coolibah held basic cover which paid limited benefits in a private hospital. Hospital staff prepared an estimate of fees based on the fund check. All of the information relating to the hospital's charges was filled in on the form. Unfortunately, staff neglected to fill in the columns indicating the benefit to be paid by the fund, or the amount the patient would be responsible for, once the fund had paid its portion of the account. The only notation in those columns was "nil" which hospital staff intended to indicate that Mrs Coolibah did not have an excess.

On admission Mrs Coolibah was given this form to sign. She assumed her hospitalisation would be fully covered by her fund, because the hospital had checked with her fund and advised her that she would not have any out of pocket costs associated with the hospitalisation. On this basis, she proceeded with her hospitalisation.

Mrs Coolibah was therefore unpleasantly surprised to receive an account for $2,000 some three months after her hospitalisation. With the account was a letter from the hospital advising that her fund had only paid a portion of the cost because of her table of cover and that she was responsible for paying the rest. Mrs Coolibah approached the Ombudsman because she believed hospital staff had misled her by advising her on admission that she would have nothing to pay.

The Ombudsman's investigation revealed that the hospital had good procedures in place for conducting member eligibility checks and informing patients of their out of pocket costs. Unfortunately, in the case of Mrs Coolibah, administrative error on the part of hospital admissions staff allowed Mrs Coolibah to be presented with an incorrect estimate, because the columns indicating the amount the patient would personally be liable for were not correctly filled in.

If the hospital had advised Mrs Coolibah prior to admission that the hospitalisation would cost her $2,000, she would have been able to investigate other treatment options if she believed she could not afford this expense.

Accordingly, the Ombudsman recommended the hospital discount the outstanding account because Mrs Coolibah was not able to give informed financial consent to incurring this charge. The hospital agreed to reduce the account in line with the Ombudsman's recommendation.





## MEDICAL GAPS AND GAPCOVER SCHEMES

The Ombudsman received 197 complaints specifically about medical gaps during the reporting period, which were less than the 280 received in 2002/03. PHIAC statistics for the June Quarter 2004 indicate that 81.2% of in-hospital medical services were provided to patients with no out-of-pocket costs. The PHIAC data indicates that the introduction of gap schemes has increased the ability of members to avoid medical gaps. Complaints to PHIO about this issue indicate, however, that there is still confusion among doctors and patients about the requirements which must be met before a health fund is permitted to pay a gap benefit.

When legislation was introduced to allow health funds to cover medical gaps, the parliament provided strict criteria to control the potential inflationary impact of gap schemes on premiums. In addition, a key feature of the legislation in encouraging doctors to participate in gap schemes was the voluntary nature of agreements between health funds and doctors.

This means that the decision to provide a no or known gap service to each individual patient rests with the doctor. The fund can only pay above the Medicare Benefits Schedule fee if the doctor agrees to participate in the fund's scheme and bill the patient under that scheme. Consumers, on the other hand, tend to believe their fund is at fault if their doctor does not bill them as a no or known gap patient under their fund's gap scheme.

Mr Tallowwood needed surgery and contacted his health fund to find a specialist who would treat him under his health fund's "no gap" scheme. Fund staff advised that he would need to ask his doctor whether he would provide a "no gap" service or not.

Accordingly, Mr Tallowwood asked his surgeon if he would agree to treat him under his fund's "no gap" scheme and the doctor agreed to do so. Mr Tallowwood felt confident in proceeding with surgery on the basis that he would not incur any out of pocket expenses for his surgeon's services.

Unfortunately, however, the surgeon did not have an agreement with Mr Tallowwood's health fund. Furthermore, the surgeon did not want to participate in the fund's gap scheme. He believed he could assist Mr Tallowwood by agreeing to treat him as a no gap patient without being part of the scheme and leaving it up to Mr Tallowwood and the fund to sort out the details.

Every doctor has the right to choose whether or not to participate in a fund's gap scheme. Legally, however, the fund cannot pay a "no gap" benefit unless the doctor agrees to participate in its scheme and accepts the conditions applying to the scheme. The fund therefore denied benefits for the gap portion of the account and Mr Tallowwood was left with an unexpected out of pocket expense of several thousand dollars.

Understandably, Mr Tallowwood was very upset to receive such a large bill after his operation, when he'd been told beforehand he would not have to pay a gap. Mr Tallowwood felt he'd been placed in the middle of a disagreement between the doctor and the fund.

PHIO investigated the matter with the health fund and the doctor. PHIO concluded that in this instance, the doctor was at fault for agreeing to treat Mr Tallowwood as a "no gap" patient when he was not part of the fund's gap scheme and had no intention of participating in the scheme. Eventually, as a result of the Ombudsman's intervention, the doctor accepted the Medicare rebate in full payment of the account.

This case raised a number of issues including the difficulty the member had when he first

telephoned the fund in finding the name of a gap doctor, the misunderstanding on the doctor's part about the legislative requirements to enable a fund to pay a gap benefit and the difficult situation the member found himself in when his fund was unable to pay a gap benefit because these requirements had not been met.

Doctors have the right to choose whether or not they bill their patients under their health fund's gap scheme. It is important, however, that doctors give their patients full information about their charges and how much of this they expect to be covered by Medicare and/or the patient's health fund and advise patients to confirm fund benefits with their health fund, where possible.

### AMBULANCE COSTS

PHIO received some 57 complaints about payment of ambulance benefits in 2003/04. While this represents only 1.5% of complaint issues overall, these complaints can be very difficult to resolve. While most complaints were presented as objections to fund decisions about benefits or requirements for member co-payments, our investigations indicated that many problems arose because of confusion or lack of knowledge about the charging policies of the various State and Territory ambulance services or a lack of coordination between health insurance and ambulance charging policy.

The range of issues included:

- The charging of a $50 patient co-payment for ambulance transport not involving an admission via an emergency department. - HBF, Western Australia. (Most complaints arose where ambulance transport was regularly required due to a medical condition and no suitable alternative transport was available.)
- Refusal of health fund benefit to cover ambulance costs because the situation did not fall within the fund definition of emergency. – Various funds, New South Wales, South Australia & Victoria (In some of these cases the fund and the ambulance service adopted a different definition of emergency.)
- Difficulty in obtaining health insurance cover for ambulance costs incurred interstate. - Various funds, Tasmania in relation to Queensland and South Australian ambulance charges (This was associated with the breakdown of interstate agreements for reciprocal ambulance cover. Tasmanian residents are provided with free ambulance services in Tasmania but may be charged for services provided interstate.)
- Charges for some inter- hospital transfers, including interstate transport to return a patient to a hospital closer to home. – Various funds, New South Wales and Victoria (This issue is also associated with the breakdown of interstate agreements for reciprocal ambulance cover and confusion about what services and which categories of patient are exempt from ambulance charges.)

Mrs Bluegum, an elderly pensioner, travelled from her home in New South Wales to the Gold Coast for a holiday. On arrival at the Gold Coast she felt unwell and was in considerable pain. She was admitted to a Gold Coast Hospital for surgery and medical treatment. After spending 5 weeks in the Gold Coast hospital Mrs Bluegum's doctor advised her that she had recovered sufficiently to be transferred to a hospital closer to her home for further hospital based rehabilitation. The Gold Coast hospital offered to arrange transportation back to the Hunter Valley by air ambulance. Mrs Bluegum said she asked the hospital to check that she would be fully covered for the cost of the ambulance service. The hospital advised her that she would not be liable for any costs, provided a doctor certified that the use of an ambulance was medically necessary.
Her doctor provided the necessary certification.
She was subsequently transported by air ambulance from the gold Coast to the Hunter Valley and admitted to a local hospital for rehabilitation.

