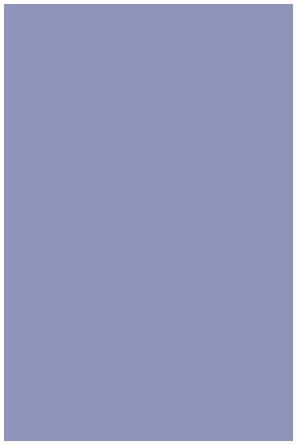
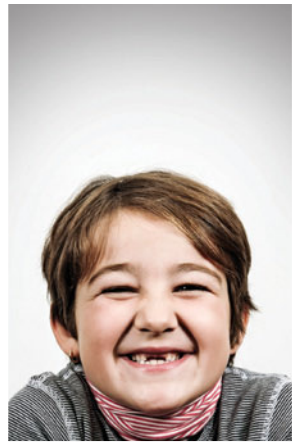
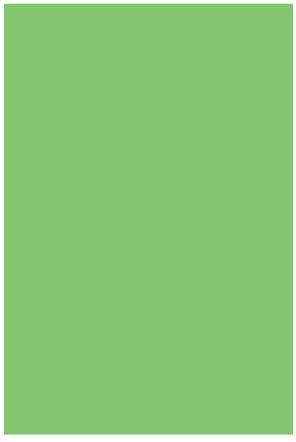


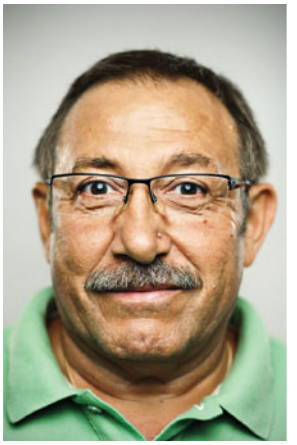



# Private Health Insurance Ombudsman
# Annual Report 2011–12

**Australian Government**
**Private Health Insurance Ombudsman**





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

# Contacts:

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

## Street and postal address

Private Health Insurance Ombudsman
Suite 2, Level 22
580 George Street
Sydney NSW 2000

## Telephone, fax and e-mail

| | |
|---|---|
| Enquiries and complaints<br>(free call from landline; higher cost from mobile) | 1800 640 695<br>9 am to 5 pm Sydney time, Monday to Friday |
| Website enquiries (normal call cost) | 1300 737 299<br>9 am to 5 pm Sydney time, Monday to Friday |
| E-mail | info@phio.org.au |
| Internet | www.phio.org.au |
| Administration | (02) 8235 8777 |
| Facsimile | (02) 8235 8778 |
| Consumers requiring translators<br>(Translating and Interpreting Service) | 13 14 50 |
| Deaf, hearing or speech impaired (National Relay Service) | 1800 555 677 |

Readers with inquiries about the Ombudsman or this report should contact the Administration Officer at the above address. Information for Senators and Members of Parliament is available from the Private Health Insurance Ombudsman, at the above telephone and facsimile numbers.



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"Overall, 90% of the Ombudsman's clients were satisfied or very satisfied with the handling of their complaint."

# Contents:

# Letter of Transmittal:

**Australian Government**
**Private Health Insurance Ombudsman**

The Hon. Tanya Plibersek MP
Minister for Health
Parliament House
CANBERRA ACT 2600

Dear Minister

In accordance with Section 253-50 of the *Private Health Insurance Act 2007*, I am pleased to present you with the Private Health Insurance Ombudsman's Annual Report for the period 1 July 2011 to 30 June 2012.

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

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

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

Yours sincerely

Samantha Gavel

Samantha Gavel
Ombudsman
26 September 2012

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

# Ombudsman's Overview:


SAMANTHA GAVEL — OMBUDSMAN

## Introduction

The overarching role of the Private Health Insurance Ombudsman (PHIO) is to protect consumers' interests in relation to private health insurance.

PHIO carries out its role in a number of ways, including:

- the provision of an independent complaints handling service which operates nationwide;
- identification of systemic issues within an individual insurer or the industry more broadly and making recommendations to industry and government to resolve these issues;
- provision of consumer information and advice, via the consumer website PrivateHealth.gov.au and the Phio.org.au website;
- production of the annual *State of the Health Funds Report*, which provides comparative information about health insurer performance to assist consumers in making decisions about their private health insurance; and
- mediation between insurers and healthcare providers to protect consumers' interests in relation to contractual disputes.

In 2011–12, complaints to PHIO remained at a similar level to the previous year, which meant that the office workload remained high. The month of June 2012 was particularly busy, as consumers were looking for information and advice about health insurance due to public information campaigns associated with changes to the Government Rebate and the Lifetime Health Cover mail-out to people turning 31 and new migrants.

Pleasingly, in spite of the high workload, consumer satisfaction with PHIO

and its services remained high and we met or exceeded all of our key performance indicators.

Highlights for the year included:

- the launch of *Health Insurance Insider*, an online newsletter focussed on consumers, which complements the office's *Quarterly Bulletin*, providing statistics and information to industry and other stakeholders;
- a series of workshops for insurers run by PHIO in conjunction with the NSW Ombudsman, to assist insurers in improving their internal complaints handling services;
- updates and improvements to the consumer website PrivateHealth.gov.au, including improvements to the insurer information pages, an enhanced agreement hospital locator and a series of tutorial videos assisting consumers to better understand private health insurance;
- continued positive feedback from consumers in relation to the consumer website PrivateHealth.gov.au, with consistently positive responses on the major criteria, including visual appeal and quality of information;
- the release of a new brochure to promote the website, which has been distributed to private hospitals and has become one of our most popular brochures;
- advice and assistance to the Department of Health and Ageing in their review of the Standard Information Statements (SISs). These one-page summaries outline the major features of each health insurance policy and are uploaded to the PrivateHealth.gov.au website and sent to members by their insurer each year;
- a continuing high level of customer satisfaction for PHIO's complaints handling service, with over 90% of those surveyed reporting they were satisfied or very satisfied with the service; and
- working with a number of individual insurers to improve customer service and their internal processes to reduce complaints about particular issues from their members.

## Health insurance complaints

There were 2,995 complaints to PHIO in 2011–12, which was similar to the 3,070 complaints received the previous year. There had been a 17% increase in complaints to the office in 2010–11, and complaints this year remained at a comparable level.

In reviewing PHIO's complaints data, the issues in 2011–12 that caused the most approaches to PHIO included complaints about oral advice, exclusions and restrictions, level of cover, waiting periods and general service issues. Not all insurers were the object of complaints about these issues, which suggests that some insurers have better communication with members and better processes in place for managing them. It also suggests that improving communications and processes within an insurer will result in fewer complaints from members about these issues.

There were 630 higher level complaints investigated by PHIO in 2011–12, which was a 12.5% decrease on the 716 higher level complaints investigated the previous year. It was pleasing to see a continued decline in the number of higher level complaints requiring investigation by PHIO. Although complaint numbers overall remained high, the reduction in complaints needing investigation suggests that insurers were continuing to resolve the complaints referred back to them, without the need for intervention by PHIO. This is a positive indicator for the industry and for the work PHIO does with insurers to improve their internal complaints handling practices.

The level of complaints to PHIO is not high, particularly when compared with other industries, such as banking and telecommunications. The Telecommunications and Financial Services Ombudsman offices receive many tens of thousands of complaints from consumers, compared with around 3,000 complaints received per year by PHIO.

FROM LEFT TO RIGHT — ALISON LEUNG, DAVID MCGREGOR, LEONIE HULL, KATIE KWONG, TRACEY SALKELD, SAMANTHA GAVEL, JIM ROBERTSON, KATE HOCKNULL, AMELIA DE GREGORIO, DAMIEN MAYNARD, KAYLIE BLYTON, ROSIE EDWARDS, HILARY BASSINGTHWAIGHTE, TANYA SNOWDEN AND HENNY OENTOJO

There are a number of reasons for the lower level of complaints about private health insurance. Private health insurance is highly regulated, in order to protect consumers' interests. Significant protections include community rating, which prevents insurers from charging higher premiums to people who are older or sicker, and the requirement for premium increases to be formally approved by the Minister for Health.

While there are millions of health insurance transactions each year, most members only claim on their hospital insurance every few years. In addition, while over two-thirds of policy holders are now covered by a for-profit health insurer[1], Australia's health insurers were originally established as mutual, not-for-profit entities with a strong member focus. That ethos still informs the way that health insurers do business today.

Although private health insurance complaints are lower than for other industries, it is important not to be complacent about these complaints. Consumers do not raise a complaint with PHIO unless the issue is of concern to them. Complaints to PHIO provide a good representative sample of the issues of concern more broadly to consumers in relation to their health insurance. Complaints to PHIO also point to systemic issues within an insurer, or the industry.

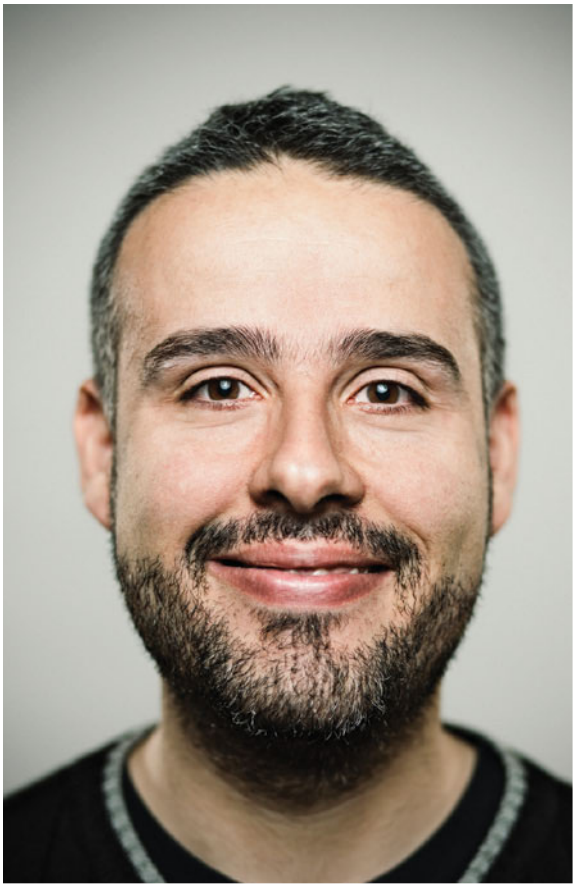
Some years ago, PHIO introduced a system of referring all complaints to a senior contact within the insurer, to allow the insurer the opportunity to resolve the matter with their member, before PHIO intervened to investigate the complaint.

PHIO's customer surveys confirm that complainants prefer this process, because it gives them a faster resolution or response to their complaint. Insurers also prefer it because it gives them the opportunity to try to resolve the matter with their member and therefore preserve the relationship they have with them. PHIO's complaint statistics suggest that this process also encourages insurers to resolve the issues referred to them by PHIO staff as assisted referrals, without the need for further intervention by PHIO, and this is reflected in the gradual decline in dispute level complaints evident in recent years.

[1] Operations of the Private Health Insurers Annual Report, 2010–11, p9, PHIAC.

## Complaint issues

The nature of health insurance products means that the issues consumers complain about are usually similar from year to year. What does change is the number of complaints about each issue, as insurers focus their efforts on reducing complaints in some areas, but complaints arise in other areas due to factors such as changes in policies, changes to rules and changes in services provided at branches.



"All too often for many consumers, private health insurance is out of sight out of mind until they get sick."

The top three complaint issues for 2011–12 were:

1. Information Oral (261 complaints);
2. Benefit — Hospital Exclusion/Restriction (215 complaints); and
3. Waiting Period — Pre-Existing Conditions (207 complaints).

What these top three complaint issues have in common is that they all relate to communication and information issues. As noted above, however, high levels of complaints about these issues are not uniform across all insurers. Some insurers receive low levels of complaint about these issues. This means that it is possible to reduce complaints about these issues, if they are causing particular problems for members of specific insurers.

It is interesting to note that complaints about oral advice have increased this year. Complaints about this issue started to decline some years ago, as insurers introduced call recording systems. In PHIO's experience, call recording systems reduce complaints, because they provide a good record of what advice was given to a member. They also assist with staff coaching and training, as they assist in identifying areas where incorrect or insufficient advice is given by staff.

An analysis of PHIO data suggests that it is the advice being given in branches that is now the cause of most complaints to PHIO about oral advice. It is not practicable to record advice given by staff to customers in a branch, but it is possible for the staff member to make a written record of the interaction in the insurer's customer contact database. The problem with many complaints about advice given in branches is that in many cases, there is no written record, or only a very poor record of the interaction. This makes these complaints more difficult to resolve.

This is an issue that PHIO has taken up with several insurers, where there are higher levels of complaints from their members about advice given in branches. PHIO is also taking the approach of giving the benefit of the doubt to the member, where inadequate records have been kept.

Complaints about exclusions and restrictions have increased in recent years. This coincides with statistics from the industry regulator, the Private Health Insurance Administration Council (PHIAC), which show increasing numbers of policies that have exclusions[2]. In 2010–11, PHIAC statistics show that 27.6% of hospital policies had exclusions, which was a 3.6% increase on the number of policies with exclusions in the previous year.

In 2010–11, PHIO introduced a complaint category that specifically identifies complaints about hospital restrictions and exclusions, to distinguish these from complaints about general treatment (extras) cover and to provide better information about which insurers and which policies are causing complaints from members about this issue.

Communication issues are at the heart of complaints about restrictions and exclusions, because in the complaints received by PHIO, it is clear that the impact of the restriction or exclusion on the policy has not been well understood by the member.

There is demand from consumers for more affordable polices, particularly from younger people. Insurers are generally happy to meet this demand, but some insurers also have concerns about potential loss of market share if they don't match other offerings on the market.

Consumers also seem happy to take up these policies, often because they are purchasing insurance primarily for tax purposes. Problems arise, however, when they then decide to make use of their policy, only to discover that its limitations are greater than they had realised.

Complainants are often surprised and disappointed to find out that there may not be a significant cost difference between a basic policy and a more comprehensive one. This is particularly the case where they have incurred a large out-of-pocket cost due to a restriction or exclusion on their policy. These are issues they need to think about when they take out a policy and not when they are sick and need treatment.

[2] Operations of the Private Health Insurers Annual Report, 2010–11, p19, PHIAC.

Of course, some consumers can be quite sophisticated in their assessments that as they are young and healthy, they can afford to take the risk of restricting or excluding cover for some services. The purpose of insurance, however, is to cover the things you cannot foresee. Again, consumers need to consider this aspect when taking out a policy.

Insurers themselves have an important information role. This is because when it comes to health insurance, there is a significant imbalance between what consumers actually know about private health insurance and what they need to know. In any discussion with a consumer about joining or changing their health insurance, there needs to be a discussion about the balance between price and features, which is initiated by customer service and sales staff.

SAMANTHA GAVEL AND DAVID McGREGOR

Many insurers do undertake communication campaigns with their members on less comprehensive covers, encouraging them to upgrade their cover. This is a good idea and one which PHIO would encourage all insurers to do.

Complaints about the pre-existing condition (PEC) waiting period have also increased this year. Some level of complaint about this waiting period is to be expected from new members. It is natural that a new member would be concerned to find they were not covered for treatment after joining an insurer, even though they have been paying premiums.

Again, however, communication issues are a significant factor in complaints about this waiting period. If a member complains about the PEC waiting period, usually what is driving the complaint is that they haven't been given clear information about the waiting period and its potential impact on them when they joined the insurer.

Some insurers receive very few complaints about this waiting period and we know from the PHIAC statistics that these insurers are attracting new members, who would be subject to this waiting period. The difference is that the insurers who receive fewer complaints about this issue are communicating better with their new members about the existence of the waiting period and the reasons why it applies to their claim.