Approximately one month later Mrs Bluegum received a bill from the NSW Ambulance service for $3500. She contacted her health fund. The health fund advised that she did not have any cover for ambulance services as part of her health insurance but should not have to pay an ambulance bill because she was a pensioner and the ambulance transport was medically necessary.
She contacted the ambulance service.
They advised that the pensioner exemption from charging did not apply to inter-hospital transfers for the purposes of returning a patient to their home location.
She contacted the Gold Coast hospital.
The hospital staff tried (unsuccessfully) to assist her to resolve the issue.

The PHIO investigation of this case is continuing. In the interim the Ambulance Service has agreed to suspend its debt recovery action.

### TRANSFERRING BETWEEN HEALTH FUNDS

This year the PHIO received 170 complaints about problems experienced when transferring between health funds. While some of these complaints raised issues about consumers' rights in this situation (portability), most arose from breakdowns in the administrative arrangements between funds.

Most health funds target members of other funds, to some extent, in their marketing activities. Promotional material stresses that changing funds is straightforward and the new fund will generally make arrangements to cancel the previous membership (once given the consumer's authority to do so) and ensure that consumer entitlements are not disrupted. To do this and ensure that the requirements of National Health Act are met the new fund needs to obtain a "clearance certificate" from the previous fund providing details of the new member's lifetime health cover status (whether a lifetime health cover loading is applicable). The clearance certificate must also confirm that the member was paid up to date with the old fund and the level of cover the new member had with their old fund. Where the transfer arrangements operate effectively, all this is done for the new member within the first month of joining and the transfer process is as straightforward as promised. However in many of the complaints to the PHIO these administrative arrangements do not operate properly leading to delays, uncertainty and, sometimes, extra costs for consumers.

Ms Bloodwood was attracted by an advertisement offering low cost health insurance as she was finding it difficult to continue to meet the cost of health insurance through her existing fund.
She contacted the new fund by telephone.
Although the product advertised was unsuitable for her and not comparable to her current health insurance, the new fund was able to offer another product that provided similar benefits to her current policy at a considerably lower price. She was assured that transferring to the new fund would be simple, the new fund would advise her old fund and obtain all necessary details so that she did not have to serve any waiting periods again and would enjoy continuous health insurance cover. She agreed to join the new fund.

Within a week Ms Bloodwood was sent a welcoming letter from her new fund giving her cover from the date of her phone call (subject to some formalities). The letter informed her

about her new policy and included forms to obtain the 30% rebate; agree to quarterly deductions from her credit card and an authority for her new fund to cancel her old policy and obtain details from her old fund. She completed these and returned them to the new fund on the same day.

However when she received her next credit card statement Ms Bloodwood noted that a deduction had been made for the new fund's quarterly premium that was considerably higher than the amount quoted and much higher than she had been paying with her previous fund. She also noted that her previous fund's premium payment had also been deducted from her account. She contacted the new fund's customer service staff who confirmed that the amount deducted was correct but were unable to satisfactorily explain why this differed from the quote she had been given initially. They advised her that it was her responsibility to cancel the deductions for her previous policy. None of the correspondence she had received contained any information about how the premium was calculated.

She contacted the previous fund. She was advised that her membership with that fund remained current and they had no instructions to cancel her membership.

As it was now evident to Ms Bloodwood that her previous fund policy was cheaper she decided to remain with that fund and wrote to the new fund asking that her policy with them be cancelled and that the premiums deducted by that fund be refunded to her as she had remained a member of the previous fund throughout the period. The new fund replied confirming that her policy with them had been cancelled with effect from the date of her letter but that premiums paid for the period prior to her cancellation request could not be refunded because her request for cancellation was outside their cooling off period. Ms Bloodwood  complained that she had been misled about the amount of the premium payable but the fund maintained its "partial refund only" position. Ms Bloodwood complained to the Ombudsman.

PHIO's investigation of Ms Bloodwood's complaint revealed that:

- The new fund had sent a request for a "clearance certificate" to the new fund but had not received the required information.
- Because this information had not been received, the new fund included a full lifetime health cover loading in Ms Bloodwood's premium payment. (This is what made the premium higher than the quoted amount.)
- Her previous fund had received the request for cancellation and transfer information but administrative delays had held up processing of that request.
- Both the new fund and the old fund rules precluded someone from being a member of two funds at the same time.

After PHIO advised Ms Bloodwood of these findings Ms Bloodwood decided she preferred to stay with her original fund. The experience had left her with a negative perception of the new fund. The new fund agreed to refund all of Ms Bloodwood's premiums less a small administration fee.

Clearly some aspects of the potential new fund's process and actions could have been improved. However most of the problems could have been avoided if the original fund had met its obligations to process requests for transfer information promptly. The National Health Act requires funds to process requests for information about lifetime health cover status within 14 days. The Ombudsman has highlighted this requirement to funds and will be closely monitoring complaints for any evidence of non-compliance by funds.





### THE RIGHT TO KNOW WHEN YOU'RE NO LONGER COVERED

This year the office received a number of complaints that highlight this fundamental consumer right. These complaints generally involve changes to health fund family memberships that remove a person (other than the contributor/primary member) from the membership. If that person (and the primary member) is not advised appropriately that they are no longer included on the membership, they may incur health expenses on the assumption that they are covered and may loose the opportunity to take up health insurance in their right or maintain continuity of coverage.

Mr Ironbark had contributed to his health fund for over 20 years and paid for a family membership to cover himself, Mrs Ironbark and their three children. His oldest child, Jarrah was aged 22 years and attended university full time. The rules of the fund allowed for children to remain as dependents on a family membership beyond age 21 up to the age of 25 years, if they remained in full time studies.

In March of each year the fund wrote to Mr Ironbark to request confirmation that Jarrah was still engaged in full time studies. (The fund also wrote to other members with student dependents at the same time.) The letter advised that the information requested was required in order to maintain coverage for Jarrah on the membership and asked Mr Ironbark to complete and return an enclosed form. Mr Ironbark put the form aside for later completion but appears to have forgotten about it.

Approximately two months later the fund took action (via a computer program) to remove Jarrah from the membership because it had not been established that she continued as a full time student. No advice was sent to Mr Ironbark because the fund considered that this action had been implied in the request sent to Mr Ironbark in March.

Mrs Ironbark discovered what had happened when she and Jarrah attended dental appointments later in the year and the dentist was unable to process an electronic claim in respect of Jarrah. After checking with the fund Mrs Ironbark discovered that Jarrah had been removed from the membership in May. The fund had not advised either Mr Ironbark or Jarrah that it had taken that action. By this time Mrs Ironbark also knew that Jarrah would be leaving university at the end of the year and was pregnant. Jarrah offered to join the fund as a single person so that she could have her own obstetrician attend the birth at a nearby private hospital. However the fund advised that as she had not joined within two months of her removal from the family membership, the fund would apply a twelve-month wait for benefits for obstetrics. Jarrah complained that had she known she had been removed from her father's membership she would have joined at that time because by then she knew she was pregnant. Mr Ironbark and Jarrah complained to PHIO.