This means that it is possible to reduce complaints about this issue through better communication with members. This communication needs to start when the member joins the insurer. Information about the waiting period then needs to be reiterated at the time a member calls to find out whether they are covered for a hospitalisation, as well as information about the process for assessing whether the claim will be subject to the waiting period.

Good communication needs to continue when the member is informed that they are not eligible for benefits because of the waiting period. This information should be clear about why their particular condition is a pre-existing condition.

## Industry developments

The Australian Government introduced income testing of the Government Rebate for Private Health Insurance and increases to the Medicare Levy Surcharge for higher income earners who did not hold a hospital policy, from 1 July 2012. These changes and the associated public information campaign and media focus meant consumers were more focussed on their health insurance than usual in the first half of 2012. They were actively looking for information, particularly from their health insurer, but also from Government sources including the Australian Taxation Office and PHIO.

Overall, insurers did a good job of informing their members about the changes and ensuring they had the systems and processes in place to allow members to nominate a rebate tier and change the amount of rebate claimed.

PHIO also ensured that information was provided on the PrivateHealth.gov.au website to assist consumers to understand the changes and consider their options. In June 2012, there was a significant increase in inquiries to the office and visits to the PrivateHealth.gov.au website.

Indeed, in June 2012, the consumer website PrivateHealth.gov.au experienced the highest number of unique visitors since the site went live in 2007. There were 72,829 unique visits to the site in June 2012, which represented a 66% increase on the previous month's traffic.

The factors driving visits to the site in June included the Lifetime Health Cover mail-out to people turning 31 and new migrants, and the public information campaign about the introduction of changes to the Government Rebate.

"Insurers that communicate well with their members can reduce the causes of complaint."

It was pleasing to see that so many consumers found their way to the PrivateHealth.gov.au website for assistance with these issues, because it is the best source of independent information about private health insurance in Australia.

In order to postpone the impact of the rebate changes, a significant number of members contacted their insurer to pre-pay their health insurance. The majority of insurers allowed members to pre-pay their premiums, in line with their usual practice of allowing pre-payment of premiums. A small number of insurers allowed members to pre-pay premiums for a longer period, of between 18 months and three years.

Because insurers' contact centres and branches were so busy in late June, due to the high demand from members wanting to pre-pay their insurance, some members were unable to get through to their insurer and missed the 30 June deadline for pre-payment. Other members thought they had met the deadline because they had pre-paid before the cut-off date of 30 June, but found out later that their payment had not been processed by their bank within the required time frame. In line with the requirements of the legislation, this meant that they were unable to postpone the change in their rebate eligibility.

During 2011–12, BUPA Australia completed its merger with MBF and re-branded all of its products under the BUPA brand. As a result of the merger, BUPA is the second largest health insurer in Australia.

There were new entrants into the industry in late 2011, with the registration of a new, web-based insurer, Health.com.au, and two new health insurance brokers, Choosi and Split It. Health.com.au is the first new health insurer to enter the industry for a number of years.

## Code of Conduct review

The private health insurance industry introduced a voluntary Code of Conduct in October 2005 to improve service standards

across the industry. The Code covers dispute resolution, training of employees, responsibilities of agents and policy documentation.

PHIO believes the introduction of the Code has been a very positive development for consumers and the industry, which has contributed to reducing complaints from members and improving customer service standards across the industry.

An independent review of the Code was carried out in late 2011, which resulted in a number of changes to the Code aimed at updating and strengthening it, including the introduction of a principles-based audit.

PHIO was one of the parties consulted in relation to the review of the Code and made a number of recommendations, which have been adopted in the new Code. In particular, new requirements around the provision of Transfer Certificates and information in relation to on-line sales should assist in reducing complaints about these issues and are a positive development for consumers.

## Consumer information and advice

A number of important updates were made to the consumer website, PrivateHealth.gov.au, which is managed by PHIO. These included an enhanced Agreement Hospital Locator, improved insurer information pages and a series of video tutorials to assist consumers to better understand their health insurance. The website survey continues to provide positive feedback from consumers in relation to these improvements and to the website overall.

A significant challenge for the office is ensuring consumers are aware of the site and its resources. The public information campaigns in June 2012 in relation to the changes to the Government Rebate and the Lifetime Health Cover mail out to people turning 31 and new migrants encouraged a significant increase in visitors to the site and assisted in raising consumer awareness of its resources.

PHIO also produced a new brochure to promote the website, which was distributed widely to private hospitals and other organisations. The brochure has proved to be very popular and is currently one of our most requested brochures.

In April 2012, PHIO launched its new consumer newsletter, *Health Insurance Insider*. The newsletter will cover current topics and issues of interest to consumers. It is intended to complement the office's *Quarterly Bulletin*, which focuses on providing statistical information to industry and government stakeholders.

During the year, PHIO assisted the Department of Health and Ageing with a review of the Standard Information Statements (SIS). These one-page statements outline the main features of each health insurance policy sold in Australia. Insurers are required to send an SIS to members each year and a copy is also loaded onto the consumer website PrivateHealth.gov.au. Consumers can download the SIS for their policy, or others they may be interested in purchasing, at any time.

PHIO, along with industry stakeholders, worked collaboratively with the Department of Health and Ageing on the SIS Review. Changes to the SISs were informed by consumer focus testing and feedback from consumers to PHIO. Changes made to the SISs include the addition of gastric banding and related services as a permitted item, adjustments to terminology and clarification of limits and sub-limits on General Treatment policies.


HILARY BASSINGTHWAIGHTE, AMELIA DE GREGORIO AND KAYLIE BLYTON

In March 2012, PHIO joined a number of other Ombudsman and complaints bodies in hosting an information stall at the Royal Easter Show in Sydney. This was the first time PHIO had participated in this type of 'outreach' service.

PHIO staff members who attended the stall were able to engage with consumers and provide them with information about private health insurance. This enabled the office to assess whether there was demand for this type of information service, for consideration of similar opportunities in future. As a result, PHIO will look for opportunities to undertake this type of activity, where we believe there are likely to be significant numbers of private health insurance consumers attending the event.

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

These brochures and fact sheets are available for viewing and/or downloading at Phio.org.au or they can be obtained in hard copy by contacting PHIO on 1800 640 695.

PHIO also provides an information and advisory service to consumers via the 'Ask a Question' feature on the PrivateHealth.gov.au website, or by contacting PHIO by telephone on 1300 737 299 during business hours. These services enable consumers to obtain quick answers to questions they may have about private health insurance. The most common questions received in 2011–12 were about Lifetime Health Cover, the Medicare Levy Surcharge, waiting periods and Overseas Visitors cover.

This service is separate from PHIO's complaints handling service, which is available through a telephone complaints hotline on 1800 640 695 or an e-mail complaints form available at Phio.org.au

## The rise of the internet

It is interesting to note the marked change in the way that consumers want to interact with organisations, including PHIO. In 2011–12, 64% of complaints to PHIO were lodged by telephone; 32% were lodged via the internet; 3% by letter and less than 1% by fax, visit or MP referral.

Ten years ago, more than 90% of complaints were lodged by telephone and less than 3% via the Internet. That represents a significant change in consumer behaviour in those 10 years. This change in behaviour is likely to accelerate, as younger people who are quite familiar with using the internet for everyday transactions come of age. It is also important to recognise that many older people are internet savvy as well.

Dealing with higher numbers of contacts via the internet has the benefit of making PHIO's workload easier to distribute and manage amongst its small complaints handling team. It also poses a number of challenges, because people expect quicker response times on e-mail and there is also a tendency for people to be more direct and less polite in e-mail.

PHIO will investigate options for introducing a social media channel in the coming year. It is clear that consumers are increasingly demanding more interactive ways of dealing with the organisation and we need to be responsive to this demand.

## Acute Care Certification consultation

PHIO has continued to work with State and Territory health departments and private health insurers to develop a consistent national approach to certification of long stay private patients in public hospitals. A draft Acute Care Certificate has now been developed through consultations between two States and two insurers and PHIO is in the process of consulting more broadly with States and Territories and insurers in order to finalise an agreed certificate for use in public hospitals across Australia.

## Corporate governance

In November 2011, the Minister for Health provided PHIO with a 'Statement of Expectations', which formally outlined how PHIO should operate in order to achieve the office's key objectives.

In response to the Statement of Expectations, PHIO provided a 'Statement of Intent' to the Minister outlining the measures PHIO will put in place to achieve the objectives set out in the Statement of Expectations. Both documents are viewable at Phio.org.au.

PHIO introduced a new Enterprise Agreement to cover all of its non-SES staff members in August 2011. The term of the Agreement is three years and the Agreement complies with Australian Government requirements in relation to the Australian Public Service Bargaining Framework and Enterprise Agreements. The Enterprise Agreement provides a framework for the fair and responsible remuneration of PHIO staff members.

PHIO was allocated additional funding of $1.4 million over four years in the 2012–13 Budget. The last increase in appropriation for PHIO was in 2004–05. PHIO's workload, including its complaints handling workload, has increased significantly in recent years, in line with the increase in people covered by private health insurance. Since 2000, health insurer membership has grown by 24.5%, and this growth has continued during 2011–12. As of 30 June 2011, the total number of hospital treatment policies was 4.97 million, covering 10.26 million people. This means there is increased demand for PHIO's complaint handling and information and advice services from consumers.

The additional funding will benefit consumers by enabling PHIO to continue to provide its services to increased numbers of insured members. The additional funding will also cover the cost of a tender process to seek a new contract for the maintenance and hosting of the PrivateHealth.gov.au website from May 2014, when the current contract expires.

The levy collected from private health insurers under the *Private Health Insurance Complaints Levy Act 1995* will fully recover the increased funding.

As a Commonwealth Government agency under the *Financial Management and Accountability Act 1997*, PHIO was also subject to the application of a one-off 2.5% Efficiency Dividend and 20% reduction in overall Capital Budget, which was announced in November 2011. This reduced PHIO's budget by a total of $266,000 over four years from 2012–13 to 2015–16. PHIO has revised its spending allocation in various areas in order to manage the impact of this on its budget. PHIO anticipates achieving break-even positions for future years to 2015–16.

As PHIO's appropriation is fully recovered by the levy on health insurers, the cost of the efficiency dividend is not passed onto insurers.

PHIO's operating result for the year ending 30 June 2012 was a deficit of $4,755, compared to a $587 surplus in 2010–11 (refer to Note 15 of the Financial Statements on page 86 of this Report). PHIO had anticipated a $28,000 loss caused solely by the impact of the decrease in the bond rate on employee entitlements. The Finance Minister approved for the agency to operate at a loss of $28,000 in 2011–12. The $4,755 deficit was below the amount approved by the Finance Minister.

## The year ahead

In the coming year, PHIO will continue to monitor consumer feedback and satisfaction with the consumer website PrivateHealth.gov.au, which will inform updates and improvements to the site. It is important to ensure the site continues to meet consumers' needs as Australia's leading independent source of reliable and engaging information about private health insurance.

PHIO will hold its bi-annual industry seminar in September 2012 focusing on issues presented to the office by consumers. Speakers at the seminar will address these issues and other current topics relevant to the industry.

PHIO will continue its work with insurers to reduce complaints about the issues that have caused problems for members in 2011–12. This will include hosting a series of workshops for insurers in 2013 to assist them in improving their internal complaints handling and focus on measures to reduce complaints from members.

PHIO will also investigate the most appropriate way to provide social media options for consumers who would like to interact with the office through these channels.

# Role and Function:

## Introduction

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

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

## Functions

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

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

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

## Who can make a complaint?

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

## Objects of complaint

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

## What can the Ombudsman do with a complaint?

The Ombudsman is able to deal with complaints by:

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

- Mediation;
- Referring the complaint to the Australian Competition and Consumer Commission; and
- Referring the complaint to any other appropriate body.

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

## What happens at the end of a complaint or investigation?

The Ombudsman is able to recommend that:

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

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

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

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

## How the Ombudsman's staff resolve complaints

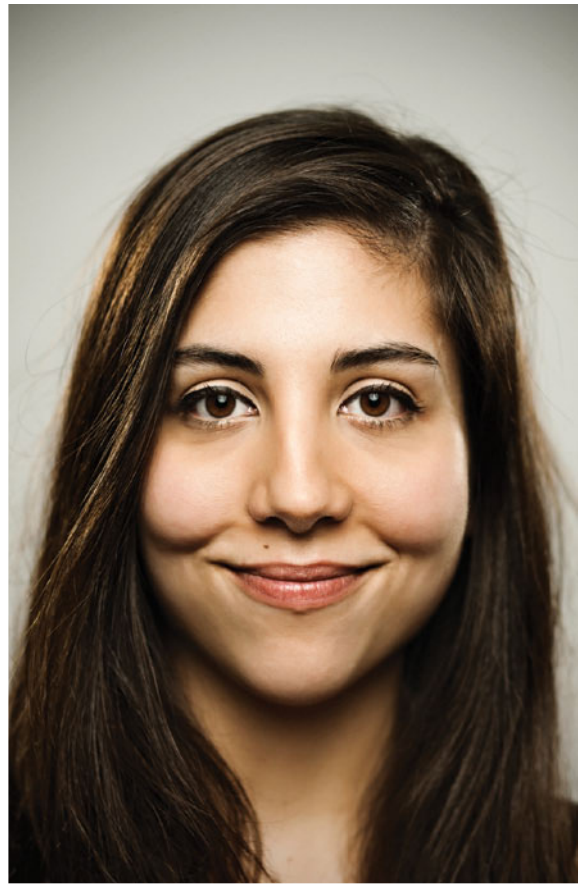
The Ombudsman deals with most complaints by telephone, fax and e-mail. Where complainants have not made a sufficient attempt to resolve their complaint with their health insurer or provider, staff will usually refer complainants back to these parties in the first instance. Staff will refer the complaint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

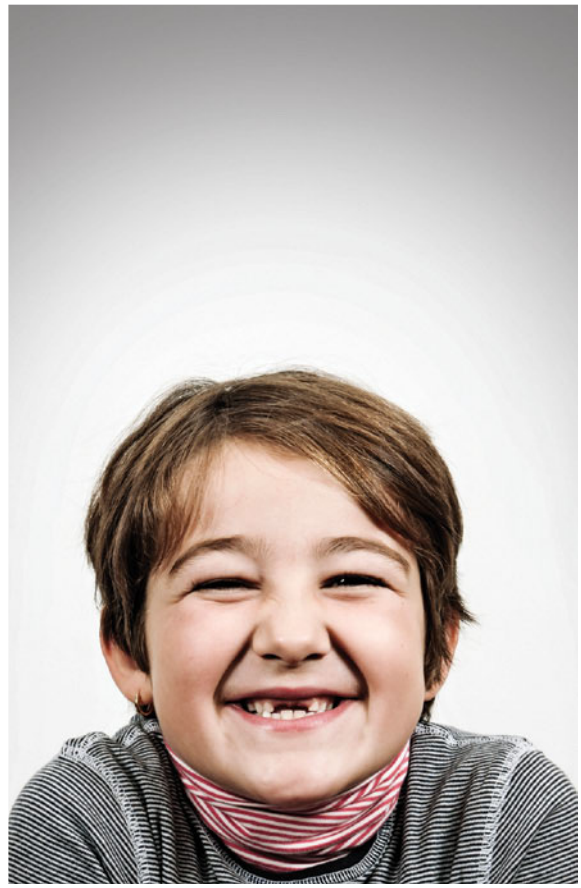
Where complaints are complex, or where formal contact with the health insurer has been unable to resolve the problem, the Ombudsman will write to the insurer or provider seeking further information.

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

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

"The Ombudsman acts as the umpire in dispute resolution at all levels within the private health industry."





# Performance:

## Performance indicators

The 2011–12 Portfolio Budget Statements (PBS) indicate that the Private Health Insurance Ombudsman contributes to the Commonwealth Department of Health and Ageing PBS Outcome Number 9, Private Health.

The Private Health Insurance Ombudsman's Agency Outcome is specified as "public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting."

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

- To protect the interests of people with private health insurance;
- To further improve the quality and accessibility of information available to consumers of private health insurance products; and
- To provide private health insurance consumers with an efficient and effective complaints handling service.

The following tables are a summary of performance outcomes against the program's formal performance indicators in 2011–12.

## Deliverables

### Protect the interests of health insurance consumers

| QUALITATIVE DELIVERABLE | 2011–12 REFERENCE POINT OR TARGET | 2011–12 RESULT |
|---|---|---|
| Investigate the practices and procedures of health insurers | Investigation and mediation of complaints as required | PHIO staff worked closely with industry stakeholders to identify and address systemic issues causing complaints within a specific insurer or the industry as a whole; PHIO staff members were also involved in mediating complaints between health insurers and healthcare providers. |
| Raise awareness of consumer issues with stakeholders | PHIO will engage with stakeholders through regular meetings, workshops and industry consultations | PHIO Website Reference Group met quarterly; series of complaint handling workshops organised for industry stakeholders; regular meetings to discuss current issues with Government and industry stakeholders; attendance by PHIO staff at industry functions and conferences. |

### Improve the quality and accessibility of private health insurance information

| QUALITATIVE DELIVERABLE | 2011–12 REFERENCE POINT OR TARGET | 2011–12 RESULT |
|---|---|---|
| Publish the annual *State of the Health Funds Report* | The *State of the Health Funds Report* is published by PHIO by 31 March 2012 | Report published on 30 March 2012 |
| Manage the private health insurance consumer website (PrivateHealth.gov.au) | Regular and timely updates of the website to ensure information is accurate and up-to-date | Website regularly updated in response to industry changes and issues of concern to consumers |

### Protect the interests of health insurance consumers

| QUANTITATIVE DELIVERABLE | 2011–12 BUDGET TARGET | 2011–12 RESULT |
|---|---|---|
| Number of high quality and timely advisory services, policy advice, and submissions and reports, measured by stakeholder feedback | ≥ 12 | 12 |

### Complaints handling service

| QUANTITATIVE DELIVERABLE | 2011–12 BUDGET TARGET | 2011–12 RESULT |
|---|---|---|
| Number of publications on PHIO complaints handling activity | 6 | 6 |
| Percentage of complaints finalised during the year | 90% | 98% |
| Percentage of complaints finalised within one month of receipt | 80% | 84% |

## Key performance indicators

### Protect the interests of health insurance consumers

| QUALITATIVE INDICATORS | 2011–12 REFERENCE POINT OR TARGET | 2011–12 RESULT |
|---|---|---|
| Production of high quality and timely advisory services, policy advice, submissions and reports | Positive stakeholder feedback on information products | Consumer brochures were sent directly to consumers, accessed online, and also distributed by health insurers, hospitals and providers, with over 124,000 brochures distributed throughout the year. The consumer website received 485,923 unique visitors throughout the year, an increase of 55% on the previous year. |

### Improve the quality and accessibility of private health insurance information

| QUALITATIVE INDICATORS | 2011–12 REFERENCE POINT OR TARGET | 2011–12 RESULT |
|---|---|---|
| Provide independent and reliable information to consumers via the private health insurance consumer website (PrivateHealth.gov.au) | Measured by website survey and consumer focus testing which indicates that information provided is viewed as independent and reliable | 80% of surveyed website clients rated information as easy to find and of very good or satisfactory quality. |

### Protect the interests of private health insurance consumers

| QUANTITATIVE INDICATORS | 2011–12 BUDGET TARGET | 2011–12 RESULT |
|---|---|---|
| Percentage of recommendations that have resulted in changes to insurer or industry practices | 75% | 75% |

### Improve the quality and accessibility of private health insurance information

| QUANTITATIVE INDICATORS | 2011–12 BUDGET TARGET | 2011–12 RESULT |
|---|---|---|
| Average number of daily visits to consumer website | 710 | 1,853 |
| Percentage of information products useful or very useful for consumers | 75% | 90% |

### Deliver a consumer complaints handling service

| QUANTITATIVE INDICATORS | 2011–12 BUDGET TARGET | 2011–12 RESULT |
|---|---|---|
| Percentage of clients satisfied with complaint handling service | 83% | 90% |

# Complaints

The Ombudsman received 2,995 complaints during 2011–12, a similar figure to the 3,070 complaints received in 2010–11, and again significantly higher than the preceding three years.

Of those complaints, 630 were classified as Level 3 Disputes, a decrease from the previous year's figure of 716. Level 3 complaints are those where the Ombudsman's staff act on behalf of a complainant by requesting a report from a health insurer or other object of a complaint. The report is then reviewed and either closed as a satisfactory response or investigated further.

**FIGURE 1** shows the distribution of complaints over the four quarters of the 2011–12 financial year.

**FIGURE 2** shows the total number of complaints received per year since 1999–2000. The increase in the number of complaints in the 2000–01 year was associated with a large increase in the number of Australians covered by private health insurance following the introduction of the 30% Health Insurance Rebate and Lifetime Health Cover.

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

# Consumer enquiries: the Ombudsman's consumer education function

Enquiries are instances where the Ombudsman's staff provided advice or information, where the matter does not meet the definition of a complaint. In 2011–12, 1,500 consumer enquiries were recorded, a 23% increase on the previous year.

The majority of enquiries (1,313 enquiries, or 88%) were received via the Ombudsman's consumer website PrivateHealth.gov.au. Using the 'Ask A Question' feature on the website, consumers can contact the Ombudsman by filling out a form.

The overall increase in enquiries was largely due to an increased volume of enquiries in May and June 2012. Changes to the Australian Government Private Health Insurance Rebate and the commencement of the Department of Health and Ageing's annual Lifetime Health Cover mailing caused heightened consumer awareness of private health insurance. (See the 'Consumer Website' section on page 49 for more information.)

**FIGURE 1 // COMPLAINTS BY QUARTER**

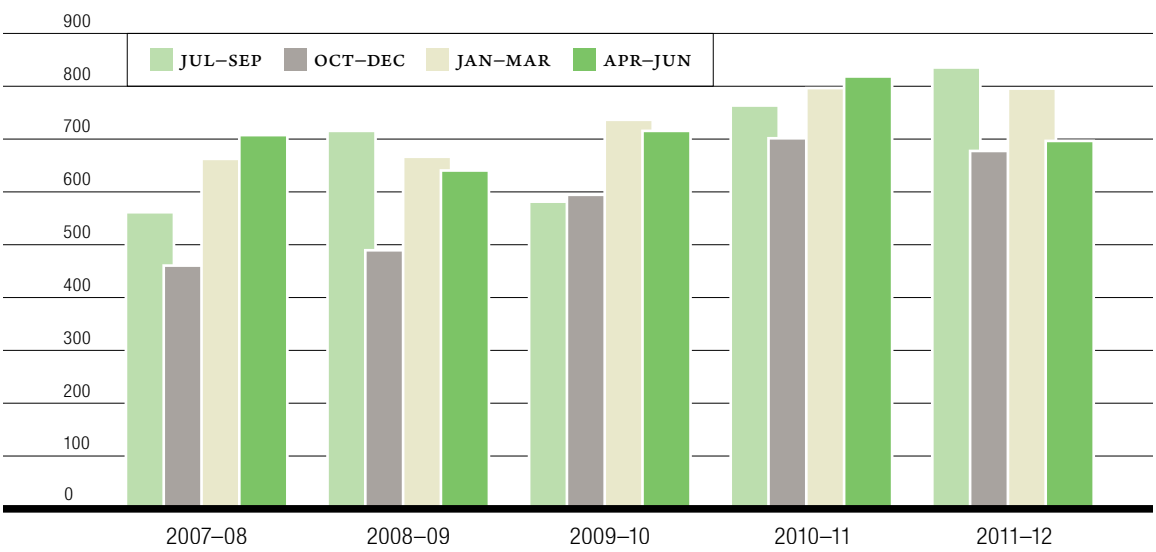
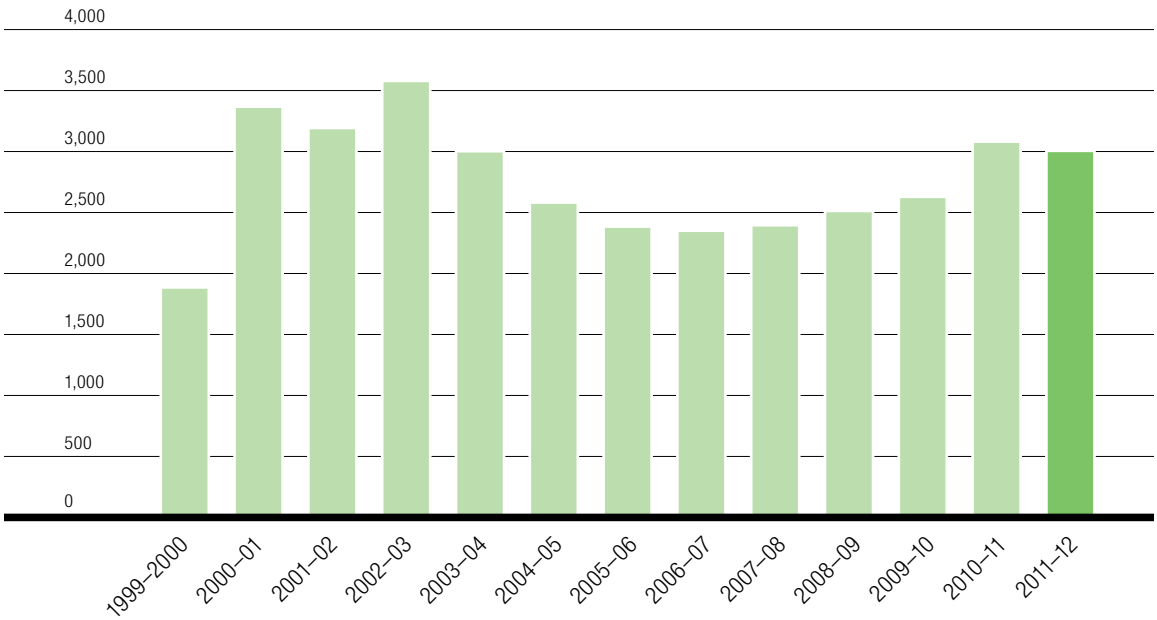


**FIGURE 2 // COMPLAINTS BY YEAR**




# Recording and categorisation of complaints

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

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

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

Currently complaints are categorised as follows:

## Complaint Level 1 (Problems): Moderate level of complaint

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

In 2011–12, 80% of Level 1 complaints were resolved as 'Assisted Referrals,' where the Dispute Resolution Officer referred a complaint directly to a specifically arranged representative in the insurer or service provider on behalf of the complainant. When this occurs, the officer will counsel the complainant, advise them of the complaint

process and timeframes; ensure the complaint is responded to by the other party and offer to investigate the complaint at a later date if the matter is not resolved.

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

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

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

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

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

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

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

**FIGURES 3 AND 4** show the ratio of complaints by level. This year, 2,004 complaints were classified as Level 1, 361 as Level 2, and 630

**FIGURE 3 // COMPLAINTS BY LEVEL**

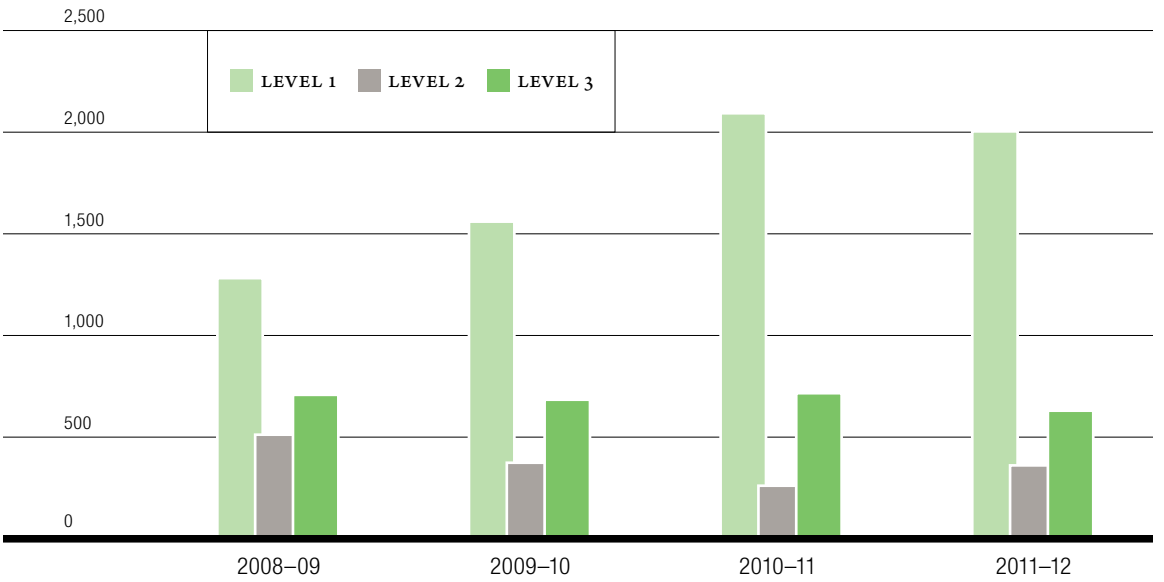
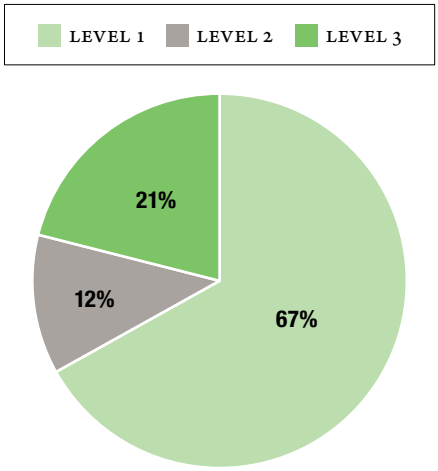


**FIGURE 4 // COMPLAINTS BY LEVEL, 2011–12**




as Level 3. The volume of Level 1 complaints remained generally steady from 2010–11, but still significantly higher than the previous years. Level 3 complaint levels have remained steady for several years; this year's total of 630 is the lowest in the previous five years.