Following the Ombudsman's intervention the fund acknowledged that it should have provided Jarrah with an opportunity to transfer to a new cover, in her own right, without imposing waiting periods. The fund agreed that the failure to provide specific advice that Jarrah's cover under her father's policy had been cancelled denied Jarrah of that opportunity. The fund offered to waive all waiting periods if Jarrah joined the fund and Jarrah took up the offer. The fund also agreed to review and alter its procedures to ensure that young people in Jarrah's situation are advised of significant changes to their coverage.

## OVERSEAS VISITOR HEALTH COVER

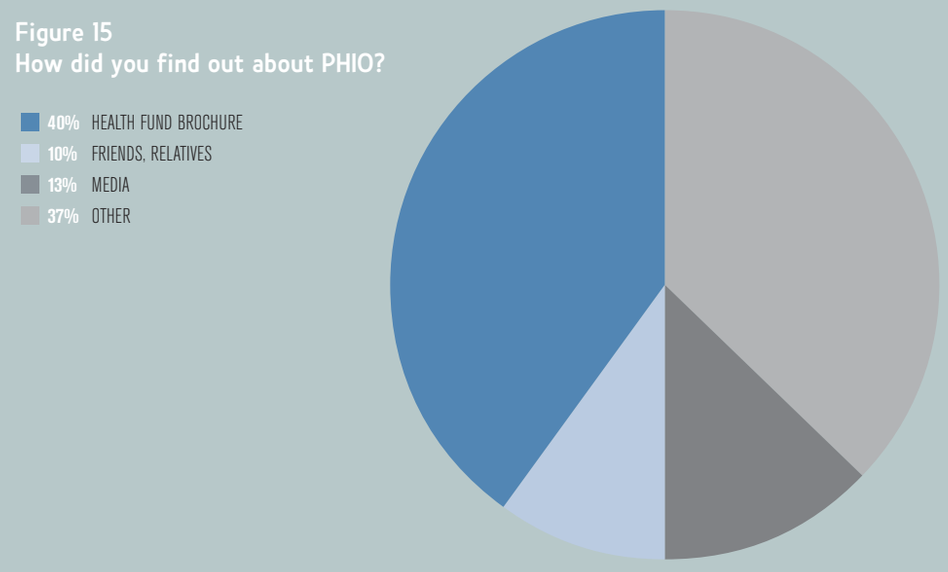
The Ombudsman dealt with a small number of complaints from non-residents about overseas visitor health cover offered by Australian health funds. Visitors in some visa categories are required as a condition of entry to Australia to have arranged their own health insurance prior to arrival.. Visitors holding visas in these categories are not eligible for Australian Medicare benefits and overseas visitor health cover includes benefits to cover those costs as well as costs that are met by domestic health insurance products. Not all Australian health funds offer overseas visitor cover. Complaints about overseas visitor cover have therefore been excluded from the count of level 3 complaints in figure 9.

The Ombudsman investigated twenty eight complaints about overseas visitor cover in 2003/2004. Medibank Private accounted for fifteen of these complaints, with most relating to a significant price increase for this type of cover in 2003. Ten complaints from holders of Australian Unity overseas visitor cover were investigated. Most of those related to the application of pre- existing ailment rules. Of the remaining funds offering overseas visitor cover the Ombudsman investigated two complaints about MBF visitors cover and one complaint about BUPA.





**Figure 15**
**How did you find out about PHIO?**




## 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. The 2004 Client Satisfaction survey asked complainants to indicate how they found out about PHIO. Responses indicated that sources other than those nominated (health fund brochures, friends and family and the media) are becoming increasingly important. These other sources include internet searches and referrals from consumer advice agencies. Future surveys will ask specifically about these sources of information.

To further raise awareness of the service provided by the Ombudsman, the following strategies were employed during 2003/2004:

- Details of the Ombudsman's services are referenced in various Government publications and in publications produced by other agencies and consumer bodies.
- Health funds provide information about the availability of the Ombudsman's services and contact details in brochures, publications and on some correspondence to fund members. These details are also included on health fund internet sites.
- The Ombudsman produces and distributes a range of brochures on health insurance issues.
- The Ombudsman participated in a number of radio and television interviews during the year and contributed or

reviewed information on private health insurance for inclusion in press articles, periodicals and public websites.

- The Ombudsman publishes a regular quarterly report which is distributed in both written format and available on the PHIO website.
- The Ombudsman hosts an internet 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. It also provides consumers with links to other useful sites. The Ombudsman's web site is located at: http://www.phio.org.au.
- The Ombudsman and staff spoke at a number of conferences during the year and again sponsored a successful national seminar open to the whole private health industry.

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 a free-call hotline,1800 640 695. Complaints may be lodged by telephone, fax, e-mail or by post.

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.

## RELATIONS WITH STAKEHOLDERS

The Ombudsman produces a Quarterly Bulletin containing general information about current problem areas and health insurance complaint statistics that is sent in printed form to members of Federal Parliament, health funds, hospitals and others who specifically request the printed version. The Bulletin is released simultaneously in electronic form on the PHIO website.

In March 2004 the Office conducted its fifth annual seminar in Melbourne, inviting participation from the private health industry. Feedback from participants was again 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.

The Ombudsman has initiated a project, with the support of the Australian Health Insurance Association (AHIA) and the Health Insurance Restricted Membership Association of Australia (HIRMAA), to assess the effectiveness of complaints management within the Private Health Insurance Industry. The project is intended to provide a basis for identifying strengths and weaknesses of current processes and developing improvement strategies that are relevant to the industry.

The Ombudsman maintains regular contact with health fund, hospital and consumer organisations. During the last year the Ombudsman gave presentations to twelve industry conferences or meetings of industry associations. The Ombudsman also provided comments and advice to health funds on proposed consumer communication products, on request.

## CLIENT SURVEY

**About the Survey**

In June 2004, the office carried out a mail survey of a randomly selected 300 complainants who had lodged completed complaints during October 2003 through to February 2004. 141 complainants responded to the survey.





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 clients through such surveys is an important element of the Federal Government's program of implementing and reporting on Service Charters for Commonwealth Government Departments and Statutory Authorities.

**Overall improvement in client satisfaction**

The survey found that client satisfaction with most aspects of PHIO services improved markedly compared to the previous year. Overall satisfaction levels increased from 75% in the previous year to 87% in 2003/2004.

Other indictors of improvement in client satisfaction with PHIO services are:

- 92% of respondents indicated staff listened to their concerns; an increase from 89% last year.
- 85% of respondents said we explained what sort of assistance we can provide, this is an increase from 83% in 2003.
- 87% of respondents said that we were easy to understand, this is an increase from 83% in 2003.
- 84% of respondents said they were satisfied or mostly satisfied with the manner in which staff handled their complaint, this is an increase from 75% in 2003.
- 70% of respondents said that we had resolved their complaint or provided an adequate explanation; this is an increase from 64% last year. There was a large improvement in relation to Level 2 Complaints (those resolved by the provision of advice or information from PHIO staff).