## Complaint audit and escalation

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

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

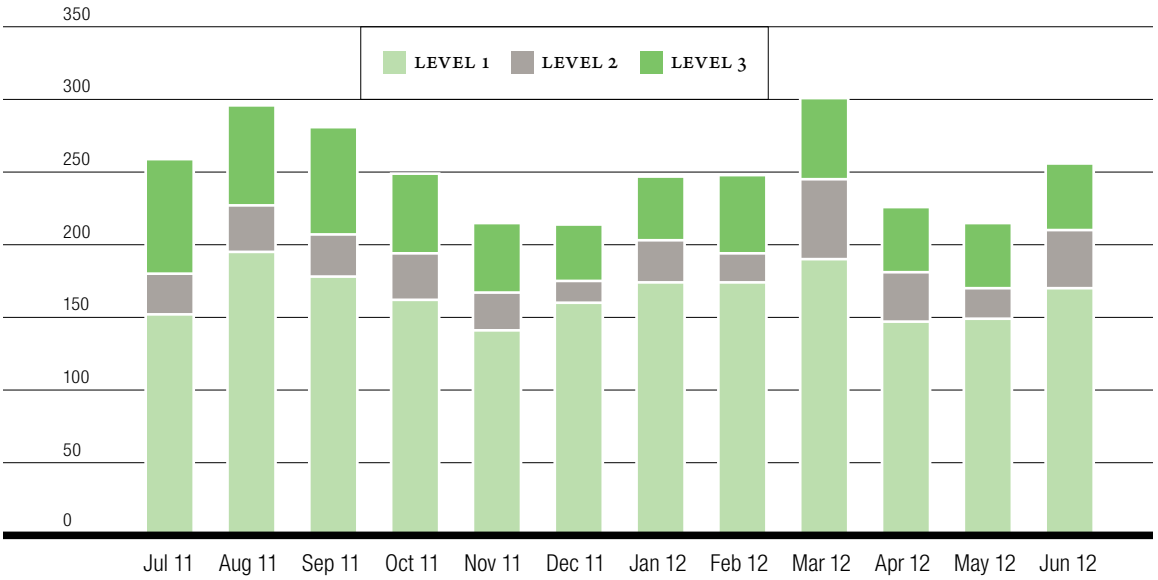
## Complaints handling procedures

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

**FIGURE 5 // STEPS IN HANDLING APPROACHES TO THE OMBUDSMAN**

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

**FIGURE 6 // COMPLAINT LEVEL BY MONTH**

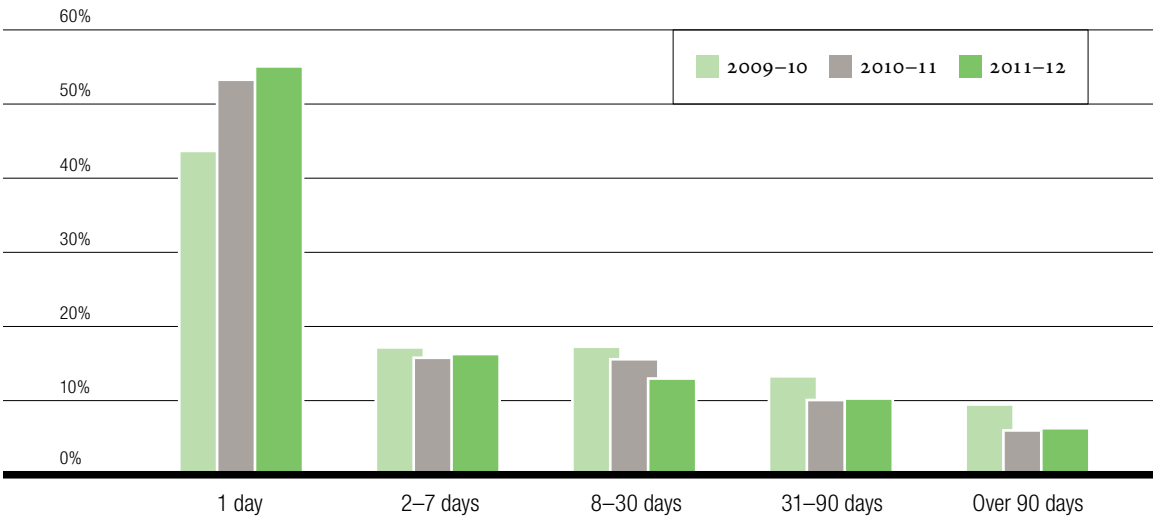



Health insurer members can also lodge complaints about health care providers, including:

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

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

**FIGURE 7 // DURATION**



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

## Workload

The office received 2,995 complaints (Level 1, 2 and 3) in 2011–12, an average of 250 per month compared to 255 per month in the previous year. Of those complaints, 630 were Level 3 complaints, compared to 716 the previous year.

The office closed 3,025 complaints in 2011–12, an average of 252 per month compared to 262 in 2010–11. Of these complaints, 661 were Level 3 complaints compared to 729 the previous year.

The Ombudsman recorded 1,500 consumer enquiries this year, compared to 1,216 the previous year.

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

## Time taken to resolve complaints

**FIGURES 7 AND 8** provide information on the time taken to resolve complaints this year compared to last year. The office continues to handle the majority of complaints within one month, with 83.8% finalised within 30 days this year compared to 84.1% in the previous year.

## Who was complained about

**FIGURE 9** shows most complaints were made about registered health insurers, followed

**FIGURE 8 // COMPLAINTS CLOSED SINCE DAY OF LODGEMENT, 2011–12**

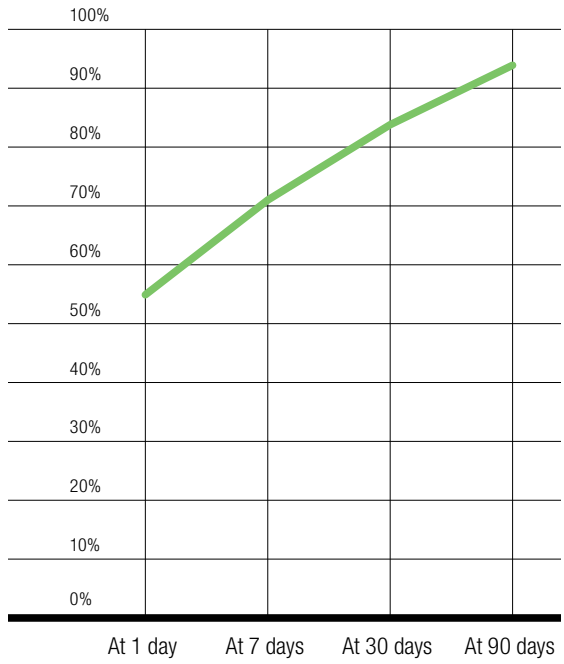



**FIGURE 9 // COMPLAINT OBJECTS, 2011–12**

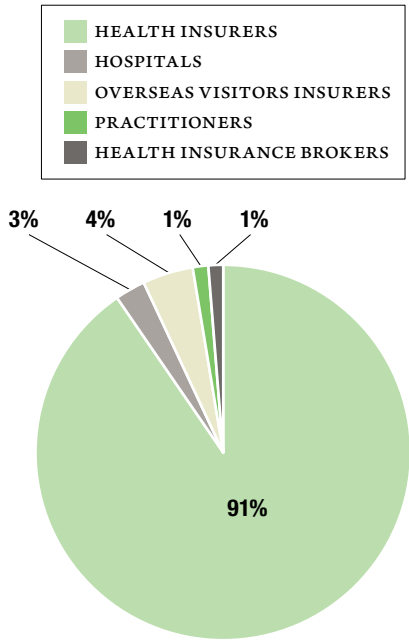


**FIGURE 10 // COMPLAINTS BY HEALTH INSURER MARKET SHARE, 2011–12**

| NAME OF INSURER | COMPLAINTS | PERCENTAGE OF COMPLAINTS | DISPUTES | PERCENTAGE OF DISPUTES | MARKET SHARE |
|---|---|---|---|---|---|
| ACA | 0 | 0% | 0 | 0% | 0.1% |
| Australian Health Management | 122 | 4.7% | 31 | 6.0% | 2.9% |
| Australian Unity | 119 | 4.6% | 29 | 5.7% | 3.1% |
| BUPA (includes MBF) | 634 | 24.3% | 108 | 21.1% | 26.9% |
| CBHS | 22 | 0.8% | 3 | 0.6% | 1.3% |
| CDH (Cessnock) | 1 | 0% | 0 | 0% | <0.1% |
| CUA | 13 | 0.5% | 4 | 0.8% | 0.4% |
| Defence | 25 | 1.0% | 3 | 0.6% | 1.6% |
| Doctors | 3 | 0.1% | 1 | 0.2% | 0.1% |
| GMHBA | 49 | 1.9% | 12 | 2.3% | 1.7% |
| Grand United Corporate | 19 | 0.7% | 3 | 0.6% | 0.4% |
| HBF | 87 | 3.3% | 12 | 2.3% | 7.7% |
| HCI | 0 | 0% | 0 | 0% | 0.1% |
| Health.com.au | 0 | 0% | 0 | 0% | <0.1% |
| Health Insurance Fund of Australia | 12 | 0.5% | 5 | 1.0% | 0.6% |
| HealthGuard (GMF/Central West) | 8 | 0.3% | 2 | 0.4% | 0.5% |
| Health-Partners | 17 | 0.7% | 3 | 0.6% | 0.7% |
| HCF (Hospitals Contribution Fund) | 300 | 11.5% | 46 | 9.0% | 10.5% |
| Latrobe | 20 | 0.8% | 3 | 0.6% | 0.7% |
| Medibank | 844 | 32.3% | 173 | 33.7% | 27.7% |
| Mildura | 6 | 0.2% | 1 | 0.2% | 0.3% |
| National Health Benefits (Onemedifund) | 0 | 0% | 0 | 0% | 0.1% |
| Navy | 2 | 0.1% | 1 | 0.2% | 0.2% |
| NIB | 165 | 6.3% | 40 | 7.8% | 7.5% |
| Peoplecare | 12 | 0.5% | 1 | 0.2% | 0.4% |
| Phoenix | 0 | 0% | 0 | 0% | 0.1% |
| Police | 5 | 0.2% | 1 | 0.2% | 0.3% |
| Queensland Country Health | 6 | 0.2% | 1 | 0.2% | 0.3% |
| Railway and Transport | 10 | 0.4% | 3 | 0.6% | 0.4% |
| Reserve | 1 | 0% | 0 | 0% | <0.1% |
| St Lukes | 1 | 0% | 0 | 0% | 0.4% |
| Teachers Health | 65 | 2.5% | 13 | 2.5% | 1.8% |
| Teachers Union | 10 | 0.4% | 1 | 0.2% | 0.4% |
| Transport | 0 | 0% | 0 | 0% | 0.1% |
| Westfund | 30 | 1.1% | 9 | 1.8% | 0.8% |
| **Totals** | **2,608** | **100%** | **509** | **100%** | **100%** |

by overseas visitor policies, hospitals, practitioners (including doctors, dentists, and other healthcare providers), and health insurance brokers.

## Complaints about registered health insurers

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

## Complaints about hospitals

The Ombudsman received 76 complaints about hospitals, steady from the 75 complaints received in the previous year.

Complaints about hospitals usually occur when patients experience unexpected gaps for a hospital admission. In most cases, there are adequate processes in place in private hospitals to ensure the provision of Informed Financial Consent (IFC) to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year. In 2011–12 the office recorded 54 IFC complaints against hospitals, compared to 57 the previous year.

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

## Complaints about practitioners

Most complaints about doctors and practitioners concerned medical gap issues and/or a lack of Informed Financial Consent (IFC).

IFC complaints against doctors decreased in the 2011–12 year. The office registered 39 complaints against practitioners (including doctors, dentists, and other practitioners) compared to 50 in the previous year. In total, 36 complaints were made about IFC against doctors and other practitioners, compared to 43 the previous year.

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## Complaints about health insurance brokers

Complaints about brokers concern issues relating to the information provided on joining and the level of cover chosen. There were 37 complaints about brokers in 2011–12, an increase from 11 complaints the previous year.

Of those complaints, 16 were made against a single broker and their staff's provision of oral advice to people joining or transferring between health insurers. In these cases, complainants later found their new cover did not meet their needs or that they had been supplied with incorrect details about their new policies.

**FIGURE 11 // OUTCOMES—ALL COMPLAINTS**

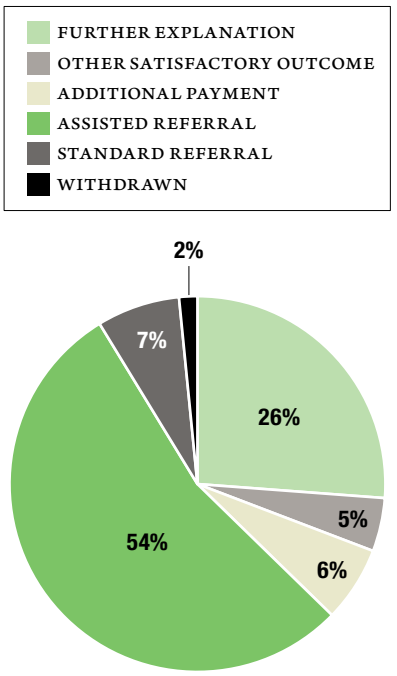
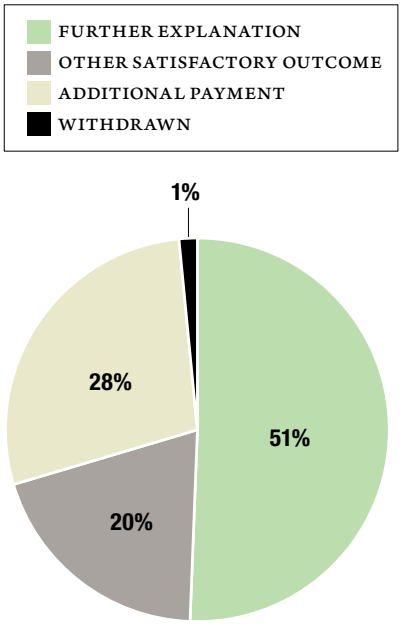



**FIGURE 12 // OUTCOMES—LEVEL 3 DISPUTES**




# Resolving complaints

**FIGURE 11 (OVER)** shows 26% of all complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint.

A further 54% of all complaints were referred directly to health insurers with the assistance of the Ombudsman's staff, on the understanding that the complainant could request a review of the complaint by the Ombudsman if they remained unsatisfied. The Ombudsman's arrangements for assisted referrals are designed to allow complainants and insurers to quickly resolve the majority of complaints using an informal approach, where the Ombudsman may suggest ways for the complaint to be resolved. Complainants are made aware that if they remain dissatisfied with the response they receive via the informal referral process, they are able to approach the Ombudsman again for a review of their case.

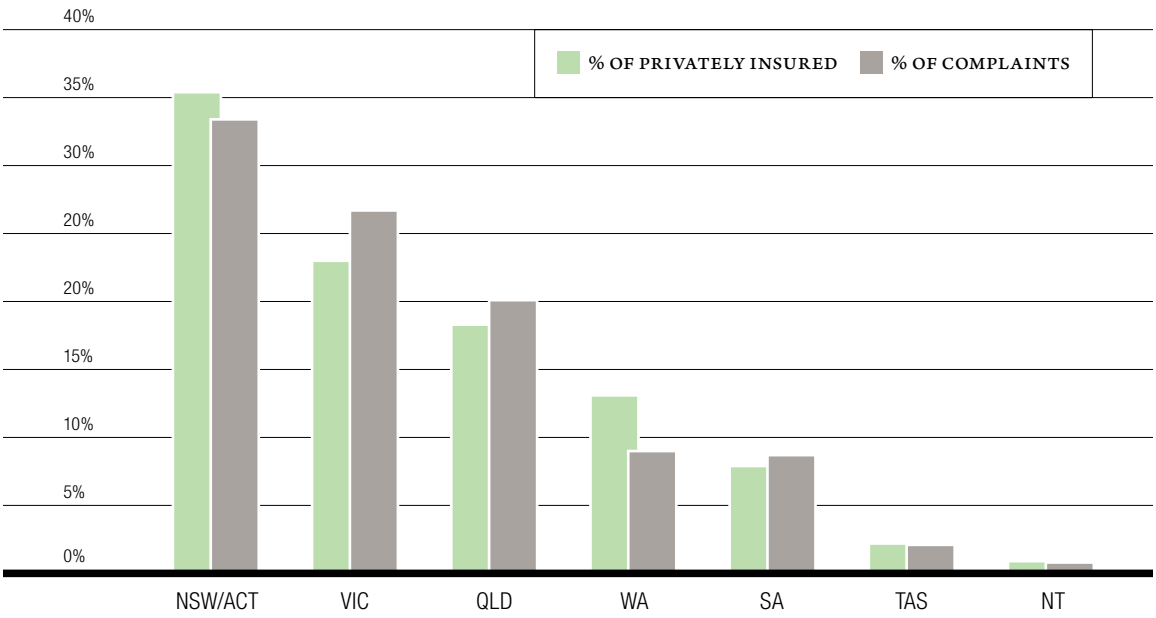
Seven percent of complaints were resolved by standard referral — that is, the complainant obtained advice from the Ombudsman's office and then referred their complaint to the appropriate body themselves. In 6% of cases the health insurer resolved the issue by making a payment, and 5% were resolved by another satisfactory outcome.