Figure 16

Improvement in Satisfaction

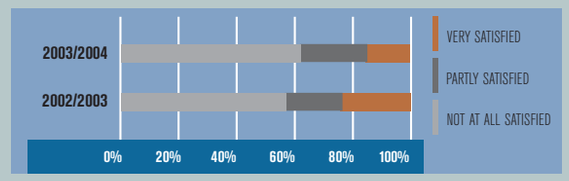
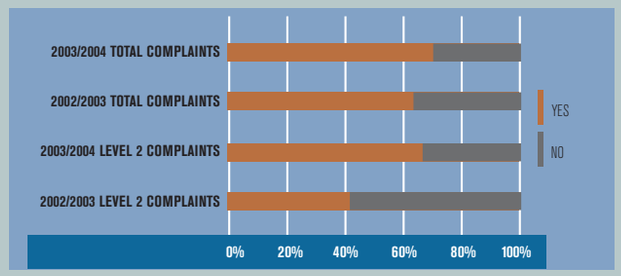



Figure 17

Were staff able to resolve your complaint or provide an adequate explanantion?



### PERCEPTIONS OF INDEPENDENCE

Seventy nine percent of respondents said that the Ombudsman was independent in dealing with their complaint. This result was similar to last year. There was however a decline in this measure in relation to level 3 complaints (those requiring more in depth investigation). In 2003, 85 percent of respondents in this category believed the Ombudsman is independent. For this group, the percentage responding in this way had declined to 72 percent. Some comments from respondents suggest that the adoption of standard Australian Government branding by the Ombudsman may have influenced the view that Ombudsman is not independent. Staff will in future ensure that complainants are aware that while the PHIO is an Australian Government Agency, complaint investigations are independent of government influence.

### AREAS REQUIRING IMPROVEMENT

Only sixty eight percent of respondents in the level 3 complaints category reported they were satisfied with the time taken to finalise their complaint. This is a decrease from 89% in 2003. Similarly, only 73% of respondents in the level 3 complaints category found us easy to understand. This is a decrease from 86% in 2003. The Private Health Insurance Ombudsman will attend to this issue in 2004.

These results suggest a need to do more to keep complainants informed of the progress of an investigation. The Ombudsman will be re-examining office procedures with the aim of improving this aspect of operations in the coming year.

### RECOMMENDING THE OMBUDSMAN'S SERVICES TO OTHERS

The clearest indication of the value respondents placed on the service they received from the Ombudsman is that 89% of respondents indicated that they would use the office's services again or recommend us to others. It is pleasing to see this important measure has improved from 76% last year.

**Figure 18**

**In your view, was the Ombudsman independent in dealing with your complaint?**

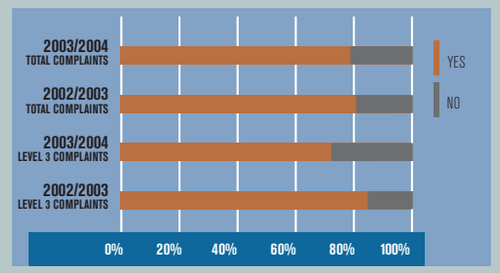
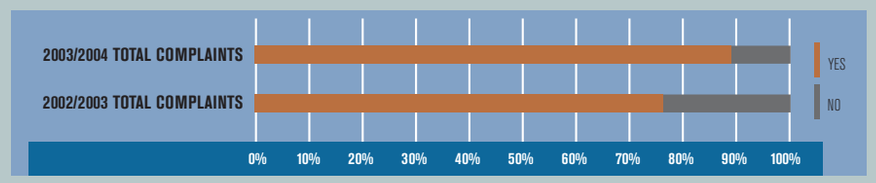



**Figure 19**

**Would you use PHIO again or recommend us to others?**








### HEALTH POLICY - LIAISON WITH OTHER BODIES

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

- Membership of the Informed Financial Consent Taskforce – to advise the Minister on strategies to improve the incidence of genuine financial consent to in-hospital medical procedures;
- Participation in industry development of new arrangements for funding the prostheses and medical devices used in private hospital treatment;
- Comment on proposed legislation to limit health fund benefits for "lifestyle" products and services.
- Advice to the department and health funds on the implementation of changes to Lifetime Health Cover levy regulations and exemptions.
- Circulation of a position paper and discussion paper on the application of portability when hospital/ health fund agreements are terminated.
- Assessment of the application of the government's cost recovery policy to the Private Health Insurance Ombudsman
- Providing statistics on complaint issues for inclusion in the ACCC's Report to the Senate on *Anti-competitive and other practices by health funds and providers in relation to private health insurance.*

This year the Ombudsman accepted membership of the Australasian Council of Health Care Complaints Commissioners and undertook work for the Council on the issue of Informed Financial Consent. The Ombudsman also provided advice and comment on the *Better Practice Guidelines on Complaints Management for Health Care Services* developed for the Australian Council of Safety and Quality and formally endorsed the guidelines for use by hospitals and health providers.

The Ombudsman regularly receives representations from professional or health consumer associations about private health insurance arrangements. The Ombudsman responds to these representations either by providing advice about the particular issue or drawing the issue to the attention of health funds, other regulators or the Minister. In some cases, such representations may lead to the Ombudsman investigating the practices or procedures of the health funds under his own volition (Section 82ZT). During 2003/2004 the Ombudsman received such representations on the following issues:

- Health Fund benefits for insulin pump consumables
- Health Fund benefits for Cochlear Implant replacement processors
- The impact of health fund policies on the availability of private dialysis facilities in Western Australia
- The introduction of health insurance products that exclude benefits for cardiac surgery and other procedures
- The introduction of new rules by a health fund that limit the level of hospital benefits payable for psychiatric treatment for an initial period
- Health Fund benefits for home births and services provided by independent midwives.

## 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.

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 tasks places a significant reliance on all staff to work as a team and to fully understand the fundamentals associated with the whole private health industry. Dispute resolution staff are responsible for the day to day management of individual complaints and to bring to the attention of the Ombudsman and the Director of Policy and Compliance, 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 2004, the staff employed by the Private Health Insurance Ombudsman comprised:

| Permanent & Part-Time Employees | Female | Male |
|---|---|---|
| Ombudsman | | 1 |
| Director, Policy & Compliance | 1 | |
| Projects and Research Officer | | 1 |
| Senior Dispute Resolution Officer | 1 | |
| Dispute Resolution Officers | 3 | 1 |
| Administrative Assistant | | 1 |
| **Total** | **5** | **4** |

## STATUTORY POSITIONS

The Private Health Insurance Ombudsman comprises one statutory office holder:

| Officer | Position | Term | Expiry Date |
|---|---|---|---|
| Mr J Powlay | Ombudsman | 3 years | November 2005 |

Mr Powlay was appointed as Private Health Insurance Ombudsman in November 2002. The Ombudsman's remuneration is determined by the Remuneration Tribunal.

## STAFF DEVELOPMENT AND TRAINING

During the 2003-2004 financial year $6199 was spent directly on PHIO staff attending training courses, conferences and seminars. During the financial year the Ombudsman continued its internal staff development and training program for dispute resolution staff.

In March 2004 the Ombudsman's Office conducted its fifth annual 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.

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

The following table shows the numbers and status of staff who were employed on 30 June 2004.

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

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

*Includes part time employees. Actual EFT = 8.5

## 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 manage the high level accounting functions including finalisation of annual accounts. The office utilises the MYOB suite of accounting programs internally and has contracted Complete GST Solutions for day-to-day administration of general accounting functions.

The Ombudsman's Audit Committee, which comprises PHIO staff, Hall Chadwick Accountants and the National Audit Office, held appropriate discussions 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. PHIO also delivers direct services (information provision and dispute resolution). These two outputs contribute to a viable private health insurance industry by improving consumer confidence in private health insurance arrangements. A report of performance against the performance indicators established for the PHIO outputs is provided at the commencement of the *Performance* section of this report.

## CONSULTANTS ENGAGED

The Ombudsman continued to engage Complete GST Solutions as a consultant during the financial year to assume responsibility for regular in-house accounting functions. The office continues to engage specialised IT staff to assist with maintaining the complaints management and reporting system, and PT and A Health as a medical referee on cases requiring a detailed medical opinion. Both of these latter consultants are engaged on an ad-hoc basis.

# statutory reporting information

This year the Ombudsman also engaged Listening Post Pty Ltd to facilitate a review of complaints management within the Health Insurance industry, analyse the results of the review and prepare individual fund and industry wide reports. This review is to take place in July and August of 2004. The Australian Health Insurance Association and The Health Insurance Restricted Membership Association of Australia have agreed to contribute to the cost of this consultancy.

## INFORMATION SYSTEMS

The Ombudsman's information system is based upon a Windows NT network server and the Microsoft Office 2000 suite. 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. The Ombudsman's Internet network and network security is maintained by Alpha Dot Net.

## PAYROLL SERVICES

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

## FRAUD CONTROL

Staff are trained in fraud awareness and procedures, which are in place to notify the Australian Federal Police and/or the Director of Public Prosecutions if loss occurs as a result of fraud. A formal fraud procedure manual has been produced and all staff made aware of their obligations and responsibilities. No cases of fraud were detected during the year.

## SERVICE CHARTER

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

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

## OCCUPATIONAL HEALTH AND SAFETY

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 Compliance 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*. The Ombudsman has reviewed the requirements of the Commonwealth Disability Strategy and the office complies with these requirements.



# 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 2003.

## 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, in or connection with a private health insurance arrangement. The Ombudsman is an independent statutory corporation.

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

## DOCUMENTS AVAILABLE FREE OF CHARGE

The following brochures are available free of charge upon request:

- A brochure "Who We Are"
- A brochure "Making a Complaint"
- A brochure "The Ten Golden Rules of Private Health Insurance"
- A brochure "Service Charter"
- A brochure "What Can I Do About My Doctor's Bill?"
- 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 Level 7, 362 Kent Street, Sydney, NSW, 2000

# freedom of information statement

- by telephoning (02) 8235 8777 or 1800 640 695 (Free-call)
- by fax on (02) 8235 8778
- by e-mail to info@phio.org.au
- from the web site http://www.phio.org.au

## INFORMATION AND PROCEDURES FOR FREEDOM OF INFORMATION ACT REQUESTS

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 Compliance
Private Health Insurance Ombudsman
Level 7
362 Kent 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 9.00 am and 5.00 pm on weekdays.



# external review and scrutiny

The office subjects itself to regular review of its performance by conducting a survey of complainants.

Detail of the review for this year is provided in the body of this report.

## COURTS

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

## COMMONWEALTH OMBUDSMAN

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

## OTHER

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

## SERVICE CHARTER

In line with requirements for all Commonwealth Government agencies, the Ombudsman introduced a Service Charter in June 1998 which was reviewed in 2004.

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

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.

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

# financial information

Australian National
Audit Office

**INDEPENDENT AUDIT REPORT**

**To the Minister for Health and Ageing**

**Scope**

The financial statements comprise:

- Statement by the Ombudsman;
- Statements of Financial Performance, Financial Position and Cash Flows;
- Schedules of Commitments and Contingencies; and
- Notes to and forming part of the Financial Statements

of the Private Health Insurance Ombudsman for the year ended 30 June 2004.

The Ombudsman is responsible for the preparation and true and fair presentation of the financial statements in accordance with the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial statements.

**Audit approach**

I have conducted an independent audit of the financial statements in order to express an opinion on them to you. My audit has been conducted in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing and Assurance Standards, in order to provide reasonable assurance as to whether the financial statements are free of material misstatement. The nature of an audit is influenced by factors such as the use of professional judgement, selective testing, the inherent limitations of internal control, and the availability of persuasive, rather than conclusive, evidence. Therefore, an audit cannot guarantee that all material misstatements have been detected.

While the effectiveness of management's internal controls over financial reporting was considered when determining the nature and extent of audit procedures, the audit was not designed to provide assurance on internal controls.

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SYDNEY NSW
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Procedures were performed to assess whether, in all material respects, the financial statements present fairly, in accordance with the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, Accounting Standards and other mandatory financial reporting requirements in Australia, a view which is consistent with my understanding of the Ombudsman's financial position and performance as represented by the Statements of Financial Performance and Cash Flows.

The audit opinion is formed on the basis of these procedures, which included:

- examining, on a test basis, information to provide evidence supporting the amounts and disclosures in the financial statements; and
- assessing the appropriateness of the accounting policies and disclosures used, and the reasonableness of significant accounting estimates made by the Ombudsman.

**Independence**

In conducting the audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate Australian professional ethical pronouncements.

**Audit Opinion**

In my opinion, the financial statements:

(i) have been prepared in accordance with the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997* and applicable Accounting Standards; and

(ii) give a true and fair view, of the matters required by applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and the Finance Minister's Orders, of the financial position of the Private Health Insurance Ombudsman as at 30 June 2004, and its performance and cash flows for the year then ended.

Australian National Audit Office

P Hinchey
Senior Director

Delegate of the Auditor-General

Sydney
13 September 2004

**Private Health Insurance Ombudsman**

**Statement by the Ombudsman**
**for the year ended 30 June 2004**

In my opinion, the attached financial statements for the year ended 30 June 2004 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997.*

In my opinion, at the date of this statement, there are reasonable grounds to believe that the Ombudsman will be able to pay all debts as and when they become due and payable.

John Powlay

Dated 13/9/04





## PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF FINANCIAL PERFORMANCE

**For the year ended 30 June 2004**

| | Note | 2004 $ | 2003 $ |
|---|---|---|---|
| **REVENUE** | | | |
| **Revenues from ordinary activities** | | | |
| Revenue from Government | 2A | **965,000** | 950,000 |
| Interest | 3A | **26,477** | 17,839 |
| Other | 3B | **23,910** | 85,508 |
| Revenue from sale of assets | 3C | **600** | - |
| ***Revenues from ordinary activities*** | | **1,015,988** | 1,053,347 |
| **Expenses from ordinary activities** | | | |
| Suppliers | 4A | **326,875** | 322,603 |
| Employees | 4B | **611,958** | 679,296 |
| Depreciation and Amortisation | 4C | **20,196** | 23,768 |
| Write down of assets | 4D | **3,680** | - |
| ***Expenses from ordinary activities*** | | **962,709** | 1,035,667 |
| ***Operating surplus from ordinary activities*** | | **53,277** | 17,680 |
| Net credit to asset revaluation reserve recognised directly in equity | | - | 4,299 |
| Increase in accumulated results on application of transitional provisions in *AASB 1041 Revaluation of Non-Current Assets* | | - | 3,252 |
| **Total revenues, expenses and valuation adjustments recognised directly in equity** | | - | 7,551 |
| **Total changes in equity other than those resulting from transactions with the Australian Government as owner** | | **53,277** | 25,231 |