# Resolving Level 3 complaints

In relation to higher Level 3 complaints investigated by the Ombudsman, **FIGURE 12** shows 51% were resolved by giving a more detailed explanation to the member; 1% was withdrawn by the complainant; and the remaining 48% were resolved by a payment or other satisfactory outcome.

These payments usually followed an investigation by the Ombudsman where the health insurer agreed that a member was entitled to a benefit payment or some other payment. In some cases, payment was made by health insurers on an ex-gratia basis; for instance, where the insurer paid a benefit the member was not entitled to under their policy. Some complaints were resolved by

**FIGURE 13 // COMPLAINTS BY POPULATION COVERED BY STATE OR TERRITORY**




a hospital agreeing to reduce an account because Informed Financial Consent to out-of-pocket gaps had not been obtained from the member.

## Who complained

The *Private Health Insurance Act 2007* allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. The overwhelming majority of complaints were made by health insurance members (2,948); a further 28 complaints were made by practitioners and 14 by hospitals.

## How complaints were made

Sixty-four percent of complaints were made initially by telephone, 33% were lodged through the internet or by e-mail, 2.8% by letter, and less than 0.5% by fax, personal visit to the Ombudsman's office in Sydney or by parliamentary representation. These figures remained steady from the previous year.

## Complaints by state or territory

**FIGURE 13** identifies where complaints originate on a state-by-state basis. This data is shown by state and territory, against the percentage of people who have private health insurance coverage. The figures show that Victorians, Queenslanders and South Australians had a greater tendency to have a health insurance complaint, while Western Australians had a lower level of complaints compared to the population covered by private health insurance.

## Investigations

From 1 July 2011 to 30 June 2012 there were no formal investigations under section 244 of the *Private Health Insurance Act 2007* (or under the preceding Act).

"The Ombudsman assisted 2,995 consumers with complaints in 2011–12 — a similar result to last year but significantly higher than 2009–10."

# Complaint Issues and Case Studies:

## Introduction

Complaints to the Ombudsman must first meet the requirements of section 241-10 of the *Private Health Insurance Act 2007*, which states that the complaint must be about a health insurance arrangement. For reporting purposes, complaints are classified in terms of broad issues and sub-issues. The most significant type of complaints concern benefits, followed by service issues, information, membership issues and waiting periods. **FIGURES 14 (OVER)** and **FIGURE 15 (SEE PAGE 33)** illustrate the proportion of complaints corresponding to each issue type. **FIGURE 16 (SEE PAGE 40)** shows the number of complaints received for each sub-issue this year compared to the previous year.

The number of complaints registered with the Ombudsman in 2011–12 was similar to the previous year — 2,995 compared to 3,070. This is significantly larger than the totals of the years preceding 2010. The Ombudsman will continue to monitor complaints for trends within the industry.

## About the case studies

The following case studies highlight some of the common types of complaints received by the Private Health Insurance Ombudsman. They illustrate the lessons that can be learned from complaints by both health insurers and consumers. The names, references, and some details have been changed as needed to protect the privacy and confidentiality of individuals.

## Benefits and level of cover

| COMPLAINTS | KEY ISSUES |
|---|---|
| 1,091 | Inadequate cover levels<br>Payment delays<br>Gaps |

The most significant area of complaint to the Ombudsman's office was benefits, with a total of 1,091 complaints for 2011–12, similar to the previous year's figure of 1,131. The main areas of concern for consumers were inadequate levels of cover, delays in payment, and hospital and medical gaps.

**CASE STUDY**

### When should consumers on restricted policies choose to go to private hospitals?

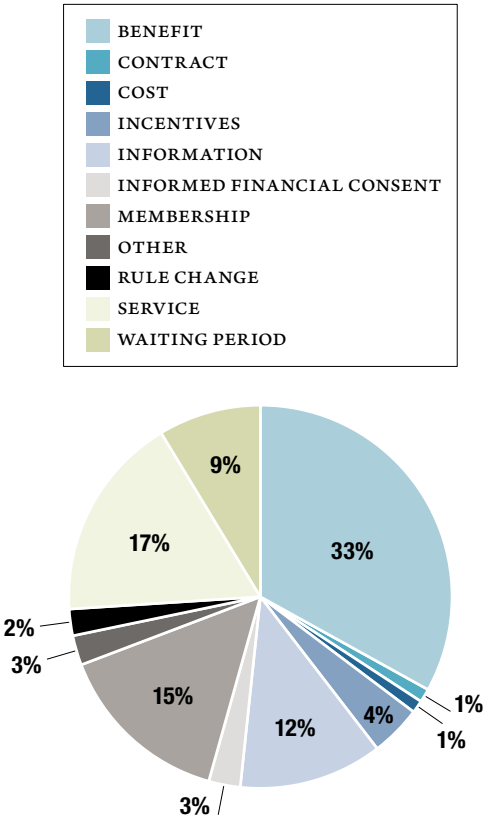
*Some consumers who have purchased a basic level of hospital cover regret their choice later on when they find they require hospital treatment that cannot be covered on their policy. When investigating complaints, the Ombudsman works with insurers by drawing their attention to how policy information can be improved to reduce the chances of someone choosing a policy that isn't suitable. Unfortunately it is a difficult message to make clear for a consumer who is seeking to buy an inexpensive policy and cannot know what health problems they might have ahead.*

Karl had purchased a level of private hospital cover which covered only five basic services,

including appendicitis, plus treatment for injuries sustained in an accident. Karl's main reason for choosing this policy was that he was young and healthy; he just needed a policy for accidents and to avoid penalties for not holding private health insurance such as the Medicare Levy Surcharge and the Lifetime Health Cover loading. Looking at the range of policies on offer, this policy seemed to be the lowest priced cover on offer that was still considered eligible to avoid the Medicare Levy Surcharge. Karl took out the policy some time ago and as his health was generally good he didn't think to update it or check it very often.

One afternoon he started feeling some strong abdominal pains and he started to suspect he was experiencing symptoms of appendicitis. The pain worsened later that evening so he decided he would go to the closest hospital with an emergency ward, which happened to be a private facility.

**FIGURE 14 // COMPLAINT ISSUES, 2011–12**




The initial examination by the emergency medical staff confirmed that he was experiencing symptoms of appendicitis and at this stage Karl recalled that he was covered in a private hospital for appendicitis, treatment. He agreed to be transferred into the private hospital for treatment and signed the paperwork from the hospital which confirmed that his health insurance policy would pay his costs.

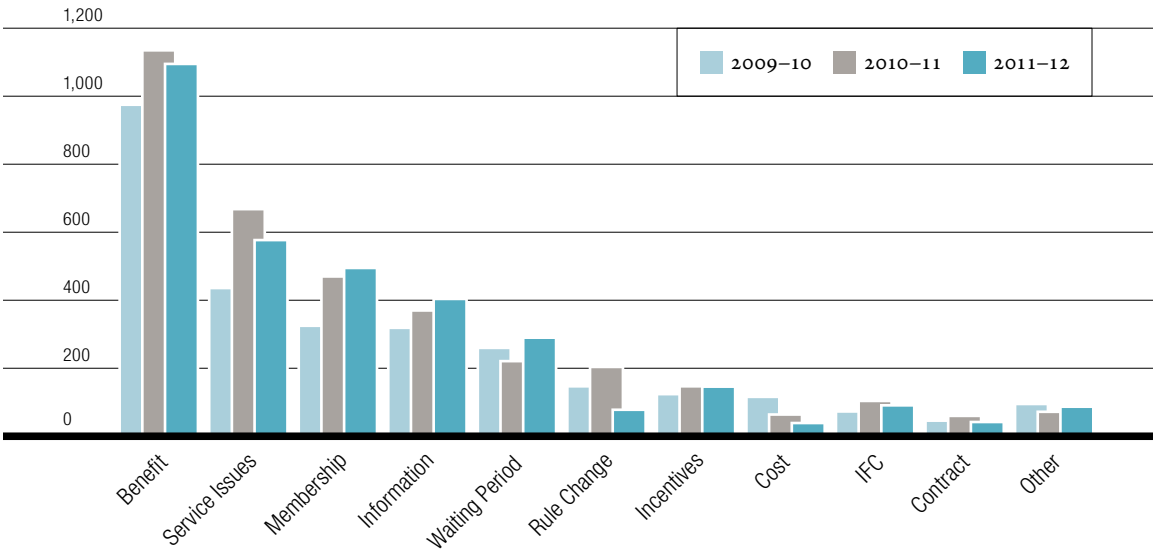
Unfortunately for Karl, his condition had similar symptoms to an appendicitis problem but the condition was very different. When the surgeon performed a laparoscopy to diagnose the problem, he found that Karl was actually experiencing a severe problem with his large intestine. The surgeon then performed a resection procedure to treat the problem. As the surgery was more complex than an appendectomy, Karl also needed to stay in hospital longer than he expected.

After he recovered from his surgery, Karl found that he was now required to pay the hospital $10,000 as the treatment he had received was not an appendectomy and therefore it wasn't covered by his policy.

Karl's complaint was that he was never given the opportunity to agree to the $10,000 hospital bill. The hospital responded by explaining that they can never be exactly sure what procedures a surgeon will perform, as treatment can change based on medical needs — in Karl's case, while the surgeon had expected to perform an appendectomy, the diagnosis and therefore the treatment had changed during the surgery. His health insurer responded by explaining that he had taken their lowest cost hospital policy and he should have understood that he wasn't covered for services in a private hospital unless they were specified on the policy's approved list of five treatments.

Not satisfied with the response from either organisation, Karl contacted the Private Health Insurance Ombudsman. In our view there was a problem with Karl's policy because it encouraged him to choose a private hospital admission because he thought he had symptoms of appendicitis. There will always be a risk with these policies that someone will go into hospital believing they require

**FIGURE 15 // COMPLAINT ISSUES, 2009–10 TO 2011–12**




treatment for one problem, which is covered, but then find after admission that they require treatment for a different or additional problem, which is not covered.

The Ombudsman's view was that either the insurer should consider removing cover for appendicitis treatment, due to the high probability of other consumers seeking emergency private hospital treatment for suspected appendicitis and then being asked to pay high hospital costs like Karl if the condition was determined not to be appendicitis; or that in cases where their members genuinely believed they were experiencing appendicitis symptoms, as Karl was, the insurer should pay benefits due to the extenuating circumstances. The Ombudsman also commented that it hadn't received many complaints like Karl's, and so it would be reasonable for the insurer to pay benefits on such rare occasions, even though the policies are clearly sold as very basic policies.

The insurer considered the Ombudsman's views on the matter and confirmed that Karl's condition was clearly suspected to be appendicitis treatment at the time of admission. Based on these factors, the insurer agreed to pay the outstanding $10,000 hospital account.

## Service issues

| COMPLAINTS | KEY ISSUES |
|---|---|
| 573 | Premium payment problems<br>Customer service<br>Delays in service |

Another significant area of complaint to the Ombudsman was service and payment administration, with 573 complaints. Of these, 153 were premium payment problems associated with direct debit systems, and the remainder were general service issues such as customer service issues or delays.

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

CASE STUDY

## What should a salesperson say to someone looking for a cheaper policy?

*Many consumers who are shopping around for a cheaper cover need assistance to understand the reasons why different policies cost less. The Ombudsman's view is that salespeople should place a high importance on explaining the difference between covers if someone is choosing to move from a top hospital cover to a lower cover that restricts or excludes a large number of hospital treatments. If a consumer chooses to downgrade their cover, the salesperson should ensure that the consumer understands each service that they are no longer covered for.*

Chris was in his fifties and had been paying for top level of health insurance for a number of years. He noticed that the premiums on his cover were increasing every year and saw advertisements on TV and the internet that offered to save him money by changing his insurer. He looked up a company online and entered a few details about what type of cover he was interested in, but didn't change his cover at that time.

Later that week, he received a phone call from a salesperson in the company who introduced himself and asked Chris whether he needed any help with reviewing his cover. Chris was initially reluctant to talk to him but the salesperson assured him that he could save him some money on his health insurance and that the process wouldn't take very long.

HILARY BASSINGTHWAIGHTE, LEONIE HULL AND SAMANTHA GAVEL

As a result of the phone call, Chris signed up to a new health insurance policy and saved almost $50 a month. Chris knew that he was not fully covered for a couple of services under the policy but the salesperson had convinced him that these were services that a healthy man in his fifties wouldn't need, such as hip replacements, pregnancy, and psychiatric treatment.

Unfortunately, in the months that followed, Chris developed an alcohol dependence problem which required urgent medical treatment. What Chris didn't understand was that his new health insurance policy did not cover this type of treatment, as it is classified as psychiatric treatment.

Chris thought psychiatric treatment was only for people with mental health issues like psychosis, post-natal depression and anorexia. He believed alcohol dependence was rehabilitation from a chemical addiction and totally different.

The Ombudsman hears similar comments from consumers regularly. There is limited understanding in the community about what is considered psychiatric treatment, or that drug and alcohol rehabilitation falls into this category.

To treat his alcohol dependence problem, Chris was admitted for treatment at a mental health facility for eight days, for a total hospital fee of over $5,000. His new health insurer looked at the claim and assessed it as psychiatric related. This meant that due to the restriction on psychiatric benefits under his new cover, he was only entitled to a minimum accommodation benefit, which covered approximately half the account. This left Chris with a bill of approximately $2,500.

Chris complained to his health insurer because he felt his policy should have covered him for the treatment. He remembered at the time that he switched his cover that the main reasons he was given for the policy being cheaper were that the insurer was a non-profit mutual organisation and that he wasn't covered for services he wouldn't need for at least 10 years or more.

The company which had arranged Chris' change in cover reviewed the sales process that was followed and explained that during his phone call, it had been mentioned that psychiatric treatment was not fully covered on the new policy, and that this was confirmed in the paperwork that was later posted to him. Dissatisfied with this response, Chris contacted the Ombudsman to request that we investigate further.

The Ombudsman's investigation raised a number of concerns about the sales process. The main problem with the call was that Chris had asked for a policy similar to his old one but lower in price, but was actually sold a policy that was dissimilar and cheaper because it had restrictions on a number of services.

In reviewing the phone call, the Ombudsman noticed that a lot of attention was paid to relatively low-cost items such as small benefits for dental treatment, but important considerations such as not being covered for more expensive hospital services were only briefly mentioned. The salesperson also claimed that the $50 per month difference in premiums was attributable the new insurer being a not-for-profit company, which could only have accounted for a very small difference in premiums if any at all.

After some discussions, the company agreed that Chris had not been provided with the best advice and that further information should have been provided about why the cover Chris was buying was cheaper. The company explained that it had updated its sales process to ensure that recommendations of cover were more suitable in future and the Ombudsman can report it has not received any similar cases from that company since then. The Ombudsman's view is that salespeople should take care to ensure that people who are joining an insurer or changing their cover consider both price and features before buying a policy, and that any restrictions or limitations on the policy are understood by the consumer.

# Membership issues

| COMPLAINTS | KEY ISSUES |
|---|---|
| 492 | Policy cancellation<br>Clearance certificates<br>Suspending and resuming<br>Continuity of benefits |

Issues with membership and policy administration increased slightly from the previous year, with 492 complaints in 2011–12, compared to 466 in the previous year. Almost 30% of these complaints were related to problems experienced by people in processing the cancellation of their health insurance policies. Difficulties in obtaining clearance certificates, suspending and resuming policies, and continuity of benefits when transferring between insurers made up the majority of the remaining complaints.