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

The accompanying notes form part of these financial statements

## PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF FINANCIAL POSITION

**As at 30 June 2004**

| | Note | 2004 $ | 2003 $ |
|---|---|---|---|
| **ASSETS** | | | |
| **Financial assets** | | | |
| Cash | 5A | **98,466** | 117,697 |
| Other Investments | 5B | **300,000** | 300,000 |
| Receivables | | **6,460** | - |
| ***Total financial assets*** | | **404,926** | 417,697 |
| **Non-financial assets** | | | |
| Infrastructure, plant & equipment | 6A,B,D,E | **69,040** | 30,301 |
| Intangibles | 6C | **740** | 4,991 |
| Prepayments | 6F | **4,105** | - |
| ***Total non-financial assets*** | | **73,885** | 35,292 |
| **Total assets** | | **478,811** | 452,989 |
| **LIABILITIES** | | | |
| **Payables** | | | |
| Suppliers | 7A | **9,645** | 26,410 |
| ***Total payables*** | | **9,645** | 26,410 |
| **Provisions** | | | |
| Employees | 7B | **145,603** | 156,295 |
| ***Total provisions*** | | **145,603** | 156,295 |
| **Total liabilities** | | **155,248** | 182,705 |
| **EQUITY** | | | |
| Reserves | 8 | **4,299** | 4,299 |
| Accumulated surplus | 8 | **319,264** | 265,986 |
| **Total equity** | | **323,563** | 270,285 |
| **Current liabilities** | | **50,043** | 81,814 |
| **Non-current liabilities** | | **105,205** | 100,891 |
| **Current Assets** | | **409,031** | 417,697 |
| **Non-current assets** | | **69,780** | 35,292 |

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



## PRIVATE HEALTH INSURANCE OMBUDSMAN STATEMENT OF CASH FLOWS

**For the year ended 30 June 2004**

| | Note | 2004 $ | 2003 $ |
|---|---|---|---|
| **OPERATING ACTIVITIES** | | | |
| **Cash Received** | | | |
| Appropriations | | **965,000** | 950,000 |
| Interest | | **26,477** | 17,839 |
| Other | | **18,052** | 85,508 |
| ***Total cash received*** | | **1,009,529** | 1,053,347 |
| **Cash Used** | | | |
| Suppliers | | **(348,100)** | (339,411) |
| Employees | | **(622,650)** | (574,414) |
| ***Total cash used*** | | **(970,750)** | (913,825) |
| **Net cash from operating activities** | 14 | **38,779** | 139,522 |
| **INVESTING ACTIVITIES** | | | |
| **Cash used** | | | |
| Purchase of investment | | **-** | (300,000) |
| Purchase of property, plant and equipment | | **(58,010)** | (7,172) |
| ***Total cash used*** | | **(58,010)** | (307,172) |
| **Net cash used by investing activities** | | **(58,010)** | (307,172) |
| ***Net decrease in cash held*** | | **(19,231)** | (167,651) |
| Cash at the beginning of the reporting period | | **117,697** | 285,348 |
| ***Cash at the end of the reporting period*** | 5A | **98,467** | 117,697 |

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

## PRIVATE HEALTH INSURANCE OMBUDSMAN SCHEDULE OF COMMITMENTS

**As at 30 June 2004**

| | 2004 $ | 2003 $ |
|---|---|---|
| **BY TYPE** | | |
| OTHER COMMITMENTS | | |
| Operating Leases | **150,177** | 97,650 |
| ***Total other commitments*** | **150,177** | 97,650 |
| **BY MATURITY** | | |
| **Operating lease commitments** | | |
| Non-cancellable operating leases contracted for but not capitalised in the financial statements | | |
| Payable: | | |
| not later than 1 year | **53,004** | 97,650 |
| later than1 year but not later than 5 years | **97,173** | - |
| ***Total operating lease commitments*** | **150,177** | 97,650 |

The lease is for office accommodation and is subject to annual increase of 4%.
The lease is current for 3 years with an option to renew for a further 3 years.

## PRIVATE HEALTH INSURANCE OMBUDSMAN SCHEDULE OF CONTINGENCIES

**As at 30 June 2004**

There were no contingent losses or gains as at 30 June 2004.

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



## PRIVATE HEALTH INSURANCE OMBUDSMAN NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

**For the year ended 30 June 2004**

### NOTE SUMMARY

## PRIVATE HEALTH INSURANCE OMBUDSMAN NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

**For the year ended 30 June 2004**

## NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

### 1.1 Basis of Accounting

The financial statements are required by clause 1(b) of Schedule 1 to the *Commonwealth Authorities and Companies Act 1997* and are a general purpose financial report.

The statements have been prepared in accordance with:

- Finance Minister's Orders (being the *Commonwealth Authorities and Companies (Financial Statements for reporting periods ending on or after 30 June 2004) Orders);*
- Australian Accounting Standards and Accounting Interpretations issued by the Australian Accounting Standards Board; and
- Consensus Views of the Urgent Issues Group.

The Statements of Financial Performance and Financial Position have been prepared on an accrual basis and are in accordance with the 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.

Assets and liabilities are recognised in the Statement of Financial Position when and only when it is probable that future economic benefits will flow and the amounts of the assets or liabilities can be reliably measured. Assets and liabilities arising under agreements equally proportionately unperformed are however not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the Schedule of Commitments and the Schedule of Contingencies (other than unquantifiable or remote contingencies).

Revenues and expenses are recognised in the Statement of Financial Performance when and only when the flow or consumption or loss of economic benefits has occurred and can be reliably measured.

### 1.2 Changes in Accounting Policy

The accounting policies used in the preparation of these financial statements are consistent with those used in 2002-03.

### 1.3 Revenue

The revenues described in this Note are revenues relating to the core operating activities of the Ombudsman.

Interest revenue is recognised on a proportional basis taking into account the interest rates applicable to the financial assets.

Revenue from the disposal of non-current assets is recognised when control of the asset has passed to the buyer.

The full amount of the appropriation for departmental outputs for the year is recognised as revenue.

### 1.4 Employee Entitlements

*Benefits*

Liabilities for services rendered by employees are recognised at the reporting date to the extent that they have not been settled.

Liabilities for wages and salaries (including non-monetary benefits) and annual leave, are measured at their nominal amounts. Other employee benefits expected settled within 12 months of their reporting date are also measured at their nominal amounts.

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

All other employee benefit liabilities are measured as the present value of the estimated future cash outflows to be made in respect of services provided by employees up to the reporting date.

*Leave*

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

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

*Superannuation*

Employees of the Ombudsman are members of the Commonwealth Superannuation Scheme and the Public Sector Superannuation Scheme. The liability for their Superannuation benefits is recognised in the financial statements of the Commonwealth and is settled by the Commonwealth in due course.

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

### 1.5 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.

### 1.6 Cash

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

### 1.7 Financial Instruments

Accounting policies for financial instruments are stated at Note 15.

### 1.8 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 $1,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

*Revaluations*

Land, buildings, infrastructure, plant and equipment are carried at valuation.

*Frequency*

Infrastructure, plant and equipment assets are revalued progressively in successive three-year cycles, so that no asset has a value greater than three years old.

PHIO completed its asset revaluation on 1 July 2002, with all asset groups being valued at fair value.

The Finance Minister's Orders require that all property, plant and equipment assets be measured at up-to-date fair values from 30 June 2005 onwards.The current year is therefore the last year in which PHIO will undertake progressive revaluations.

In the move to adopt the Australian Equivalents to International Financial Reporting Standards, the Council will revalue all its assets in 2004-05.

*Depreciation and Amortisation*

Depreciable property plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Ombudsman 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 revalued.

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

| | **2004** | 2003 |
|---|---|---|
| Leasehold improvements | **Lease term** | Lease term |
| Plant and equipment | **4 to 9 years** | 3 to 7 years |

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 4C.

### 1.9 Intangibles

The Ombudsmans's intangibles comprise internally-developed software for internal use. The asset is carried at cost.

All software assets were assessed for impairment as at 1 July 2004. None were found to be impaired.

Software is amortised on a straight-line basis over its anticipated useful life.

| | **2003** | **2002** |
|---|---|---|
| Useful lives are: Internally developed software | **7 years** | 7 years |

### 1.10 Taxation

The Ombudsman is exempt from all forms of taxation except fringe benefits tax and the goods and services tax.

### 1.11 Insurance

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

### 1.12 Comparative Figures

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

### 1.13 Adoption of Australian Equivalents to International Financial Reporting Standards

The Australian Accounting Standards Board has issued replacement Australian Accounting Standards to apply from 2005-2006. The new standards are the Australian Equivalents (AE) to International Financial Reporting Standards (IFRSs) which are issued by the International Accounting Standards Board. The new standards cannot be adopted early. The standards being replaced are to be withdrawn with effect from 2005-2006, but continue to apply in the meantime.

For the accounting periods beginning on and after 1 July 2005 PHIO must comply with the AE issued by the Australian Accounting Standards Board.

The Ombudsman has established a formal project, to manage the transition to IFRS reporting. An assessment and planning phase is complete in most respects at 30 June 2004. This phase produced an overview of the impacts of conversion to IFRS reporting on existing accounting and reporting policies and procedures, systems and processes, business structure and staff which indicated there is likely to be very little impact as there are no major changes in accounting policies. The Ombudsman will continue to monitor the requirements for transition to IFRS.

| | 2004 $ | 2003 $ |
|---|---|---|
| **2 REVENUES FROM GOVERNMENT** | | |
| **2A Parliamentary appropriations** | | |
| Appropriation for outputs | **965,000** | 950,000 |
| ***Total revenue from government*** | **965,000** | 950,000 |
| **3 REVENUES FROM INDEPENDENT SOURCES** | | |
| **3A Interest revenue** | | |
| Interest on Deposits | **26,477** | 17,839 |
| ***Total Interest revenue*** | **26,477** | 17,839 |
| **3B Other Revenue** | | |
| Transfer of employee benefits from other agency | **-** | 85,508 |
| Seminar Income | **23,000** | - |
| Other | **910** | - |
| ***Total Other revenue*** | **23,910** | 85,508 |
| **3C Net gain from Sale of Assets** | | |
| Property Plant and Equipment: | | |
| Proceeds from disposal | **600** | - |
| Net book value at sale | **-** | - |
| ***Net gain from disposal of property, plant & equipment*** | **600** | - |
| **4 GOODS AND SERVICES EXPENSES** | | |
| **4A Suppliers expenses** | | |
| Supply of Goods and Services - all external | **227,666** | 207,957 |
| Operating Lease Rentals | **99,209** | 124,646 |
| ***Total suppliers expenses*** | **326,875** | 332,603 |
| **4B Employee expenses** | | |
| Wages and Salaries | **499,592** | 500,005 |
| Superannuation | **90,941** | 68,529 |
| Leave and other entitlements | **18,706** | 107,798 |
| Other employee expenses | **2,719** | 2,964 |
| ***Total employee expenses*** | **611,958** | 679,296 |
| **4C Depreciation and Amortisation** | | |
| Depreciation of property, plant and equipment | **19,627** | 17,180 |
| Amortisation - Lease Fitout | **569** | 6,588 |
| ***Total depreciation and amortisation expense*** | **20,196** | 23,768 |
| **4C Write-Down of Assets** | | |
| Plant & equipment written down | **3,680** | - |
| ***Total Write-Down of Assets*** | **3,680** | - |

| | 2004 $ | 2003 $ |
|---|---|---|
| **5 FINANCIAL ASSETS** | | |
| **5A Cash** | | |
| Cash on Hand | **158** | 149 |
| Cash at Bank | **98,308** | 117,548 |
| ***Total cash*** | **98,466** | 117,697 |
| **5B Investments** | | |
| Term Deposits - current | **300,000** | 300,000 |
| ***Total Investments*** | **300,000** | 300,000 |
| **6 NON FINANCIAL ASSETS** | | |
| **6A Buildings** | | |
| Lease Fitout at Cost | **5,531** | - |
| Less: Accumulated Amortisation | **(194)** | - |
| | **5,337** | - |
| Leasehold Fitout - at valuation 1 July 2002 | **-** | 6,230 |
| Less: Accumulated Amortisation | **-** | (2,546) |
| | **-** | 3,684 |
| ***Total Building*** | **5,337** | 3,684 |
| **6B Infrastructure, Plant and Equipment** | | |
| Plant and Equipment - at valuation 1 July 2002 | **32,238** | 34,079 |
| Less: Accumulated Depreciation | **(24,557)** | (13,262) |
| | **7,681** | 20,817 |
| Plant and Equipment - at cost | **61,476** | 7,172 |
| Less: Accumulated Depreciation | **(5,454)** | (1,372) |
| | **56,022** | 5,800 |
| ***Total Infrastructure, Plant and Equipment*** | **63,703** | 26,617 |
| Intangibles - at cost | **17,412** | 17,412 |
| Less: Accumulated Depreciation | **(16,672)** | (12,421) |
| ***Total intangibles*** | **740** | 4,991 |

### 6D Analysis of Property, Plant, Equipment and Intangibles

| Item | Leasehold Fitout $ | Plant & Equipment $ | Intangibles $ | Total $ |
|---|---|---|---|---|
| As at 1 July 2003 | | | | |
| Gross Book Value | 6,230 | 41,251 | 17,412 | 64,893 |
| Accumulated Depreciation/amortisation | (2,546) | (14,634) | (12,421) | (29,601) |
| ***Net book value*** | **3,684** | **26,617** | **4,991** | **35,292** |
| Addition by purchase | **5,531** | 52,833 | - | 58,364 |
| Depreciation / amortisation expense | (569) | (15,377) | (4,251) | (20,196) |
| Disposals Cost | **5,230** | 1,841 | - | 7,071 |
| Accum. Depreciation | (1,920) | (1,471) | - | (3,391) |
| **As at 30 June 2004** | | | | |
| Gross Book Value | 6,532 | 92,243 | 17,412 | 116,187 |
| Accumulated Depreciation/amortisation | (1,195) | (28,540) | (16,672) | (46,407) |
| ***Net book value*** | **5,337** | **63,703** | **740** | **69,780** |