**CASE STUDY**

## Reminding people to add children onto their memberships

*Some consumers are surprised that they are required to formally add a newly born baby to their health insurance policy in order for them to be covered. There is often an expectation that the hospital or Medicare will inform the health insurer about the new child, particularly when the insurer has paid the claim relating to the mother's admission to hospital for the birth.*

Some insurers will allow up to sixty days after the birth for the baby to be added to the mother's policy, while others will require the mother to upgrade to a family cover before the baby is born. Fortunately, insurers are flexible with respect to backdating the addition of a newborn if it is clear a mistake has occurred.

Jenny was covered by a single hospital policy. Although she was pregnant, she thought her policy would be suitable because she was advised that her baby probably wouldn't need to be formally admitted into the hospital as a patient. The normal procedure for the delivery of a baby in a private hospital is that

the mother is admitted to hospital as a patient and billed, but the baby is not admitted unless extra nursing care is required.

When Jenny gave birth to her new son, unfortunately he did require a few days in the special care nursery. When Jenny was told her baby needed to go to the special care nursery, hospital records indicated she was told the cost would be about $1,200 per day, although Jenny later stated she had no recollection of being given this advice.

Since Jenny didn't have cover for her baby, due to holding only a single policy, she was told to contact her health insurer, as her insurer permitted newborn babies to be added within sixty days after the date of birth. If she added her baby to her policy, this would ensure the daily $1,200 charge would be covered by her insurance.

"PHIO encourages all insurers to communicate with members holding less comprehensive hospital policies to consider upgrading their cover."

Jenny and her son recovered and were discharged from the hospital. A few days later, Jenny contacted her health insurer to enquire about adding her son onto her membership. The addition of her baby would change her single policy into a family one — while this would double her premium, the family policy would also cover her husband and older children. Due to the increased cost, Jenny said she would need to think about it.

Jenny phoned a second time to enquire about the family policy and this time the staff member made it clear that the sixty day grace period to add her child onto the membership was going to lapse soon. Jenny said she wouldn't add her child to the policy because the increase in premiums was too high, especially as the insurer wanted to backdate the cost to when her son was born.

Over three months after she and her son were discharged from hospital, Jenny received a bill for $2,500 for the care her son received in the special care nursery. She contacted the hospital and complained that the hospital hadn't warned her of the cost and also that the account had been sent three months after the service had occurred.

The hospital believed it had explained that she would be required to pay for the special care nursery unless she joined her son onto her private health insurance membership. The hospital assumed that she would add her son because that was clearly in her interests to do so. The delay in the sending the hospital account was deliberate because the hospital had waited two months before lodging the claim with the health insurer to give Jenny enough time to add her son onto the policy. When the hospital had eventually lodged the claim, it was returned by the insurer, unpaid, a couple of weeks later.

Jenny was dissatisfied with the response she received both from the hospital and her health insurer. The Ombudsman listened to her concerns and offered to investigate.

The investigation confirmed that Jenny had been advised on three occasions to add her child to her policy or she would be required

to pay the hospital account. When the Ombudsman investigation officer asked Jenny why she overlooked these warnings, it seemed she felt her baby's treatment wouldn't incur a bill.

In this case, after investigating the Ombudsman felt it was reasonable for the hospital to charge the account because the records showed they had provided sufficient advice to Jenny and they couldn't anticipate that she would choose not to add her child to her policy. The outcome was that the hospital reduced the outstanding account and in future sought to ensure that the message for parents to add babies to their memberships was very clear.

## Health insurer premium increases

| COMPLAINTS | KEY ISSUES |
|---|---|
| 30 | Limited (average premium increases have been low) |

The Ombudsman has received a relatively low number of premium increase complaints for a number of years. This can be attributed to two developments in recent years. Average premium increases for individual policy holders have been lower, and there has been greater transparency by insurers in communicating with the public about the reasons for health insurance premium increases. During the year, the Ombudsman received only 30 complaints (less than 1% of all complaints) about premium increases, which was a reduction from the 58 complaints received the previous year.

## Information

| COMPLAINTS | KEY ISSUES |
|---|---|
| 400 | Oral advice by insurers<br>Belief that policy change not advised |

Complaints about information are usually brought to the office by consumers because they have misunderstood oral advice or written information provided by an insurer in relation to benefit amounts. A total of 400 complaints about information issues were received, with 65% relating to oral advice provided by customer service staff at health insurers, and 13% relating to consumers believing they weren't advised of a change to their policy or because they didn't receive a letter.

**CASE STUDY**

### Should health insurers retain records of conversations in retail centres?

*Health insurers have greatly improved their record keeping for telephone contacts from consumers over the last two years. Almost all telephone conversations where an insurer advises a person of their entitlements are recorded, so the recordings can be examined if there is a disagreement over what advice was provided. This is an important consumer protection and also helps insurers monitor the quality of the advice their staff provide.*

*Unfortunately, the Ombudsman still regularly receives complaints from consumers who have enquired about benefits from a retail centre (branch office) where, on investigation, we find no record of advice has been kept. In 2012–13 the Ombudsman will be focussing on the issue of record keeping in retail centres.*

Mavis's usual way of talking to her health insurer about her membership or what she could expect to claim back for services was to walk into her local retail centre and talk to the staff members.

Last year Mavis was experiencing problems with her right knee and she was advised by her doctor that she would need an arthroscopy and, depending on the result of this, possibly a knee replacement. Mavis visited her local retail centre to check what she would be covered for because she understood she could have the surgery straight away in a private hospital.

DAMIEN MAYNARD, AMELIA DE GREGORIO AND KAYLIE BLYTON

Mavis's version of events was that she was told on two occasions at the retail centre that she would be covered for both a knee arthroscopy, which is a relatively simple and low cost procedure, and a knee replacement, which is a more complex and relatively expensive procedure.

Unfortunately, the level of cover that Mavis held was one that covered knee arthroscopies but not knee replacements. Some complainants experience a problem with this type of policy because it is fairly common for an orthopaedic surgeon to want to conduct an arthroscopy as an initial step before completing a knee replacement. In Mavis's case, she was covered for the investigation (arthroscopy) but she wasn't covered for the surgery that would actually treat the problem.

Mavis discovered she wasn't covered in the lead up to her hospitalisation. She complained to her insurer and eventually to the Ombudsman about the advice she received from the retail centre. The Ombudsman obtained Mavis's version of events and then sought her insurer's response.

The insurer responded that it didn't have a record of the conversations at the retail centre because they are very busy environments where staff needed to attend to customers. The processes in place at the retail centres were different to those at the same insurer's call centres, where records of conversations were always kept and able to be played back to customers who disputed the advice they had been given.

Mavis's cover had also undergone a number of changes in the last few years and this had increased the likelihood of confusion about the cover.

In reviewing the case, the Ombudsman suggested the insurer should allow Mavis to update her cover from the date she had visited the retail centre. Records indicated she had visited the retail centre 11 months before the date the case was concluded, which meant she would only need to wait one further month for her surgery (due to the 12 month waiting period for pre-existing conditions). This outcome recognised that if Mavis had been well advised at the time she visited the retail centre and fully understood her planned surgery wouldn't be covered, she would had the opportunity to upgrade to a policy that covered knee replacement at that time.

## Rule changes

| COMPLAINTS | KEY ISSUES |
|---|---|
| 74 | Reduction of services in hospital policies<br>Adequate notice |

The Ombudsman received 74 rule change complaints during the year. This is a pleasing decrease on last year's figure of 200 complaints, especially as complaints about rule changes had trended upwards over several years.

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

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

It should also be noted that complaints about rule changes continue to affect members several years after a change is made. For instance, consumers who have had pregnancy benefits removed from their policy due to an insurer rule change may not realise until they need the service, often several years later, at which point the complaint is usually registered by our office as a complaint about benefits rather than a rule change.

This means that it is also important for insurers to do follow-up communication to members in cases where there is a significant rule change, such as the removal of benefits for a service such as pregnancy or gastric banding from a hospital policy.

## Pre-existing condition waiting period

| COMPLAINTS | KEY ISSUES |
|---|---|
| 207 | Pre-existing condition waiting period |

Health insurers are able to apply a 12-month waiting period to new members if treatment is for a pre-existing condition (PEC). Details about how the PEC waiting period is applied can be obtained by referring to our brochure 'Waiting Periods' and our Factsheet on pre-existing conditions, which are available at Phio.org.au or by contacting our office.

The Ombudsman received 207 complaints about the PEC waiting period during the year, increasing from 149 complaints in 2010–11. The Ombudsman's role in investigating complaints about this waiting period is to ensure that the insurer has applied the waiting period correctly and that the insurer and hospital have complied with the *Best Practice Guidelines*. A copy of the guidelines for the industry is also available from the PHIO website.

**CASE STUDY**

### Providing clear advice about waiting periods

*Some consumers who upgrade their policy from an existing hospital or extras policy can become confused about which waiting periods apply especially if a health insurer only provides general information about waiting periods. Consumers often require specific and personalised advice to understand which waiting periods apply to them and which have already been completed.*

Benita had held an extras policy for many years. Recently she had decided to add hospital cover as well, so she contacted her health insurer to upgrade her policy.

During the sales call she asked which waiting periods would apply to her. Benita knew that she would require wisdom teeth extractions in the next few years and asked the consultant how soon these would be covered, as she had already completed waiting periods for dental cover.

The consultant responded by providing the general advice that Benita would need to complete a 12-month waiting period for pre-existing conditions and a two-month waiting period for other conditions. No further advice was provided.

As Benita knew she had already completed all the dental waiting periods on her extras policy, she assumed this meant that she only had to wait two months to be covered for her wisdom tooth extraction. She went ahead with a hospital admission for her extractions, three months after upgrading her cover.

However, Benita was not covered for the hospital admission. While Benita was covered for the wisdom tooth extraction had it happened in a dentist's rooms, she was not

## FIGURE 16 // COMPLAINT SUB-ISSUES

| BENEFIT | 2010–11 | 2011–12 |
|---|---|---|
| Accident and emergency | 10 | 20 |
| Accrued benefits | 5 | 8 |
| Ambulance | 47 | 47 |
| Amount | 50 | 21 |
| Delay in payment | 216 | 172 |
| Excess | 47 | 35 |
| Gap — Hospital | 51 | 44 |
| Gap — Medical | 65 | 47 |
| General treatment | 113 | 102 |
| High cost drugs | 7 | 7 |
| Hospital exclusion/restriction | 175 | 215 |
| Insurer rule | 139 | 185 |
| Limit reached | 29 | 27 |
| New baby | 7 | 20 |
| Non-health insurance | 25 | 20 |
| Non-health insurance — Overseas benefits | 7 | 6 |
| Non-recognised other practitioner | 28 | 17 |
| Non-recognised podiatry | 28 | 22 |
| Other compensation | 6 | 11 |
| Out of pocket not elsewhere covered | 27 | 8 |
| Out of time | 29 | 27 |
| Preferred provider schemes | 27 | 23 |
| Prostheses | 10 | 15 |
| Workers compensation | 3 | 1 |

| CONTRACT | 2010–11 | 2011–12 |
|---|---|---|
| Hospitals | 24 | 24 |
| Preferred provider schemes | 23 | 9 |
| Second tier default benefit | 9 | 5 |

| COST | 2010–11 | 2011–12 |
|---|---|---|
| Dual charging | 2 | 5 |
| Rate increase | 58 | 30 |

| IFC | 2010–11 | 2011–12 |
|---|---|---|
| Doctors | 39 | 31 |
| Hospitals | 57 | 54 |
| Other | 4 | 5 |

| INCENTIVES | 2010–11 | 2011–12 |
|---|---|---|
| Lifetime health cover | 123 | 124 |
| Medicare levy surcharge | 10 | 10 |
| Rebate | 10 | 7 |

| INFORMATION | 2010–11 | 2011–12 |
|---|---|---|
| Brochures and websites | 39 | 45 |
| Lack of notification | 59 | 53 |
| Oral | 219 | 261 |
| Radio and television | 4 | 1 |
| Written advice | 46 | 40 |

| MEMBERSHIP | 2010–11 | 2011–12 |
|---|---|---|
| Adult dependents | 26 | 23 |
| Arrears | 68 | 69 |
| Authority over membership | 13 | 13 |
| Cancellation | 117 | 148 |
| Clearance certificates | 95 | 89 |
| Continuity | 83 | 93 |
| Rate and benefit protection | 10 | 4 |
| Suspension | 59 | 61 |

| SERVICE | 2010–11 | 2011–12 |
|---|---|---|
| Customer service advice | 129 | 164 |
| General service issues | 220 | 139 |
| Premium payment problems | 216 | 153 |
| Service delays | 114 | 132 |

| WAITING PERIOD | 2010–11 | 2011–12 |
|---|---|---|
| Benefit limitation period | 1 | 4 |
| General | 26 | 18 |
| Obstetric | 32 | 45 |
| Other | 9 | 12 |
| Pre-existing conditions | 149 | 207 |

| OTHER | 2010–11 | 2011–12 |
|---|---|---|
| Access | 0 | 0 |
| Acute care certificates | 3 | 1 |
| Community rating | 1 | 0 |
| Complaint not elsewhere covered | 34 | 45 |
| Confidentiality and privacy | 27 | 19 |
| Demutualisation/ sale of health insurers | 5 | 1 |
| Discrimination | 1 | 5 |
| Non-english speaking background | 0 | 0 |
| Non-medicare patient | 1 | 4 |
| Private patient election | 3 | 8 |
| Rule change | 200 | 74 |

covered for the same procedure as part of a hospital admission because she was still within the 12-month waiting period for pre-existing conditions under the hospital policy.

On discovering she was not covered for the hospital admission, Benita felt that she had been advised incorrectly and asked the Ombudsman to investigate. The Ombudsman's view was that the advice given to Benita was not sufficient, because she had advised the health insurer that she needed cover for a wisdom tooth extraction at the time of upgrading to hospital cover and it would be natural to assume she was seeking to obtain benefits for in-hospital treatment.

During the phone call, the consultant discussed the policy in general terms but didn't respond adequately to Benita's advice that she was seeking to receive benefits for wisdom tooth extraction.

The consultant should have provided specific advice to Benita that if her wisdom teeth were extracted as an in-patient in hospital then the waiting period would be 12 months as it is considered a pre-existing condition. After reviewing the information provided, the insurer waived the waiting period in Benita's case and a benefit was paid for her surgery.

# Informed Financial Consent and hospitals

| COMPLAINTS | KEY ISSUES |
|---|---|
| 54 | Unexpected gaps for hospital admission |

Complaints about hospitals usually occur when patients experience unexpected gaps for a hospital admission. In most cases, there are adequate processes in place in private hospitals to ensure the provision of Informed Financial Consent (IFC) to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year. In 2011–12 the office recorded 54 IFC complaints against hospitals, compared to 57 the previous year.

**CASE STUDY**

## "100% cover — no strings attached"

*Health insurance is a complex area for a consumer to understand. When a person goes to a private hospital for treatment and is fully covered, it is because the health insurer and hospital have come to an agreement on costs and the person holds an appropriate level of cover. However, sometimes there are services that are not included in such an agreement and these can cause disagreements about whether the charge should be payable by the health insurer, the hospital or the patient. If the patient receives an account for such a service, it is very difficult to explain why such a charge is necessary when the person has a health insurance policy that says their hospital treatment is fully covered.*

Rohan held a top level of hospital insurance and had been admitted to a private hospital for heart surgery. During the admission process, he noted that hospital administration had asked for his health insurance details and had confirmed that there were no excess or other charges he would be required to pay.

Unfortunately, Rohan experienced severe complications on the operating table and the medical staff had to work very hard for several hours to save his life. As part of the treatment, the doctors administered a drug called Novoseven which is used in situations where blood loss could result in death.