### 6E Assets At Valuation

| | Leasehold $ | Plant & equip. $ |
|---|---|---|
| As at 30 June 2004 | | |
| Gross Value | - | 32,238 |
| Accumulated depreciation/amortisation | - | (24,557) |
| **Net Book Value** | - | 7,681 |
| As at 30 June 2003 | | |
| Gross Value | **6,230** | 34,079 |
| Accumulated depreciation/amortisation | (2,546) | (13,262) |
| **Net Book Value** | 3,684 | 20,817 |



| | 2004 $ | 2003 $ |
|---|---|---|
| **6F Other Non-Financial Assets** | | |
| Prepayments - current | **4,105** | - |
| ***Total non-financial assets*** | **4,105** | - |

## 7 PROVISIONS AND PAYABLES

| | | |
|---|---|---|
| **7A Supplier Payables** | | |
| Trade creditors - current | **4,745** | 18,155 |
| Accruals - current | **4,900** | 8,255 |
| ***Total supplier payables*** | **9,645** | 26,410 |
| **7B Employee Provisions** | | |
| Salaries and Wages | **575** | 16,026 |
| Annual Leave | **39,823** | 39,378 |
| Long Service Leave | **105,205** | 100,891 |
| ***Aggregate Employee Benefit Liability*** | **145,603** | 156,295 |
| Current | **40,398** | 55,404 |
| Non-current | **105,205** | 100,891 |

## NOTE 8: EQUITY

### 8A Analysis of Equity

| Item | Accumulated Results | | Asset Revaluation Reserve | | Total | |
|---|---|---|---|---|---|---|
| | 2004 $ | 2003 $ | 2004 $ | 2003 $ | 2004 $ | 2003 $ |
| Opening balance at 1 July | 265,986 | 245,054 | 4,299 | - | 270,285 | 245,054 |
| Net surplus | 53,277 | 17,680 | | - | 53,277 | 17,680 |
| Net revaluation increment/(decrement) | | | | 4,299 | - | 4,299 |
| Increase in accumulated results on application of transitional provisions in AASB 1041 Revaluation of Non-Current Assets | | 3,252 | | | | 3,252 |
| **Closing balance at 30 June 2004** | **319,263** | **265,986** | **4,299** | **4,299** | **323,562** | **270,285** |

| | 2004 $ | 2003 $ |
|---|---|---|
| **9 REMUNERATION OF OFFICERS** | | |
| The remuneration, when at least $100,000 fell within the following bands: | | |
| $170,000 - $179,999 | **1** | - |
| $180,000 - $189,999 | **-** | 1 |
| The aggregate amount of total remuneration of officers shown above. | **178,710** | 182,734 |
| **10 REMUNERATION OF AUDITORS** | | |
| Remuneration to the Auditor-General for Auditing the Financial Statements | **5,000** | 5,000 |

The auditors received no other benefits

## 11 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 11.9% 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 9%.

## 12 ECONOMIC DEPENDENCY

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

## 13 SEGMENT REPORTING

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

| | 2004 $ | 2003 $ |
|---|---|---|
| **14 CASH FLOW RECONCILIATION** | | |
| **Operating Surplus** | **53,277** | 17,680 |
| Depreciation and amortisation | **20,196** | 23,768 |
| Write Down of Assets | **3,680** | - |
| **Changes in Assets and Liabilities** | | |
| (Increase)/decrease in Other Debtors | **(6,460)** | - |
| Increase/(decrease) in Suppliers | **(16,765)** | (7,453) |
| (Increase)/decrease in Other Prepayment | **(4,105)** | 646 |
| Increase/(decrease) in emplyee provisions | **(11,045)** | 104,882 |
| **Net Cash provided by operating activities** | **38,779** | 139,523 |

## 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 (2002-03: 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:

| Financial Instruments | Note | Carrying amount | | Weighted average effective interest rate | |
|---|---|---|---|---|---|
| | | **2004** $ | **2003** $ | **2004** % | **2003** % |
| **Financial Assets** | | | | | |
| Cash | 5A | 98,466 | 117,697 | 4.65 | 4.15 |
| Investments | 5B | 300,000 | 300,000 | 4.95 | 4.75 |
| Receivables | | 6,460 | | | |
| Total | | **404,926** | 417,697 | | |
| **Financial Liabilities** | | | | | |
| Trade Creditors | 7A | 4,745 | 18,155 | N/A | N/A |
| Total | | **4,745** | 18,155 | | |

**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.

## 16 APPROPRIATIONS

| **Particulars** | Department Outputs | | TOTAL | |
|---|---|---|---|---|
| | 2004 **$** | 2003 $ | 2004 **$** | 2003 $ |
| **Year ended 30 June 2004** | | | | |
| Balance carried forward from previous year | - | - | - | - |
| Appropriation Acts 1 and 3 | 965,000 | 950,000 | 965,000 | 950,000 |
| Available for payment of CRF | 965,000 | 950,000 | 965,000 | 950,000 |
| Payments made out of CRF | 965,000 | 950,000 | 965,000 | 950,000 |
| **Balance carried forward to next year** represented by: | - | - | - | - |
| Appropriation Receivable | - | - | - | - |



## 17 STAFFING LEVELS

| | **2004** | 2003 |
|---|---|---|
| The average staffing levels for the Authority during the year were: | **9** | 8 |

## 18 REPORTING OF OUTCOMES

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

Two output groups support the outcome:
Output 1: To provide advice and recommendations about the Private Health Services Industry.
Output 2: To facilitate direct delivery of services.

| **18A Net Cost of Outcome Delivery** | **Outcome 1** | |
|---|---|---|
| | **Year 2004** | Year 2003 |
| Departmental expenses | 962,710 | 1,035,667 |
| **Total** | **962,710** | **1,035,667** |
| *Other external revenues* | | |
| Interest | 26,477 | 17,839 |
| Other | 23,910 | 85,508 |
| Revenue from sale of assets | 600 | - |
| **Total** | **50,988** | **103,347** |
| **Net cost of outcome** | **911,722** | **932,320** |

**18B Departmental Revenues and Expenses by Output Groups and Outputs**

PHIO's revenues, expenses, assets and liabilities are attributable to two outputs.

**Outcome 1**

| | **Output 1** | | **Output 2** | | **Total** | |
|---|---|---|---|---|---|---|
| | **2004** | 2003 | **2004** | 2003 | **2004** | 2003 |
| **Operating Expenses** | | | | | | |
| Employees | **124,877** | 138,632 | **487,081** | 540,664 | **611,958** | 679,296 |
| Suppliers | **66,703** | 67,878 | **260,172** | 264,725 | **326,876** | 332,603 |
| Depreciation and Amortisation | **4,121** | 4,851 | **16,075** | 18,917 | **20,196** | 23,768 |
| Write down of assets | **751** | - | **2,929** | - | **3,680** | - |
| **Total** | **196,452** | **211,361** | **766,256** | **824,307** | **962,709** | **1,035,667** |
| *Funded by* | | | | | | |
| Revenues from Government | **196,919** | 193,878 | **768,081** | 756,122 | **965,000** | 950,000 |
| Interest | **5,403** | 3,641 | **21,074** | 14,198 | **26,477** | 17,839 |
| Other | **4,879** | 17,451 | **19,031** | 68,057 | **23,910** | 85,508 |
| Revenue from sale of assets | **122** | - | **478** | - | **600** | - |
| **Total** | **207,324** | **214,969** | **808,664** | **838,378** | **1,015,988** | **1,053,347** |

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