KATE HOCKNULL, JIM ROBERTSON AND KATIE KWONG

During his recovery in hospital, Rohan says he was advised that Novoseven had to be used to save his life, but unfortunately it was not covered by his health insurer because it was not included under the hospital and insurer's contract. As the drug is very expensive and the hospital operated on a non-profit basis, he would be required to pay $8,000 to cover its cost. Rohan was very upset to be asked to pay such a large bill and after raising the complaint with the hospital and his health insurer, he asked the Ombudsman to investigate.

Rohan had reviewed his health insurance policy to try to see where it included a warning that he could be asked to pay $8,000 for a drug administered during surgery. He could not find the warning anywhere and, in fact, he found that for heart surgery, theatre, coronary and intensive care the policy said it paid "100%" with no qualifiers.

The Ombudsman has long held the view that because health insurance is complex, the term 100% should be avoided in relation to describing a benefit. In this case, we could see why Rohan thought the policy document was incorrect because the drug he was being billed for was required to save his life and was obviously part of his treatment in theatre.

The hospital and health insurer explained that such drugs had been omitted when they agreed to a contract of prices for insurer members attending that hospital. The Ombudsman understands that there is some tension between hospitals and health insurers about who should cover new, and sometimes very expensive, drugs that seem to come onto the market each year. The hospitals' view is that they require additional funding from the insurer to ensure they are providing the best medical service possible; while health insurers explain that while this would be beneficial, they are under pressure not to increase costs as these in turn lead to premium increases for contributors over time.

In Rohan's case, the Ombudsman determined that the health insurer's policy material was not clear enough and would have lead Rohan to believe this drug would be covered. Furthermore, the Ombudsman's view is that policy holders are entitled to expect their health insurer understands that the new drugs and technologies are being used in hospitals and to ensure that a reasonable attempt is made to cover high cost drugs through regular negotiations with hospitals, such as agreeing to share the costs between both parties.

After some discussions with the health insurer and hospital, Rohan was not required to pay the $8,000 and the health insurer agreed to examine its hospital contracting arrangements to ensure Novoseven would be included in future negotiations with hospitals.

# Overseas Visitors Health Cover:

Each year, the Ombudsman assists a number of consumers with complaints about Overseas Visitor Cover policies for visitors to Australia. These policies are not "complying health insurance policies" under the Act and these complaints are therefore not included in Figure 10, which lists complaints by each health insurer.

The Ombudsman assisted 127 consumers with complaints about Overseas Visitors Cover (for visitors to Australia), increasing from the 58 complaints received in 2010–11.

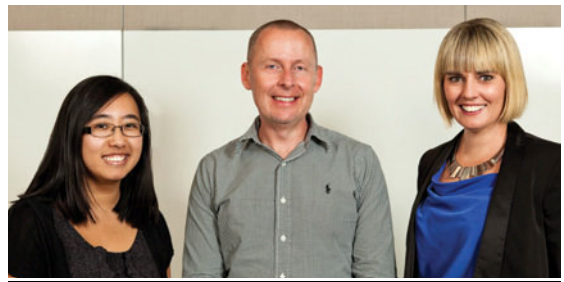
The complaints were registered across a small number of insurers who offer these policies. As market share information for overseas visitor cover was unavailable at the time of publishing, the number of complaints against each insurer has not been listed, because it would not allow a fair comparison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

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

To insure themselves against potential medical expenses, overseas visitors can take out Overseas Visitors Health Cover (OVHC).

A number of insurers offer cover specifically for people who aren't eligible for Medicare benefits, including: Australian Unity, BUPA, HBF, HIF, Medibank Private, NIB (trading as IMAN) and HCF (diplomats and certain visas only).

Some Overseas Visitor Health Cover (OVHC) policies provide similar cover to that available to Australian residents, while others can be very different. Benefits, membership costs and eligibility can vary greatly between insurers, so the Ombudsman recommends that anyone looking to take out OVHC should take care to ensure the policy they select is suitable for their needs. Information to assist overseas visitors with selecting health insurance is available at PrivateHealth.gov.au.



ALISON LEUNG, DAVID MCGREGOR AND TANYA SNOWDEN

The most common complaints investigated by the office in relation to OVHC concern waiting periods and other restrictions on the policy. Almost 14% of the complaints received in 2011–12 were about the pre-existing conditions waiting period, with a further 10% about delays in payment.

Complaints about the application of the pre-existing condition (PEC) waiting period

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

## Overseas Student Health Cover

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

"The Ombudsman assisted 127 consumers with complaints about Overseas Visitors Cover, increasing from the 58 complaints received in 2010–11."

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

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

PHIO received a small number of complaints in late 2011 from overseas visitors and students who had encountered difficulty in booking into public hospitals as private patients for maternity services. PHIO investigated these complaints and was able to assist these members to resolve their complaints. PHIO has not received any additional complaints about this issue since February 2012, but will investigate any complaints about this issue as per its usual complaint handling process.

# General Issues:

## Access and public awareness

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

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

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

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

To raise public awareness of the services provided by the Ombudsman, the following strategies were employed during 2011–12:

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

HENNY OENTOJO, TRACEY SALKELD AND ROSIE EDWARDS

# Relations with stakeholders

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

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

JOANNA WONG

In April 2012, the Ombudsman launched *Health Insurance Insider*, a new consumer e-bulletin which will be released on a six-monthly basis. The first issue focused on the important issue of reviewing your policy, while the next issue (due in the second half of 2012) will explain what consumers can expect when going to hospital. To view the first issue or to subscribe to e-mail updates, visit Phio.org.au.

The Ombudsman has continued to add new topics to the website's 'Facts and Advice' section. This section provides factsheets about topics which are regularly raised by consumers, such as why and how health premiums are increased, and how to plan to be covered for pregnancy and obstetrics services. Recent additions include factsheets on how the pre-existing conditions rule is applied, and how private health insurance covers podiatric surgery. This area will continue to be reviewed and updated in response to consumer needs.

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

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

# Client survey

## About the survey

The Ombudsman regularly carries out a postal survey of randomly selected complainants. Each fortnight, surveys are posted to a sample of complainants whose cases have been closed during the previous period. The office received 163 responses (31%), a good participation rate for a postal survey of this kind.

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

Overall, 90% of clients were satisfied or very satisfied with the overall handling of their complaint, compared to 88% in the previous year. It was pleasing to see that on most criteria the office equalled or improved on the results from the previous year.

This year 85% of clients were happy with the time taken to resolve complaints, which was down compared to 92% of respondents in the previous year. While still well up from 77% in the year before, this is an area which the Ombudsman's office will concentrate on improving in 2012–13.

In summary, of the respondents to the survey:

| | 2009–10 | 2010–11 | 2011–12 |
|---|---|---|---|
| Overall satisfaction | 87% | 88% | 90% |
| Agreed that staff listened adequately | 96% | 91% | 96% |
| Satisfied with staff manner | 86% | 88% | 91% |
| Resolved complaint or provided adequate explanation | 89% | 89% | 90% |
| Thought PHIO acted independently | 85% | 85% | 90% |
| Would recommend PHIO to others | 87% | 88% | 94% |
| Happy with time taken to resolve complaint | 77% | 92% | 85% |

Analysis of the results has shown that for complainants who obtain a payment or other outcome from a health insurer, satisfaction levels with the office were at 97%. This indicates there is a correlation between the service that the office provides directly with the outcome that the office is able to achieve for the complainant, regardless of whether they are satisfied with the way the Ombudsman's staff deal with their complaint.

"94% of surveyed clients would recommend PHIO's services to friends and family."

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

## Health policy — liaison with other bodies

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

Some significant activities included:

- Submission to the ACCC's report to the Senate on Anti-Competitive and Other Practices by Health Funds and Providers in relation to private health insurance;
- Advice and assistance to the Department of Health and Ageing in relation to the updating of the Standard Information Statements (SISs);
- Submission to Private Health Insurance Industry Code of Conduct Review; and
- Consultation with State Health Departments, public hospitals and health insurers in relation to acute care certification processes for long stay private patients in public hospitals.

"The consumer website PrivateHealth.gov.au is Australia's leading source of independent information for consumers about health insurance."

# Consumer Website: PrivateHealth.gov.au

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

The website's major features include:

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

## Usage

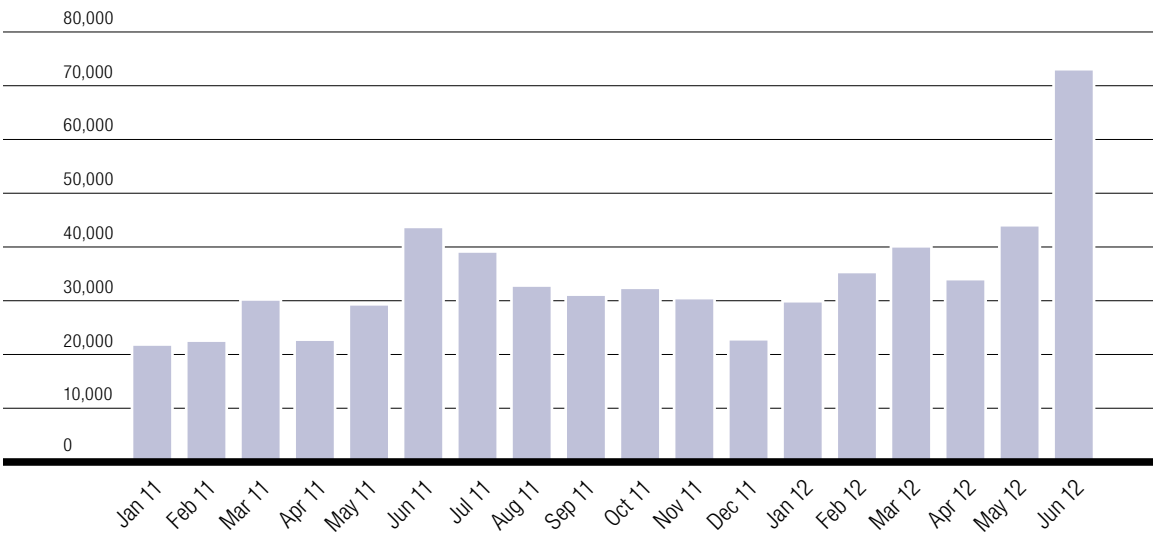
The website recorded 485,923 unique visitors during the year, an increase of 55% on the previous year. Analysis of the available data suggests that general growth of the site's usage can be attributed to the site becoming better known via recommendations and search results, as well as regular reminders of the site's existence in annual mailings of standard information statements and Lifetime Health Cover letters.

In June 2012, the website experienced an extremely high level of traffic. Changes to the Australian Government Private Health Insurance Rebate, effective from 1 July, and the Department of Health and Ageing's annual Lifetime Health Cover mailing to new migrants and Australians turning 31 resulted in a very high level of PHI awareness among consumers. The total number of unique visitors in June (72,829) outstripped the previous month's visitor numbers by approximately 66%. This was the heaviest period of traffic to the website since the launch period in May 2007 when an advertising campaign occurred.

## Website enquiries

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

**FIGURE 17 // UNIQUE VISITORS TO PRIVATEHEALTH.GOV.AU**




The office responded to 1,313 consumer enquiries through the website in 2011–12, making up 88% of the total number of enquiries received by the office. This year, changes to the Australian Government Private Health Insurance Rebate and the Medicare Levy Surcharge effective from 1 July 2012 contributed to a higher rate of enquiries, especially in the May to June period.

The most frequently raised questions are about the following topics:

- Lifetime Health Cover, especially regarding how this affects new migrants to Australia and Australians returning from overseas. The Lifetime Health Cover rules determine how much a person pays for hospital insurance;
- The Medicare Levy Surcharge for high income earners and how to avoid the Surcharge by purchasing appropriate private hospital insurance;
- Waiting periods for people who are currently uninsured;

**FIGURE 18 // UNIQUE VISITORS TO PRIVATEHEALTH.GOV.AU**

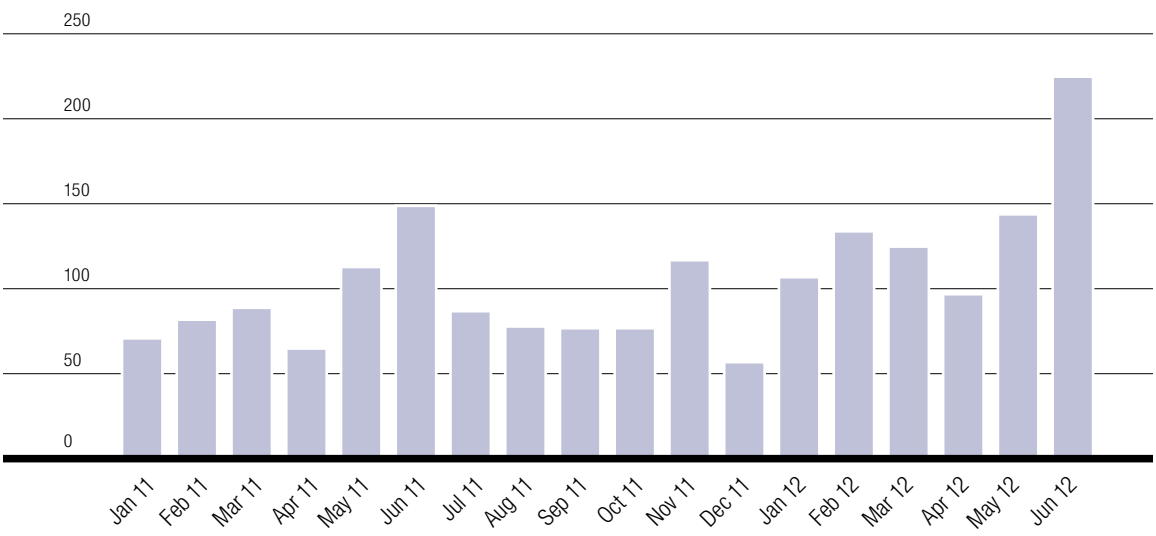
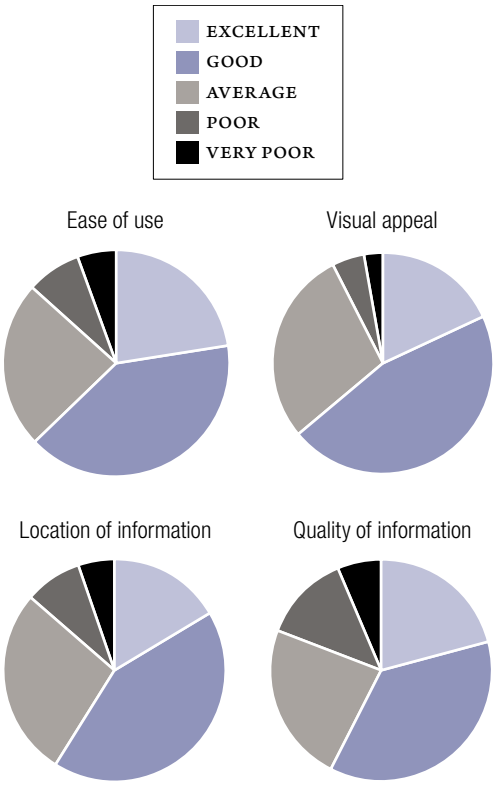


**FIGURE 19 // WEBSITE SURVEY RATINGS FOR PRIVATEHEALTH.GOV.AU**




- How to use the website, locate information and compare policies;
- How to choose a health insurance policy; and
- Overseas visitors health cover, especially for subclass 457 visa holders and student visa holders.

## Survey results

During the year, 776 users completed a survey about the website. Survey results are used to highlight areas where improvements can be made to the website, to track satisfaction with the site and whether changes have been successful.

Since July 2010, when the website re-launched in its current form, consumer satisfaction for major rating criteria has remained consistently high, especially for 'visual appeal'. PHIO will continue to monitor user feedback and work on improving survey results. The key ratings for the site are summarised in **FIGURE 19**.

## Website developments

In 2011, PHIO received additional funding from the Department of Health and Ageing to maintain and improve the website. Under the Memorandum of Understanding with the Department, new developments which were released in the 2011–12 year included:

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

PHIO also undertook a number of website updates and content management developments as a result of changes to the Private Health Insurance (Complying Product) Rules, which set out the format and content of Standard Information Statements, and the Australian Government's changes to the Private Health Insurance Rebate and Medicare Levy Surcharge.

# Appendix: Statutory Reporting Information

## Management of human resources

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

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

## Statutory positions

The Private Health Insurance Ombudsman comprises one statutory office holder:

| OFFICER | POSITION | TERM | EXPIRY DATE |
|---|---|---|---|
| Ms Samantha Gavel | Ombudsman | 3 years | 2014 |

## Organisational structure

At 30 June 2012, the permanent staff employed by the Private Health Insurance Ombudsman comprised:

| FULL-TIME AND PART-TIME EMPLOYEES | FEMALE | MALE | EFT [1] |
|---|---|---|---|
| SES 2 | 1 | – | 1.0 |
| EL 2 | 1 | 1 | 1.4 |
| EL 1 | 2 | – | 1.4 |
| APS 6 | 3 | – | 2.9 |
| APS 5 | 3 | 1 | 3.8 |
| APS 4 | 1 | – | 0.7 |
| APS 3 | 1 | – | 0.7 |

1 Equivalent full-time employee.

## Staff employment status

All Ombudsman staff members are employed under the provisions of the *Public Service Act 1999* and are required to adhere to the Public Service Values and Code of Conduct. All staff members, other than Senior Executive Service staff, are covered under an Enterprise Agreement in accordance with the *Fair Work Act 2009*.

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

Workplace structures, systems and procedures are in place to assist employees in balancing

their work and family responsibilities effectively. The following table shows the numbers and status of staff who were employed on 30 June 2012:

| OCCUPATIONAL GROUP | FEMALE | MALE | TOTAL | NESB1 [2] |
|---|---|---|---|---|
| SES [3] | 1 | 0 | 1 | 0 |
| Other [4] | 13 | 2 | 15 | 3 |
| **Total** | **14** | **2** | **15** [5] | **3** |

2 Non-English speaking background, first generation
3 Senior Executive Service, Ombudsman
4 All other staff — temporary and permanent
5 Includes part-time employees and those on maternity leave. Actual EFT = 11.9

## Staff development and training

During the 2011–12 financial year, $59,255 was spent directly on the Ombudsman's staff attending training and development courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff. Staff training and development is an important priority for the office, to ensure staff members have the appropriate skills and knowledge to provide high level advice and services to consumers, as well as providing for staff career development, satisfaction and retention.

## Performance appraisal

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

All staff members are subject to a half-yearly and an annual performance appraisal. Salary and promotion advancement is based on performance and productivity. A total of $41,351 in performance bonuses was paid in 2011–12; this figure has been aggregated to preserve employees' privacy.

## Industrial democracy

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

## Corporate governance

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

## Accounting

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

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

## Consultancy services

The PHIO engages consultants where it lacks specialist expertise or when independent research, review or assessment is required. Consultants are typically engaged to investigate or diagnose a defined issue or problem; carry out defined reviews or evaluations; or provide independent advice, information or creative solutions to assist in PHIO's decision making.

Prior to engaging consultants, PHIO takes into account the skills and resources required for the task, the skills available internally, and the cost-effectiveness of engaging external expertise. The decision to engage a consultant is made in accordance with the *Financial Management and Accountability Act 1997* and related regulations including the Commonwealth Procurement Guidelines (CPGs) and PHIO's procurement policies.

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

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

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

During 2011–12, PHIO did not engage any consultancy services of $10,000 or more.

## Information systems

The Ombudsman's information system is based on a Windows 2008 Network Server and the Microsoft Office suite. Accounting software used is Mind Your Own Business (MYOB) Accounting and Asset Manager. In addition, the Ombudsman has a purpose built Complaints Management and Reporting system on-site. PHIO's Internet service is supplied by iiNET.

## Payroll services

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

## Service charter

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

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

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

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


SELECTED BROCHURES PUBLISHED BY PHIO

## External review and scrutiny

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

During this year there were no judicial decisions or decisions of administrative tribunals which directly affected the office. No complaints about the Private Health Insurance Ombudsman were made to the Commonwealth Ombudsman or investigations notified during the year.

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

## Fraud control

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

## Work health and safety

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

The Ombudsman complies with all provisions of the *Work Health and Safety Act 2011*.

No reportable incidents occurred during the year.

## Equal employment opportunity

The Ombudsman is committed to the principles outlined in the *Disability Discrimination Act 1992* and the *Equal Employment Opportunity (Commonwealth Authorities) Act 1987*.

## Advertising and market research

The Ombudsman did not conduct any advertising or market research in 2011–12 that meets the reporting requirements under section 311A of the *Commonwealth Electoral Act 1918*.

## Ecologically sustainable development and environmental performance

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

The Ombudsman's office is located in a building that has achieved 3 Stars under the National Australian Built Environment Rating: Water and 4.5 Stars under the National Environment Building Rating: Energy. The building is committed to purchasing 25% of base building energy from Government accredited GreenPower renewable energy resources.

## Grant programs

The Ombudsman did not administer any grant programs during the 2011–12 financial year.

## Changes to disability reporting

Since 1994, Commonwealth departments and agencies have reported on their performance as policy adviser, purchaser, employer, regulator and provider under the Commonwealth

Disability Strategy. In 2007–08, reporting on the employer role was transferred to the Australian Public Service Commission's *State of the Service Report* and the *Australian Public Service Statistical Bulletin*. These reports are available at www.apsc.gov.au. From 2010–11, departments and agencies have no longer been required to report on these functions.

The Commonwealth Disability Strategy has been overtaken by a new National Disability Strategy which sets out a 10-year national policy framework for improving life for Australians with disability, their families and carers. A high level report to track progress for people with disability at a national level will be produced by the Standing Council on Community, Housing and Disability Services to the Council of Australian Governments and will be available at www.fahcsia.gov.au. The Social Inclusion Measurement and Reporting Strategy agreed by the Government in December 2009 will also include some reporting on disability matters in its regular *How Australia is Faring* report and, if appropriate, in strategic change indicators in agency Annual Reports. More detail on social inclusion matters can be found at www.socialinclusion.gov.au.

## Freedom of Information and Information Publication Scheme

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

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

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

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

## PHIO publications

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

| | |
|---|---|
| **Brochures** | Making a Complaint |
| | The 10 Golden Rules of Private Health Insurance |
| | About Our Service |
| | Doctors' Bills |
| | The Right to Change — Portability in Health Insurance |
| | Waiting Periods |
| | Health Insurance Choice |
| | Privatehealth.gov.au |
| **Reports** | *State of the Health Funds Report* |
| | Individual Summaries for each insurer of *State of the Health Funds Report* |

To request brochures, please contact PHIO:

| | |
|---|---|
| **Post** | Suite 2, Level 22<br>580 George Street<br>Sydney NSW 2000 |
| **Phone** | (02) 8235 8777<br>or 1800 640 695 |
| **Fax** | (02) 8235 8778 |
| **E-mail** | info@phio.org.au |
| **From the PHIO website** | www.Phio.org.au |

# Financial Information:

## Table of contents

# Independent Auditor's Report

Australian National Audit Office

**INDEPENDENT AUDITOR'S REPORT**

**To the Minister for Health and Ageing**

I have audited the accompanying financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2012, which comprise: a Statement by the Ombudsman; a Statement of Comprehensive Income; Balance Sheet; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments; Schedule of Contingencies; and Notes comprising a Summary of Significant Accounting Policies and other explanatory information.

***Chief Executive's Responsibility for the Financial Statements***

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

***Auditor's Responsibility***

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

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

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

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

***Independence***

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

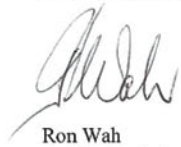
***Opinion***

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

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

(b) give a true and fair view of the matters required by the Finance Minister's Orders including the Private Health Insurance Ombudsman's financial position as at 30 June 2012 and of its financial performance and cash flows for the year then ended.

Australian National Audit Office



Ron Wah
Audit Principal

Delegate of the Auditor-General

Canberra
29 August 2012

# Statement by the Ombudsman

**Private Health Insurance Ombudsman**

**STATEMENT BY THE OMBUDSMAN**

In my opinion, the attached financial statements for the year ended 30 June 2012 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*, as amended.

Signed Samantha Gavel

Samantha Gavel
Chief Executive and Chief Financial Officer

29 August 2012

# Statement of Comprehensive Income

For the period ended 30 June 2012

| | NOTES | 2012 $ | 2011 $ |
|---|---|---|---|
| **EXPENSES** | | | |
| Employee benefits | 3A | **1,236,090** | 1,154,236 |
| Supplier | 3B | **847,985** | 846,770 |
| Depreciation and amortisation | 3C | **354,609** | 313,695 |
| Finance costs | 3D | **4,719** | 1,676 |
| Write-down and impairment of assets | 3E | **–** | 8,489 |
| **Total Expenses** | | **2,443,403** | 2,324,866 |
| | | | |
| **LESS: OWN-SOURCE INCOME** | | | |
| **Own-source revenue** | | | |
| Sale of goods and rendering of services | 4A | **19,636** | 24,591 |
| Other | 4B | **152,403** | 45,186 |
| **Total own-source revenue** | | **172,039** | 69,777 |
| **Gains** | | | |
| Other | 4C | **16,000** | 16,000 |
| **Total gains** | | **16,000** | 16,000 |
| | | | |
| **Net cost of (contribution by) services** | | **2,255,364** | 2,239,089 |
| | | | |
| Revenue from government | 4D | **1,896,000** | 1,826,000 |
| **Deficit** | | **(359,364)** | (413,089) |
| | | | |
| **OTHER COMPREHENSIVE INCOME** | | | |
| Other comprehensive income | | **–** | 99,981 |
| **Total Other Comprehensive Income** | | **–** | 99,981 |
| | | | |
| **Total comprehensive loss** | | **(359,364)** | (313,108) |

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

# Balance Sheet

As at 30 June 2012

| | NOTES | 2012 $ | 2011 $ |
|---|---|---|---|
| **ASSETS** | | | |
| **Financial assets** | | | |
| Cash and cash equivalents | 5A | **91,451** | 22,742 |
| Trade and other receivables | 5B | **1,905,047** | 2,316,722 |
| **Total financial assets** | | **1,996,498** | 2,339,464 |
| **Non-financial assets** | | | |
| Leasehold improvements | 6A,C | **161,650** | 165,480 |
| Property, plant and equipment | 6B,C | **65,160** | 76,044 |
| Intangibles | 6D,E | **799,277** | 832,446 |
| Other | 6F | **5,585** | 7,482 |
| **Total non-financial assets** | | **1,031,672** | 1,081,452 |
| **TOTAL ASSETS** | | **3,028,170** | 3,420,916 |
| | | | |
| **LIABILITIES** | | | |
| **Payables** | | | |
| Suppliers | 7A | **76,464** | 33,285 |
| Other payables | 7B | **89,889** | 279,700 |
| **Total payables** | | **166,353** | 312,985 |
| **Provisions** | | | |
| Employee provisions | 8A | **328,486** | 293,955 |
| Other | 8B | **39,570** | 34,851 |
| **Total provisions** | | **368,056** | 328,806 |
| **TOTAL LIABILITIES** | | **534,409** | 641,791 |
| | | | |
| **Net assets** | | **2,493,761** | 2,779,125 |
| | | | |
| **EQUITY** | | | |
| Contributed equity | | **2,322,041** | 2,248,041 |
| Reserves | | **99,981** | 99,981 |
| Retained surplus | | **71,739** | 431,103 |
| **TOTAL EQUITY** | | **2,493,761** | 2,779,125 |

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

# Statement of Changes in Equity

| For the period ended 30 June 2012 | RETAINED SURPLUS | | ASSET REVALUATION RESERVE | | CONTRIBUTED EQUITY | | TOTAL EQUITY | |
|---|---|---|---|---|---|---|---|---|
| | 2012 $ | 2011 $ | 2012 $ | 2011 $ | 2012 $ | 2011 $ | 2012 $ | 2011 $ |
| **OPENING BALANCE** | | | | | | | | |
| Balance carried forward from previous period | **431,103** | 844,192 | **99,981** | – | **2,248,041** | 2,110,041 | **2,779,125** | 2,954,233 |
| **Adjusted opening balance** | **431,103** | 844,192 | **99,981** | – | **2,248,041** | 2,110,041 | **2,779,125** | 2,954,233 |
| **COMPREHENSIVE INCOME** | | | | | | | | |
| Other comprehensive income | **–** | – | **–** | 99,981 | **–** | – | **–** | 99,981 |
| Deficit for the period | **(359,364)** | (413,089) | **–** | – | **–** | – | **(359,364)** | (413,089) |
| **TOTAL COMPREHENSIVE INCOME** | **(359,364)** | (413,089) | **–** | 99,981 | **–** | – | **(359,364)** | (313,108) |
| **CONTRIBUTIONS BY OWNERS** | | | | | | | | |
| Departmental capital budget | **–** | – | **–** | – | **74,000** | 138,000 | **74,000** | 138,000 |
| **Sub-total transactions with owners** | **–** | – | **–** | – | **74,000** | 138,000 | **74,000** | 138,000 |
| **Closing balance as at 30 June** | **71,739** | 431,103 | **99,981** | 99,981 | **2,322,041** | 2,248,041 | **2,493,761** | 2,779,125 |

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

# Cash Flow Statement

For the period ended 30 June 2012

| | NOTES | 2012 $ | 2011 $ |
|---|---|---|---|
| **OPERATING ACTIVITIES** | | | |
| **Cash received** | | | |
| Appropriations | | **2,130,000** | 2,065,000 |
| Sales of goods and rendering of services | | **19,636** | 24,591 |
| Net GST received | | **176,050** | – |
| Other | | **1,722** | 31,760 |
| **Total cash received** | | **2,327,408** | 2,121,351 |
| **Cash used** | | | |
| Employees | | **1,201,559** | 1,116,909 |
| Suppliers | | **824,414** | 828,040 |
| Net GST paid | | **–** | 16,557 |
| **Total cash used** | | **2,025,973** | 1,961,506 |
| **NET CASH FROM OPERATING ACTIVITIES** | 9 | **301,435** | 159,845 |
| **INVESTING ACTIVITIES** | | | |
| **Cash used** | | | |
| Purchase of property, plant and equipment | | **43,998** | 90,024 |
| Purchase of intangibles | | **262,728** | 239,272 |
| **Total cash used** | | **306,726** | 329,296 |
| **NET CASH USED BY INVESTING ACTIVITIES** | | **(306,726)** | (329,296) |
| **FINANCING ACTIVITIES** | | | |
| **Cash received** | | | |
| Contributed equity | | **74,000** | 138,000 |
| **Total cash received** | | **74,000** | 138,000 |
| **Net increase (decrease) in cash held** | | **68,709** | (31,451) |
| Cash and cash equivalents at the beginning of the reporting period | | **22,742** | 54,193 |
| **Cash and cash equivalents at the end of the reporting period** | 5A | **91,451** | 22,742 |

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

# Schedule of Commitments

| As at 30 June 2012 | 2012 $ | 2011 $ |
|---|---|---|
| **BY TYPE** | | |
| **Commitments receivable** | | |
| Net GST recoverable on commitments | **111,716** | 146,703 |
| **Total commitments receivable** | **111,716** | 146,703 |
| **Commitments payable** | | |
| **Other commitments** | | |
| Operating leases | **1,067,300** | 1,336,750 |
| Other | **161,572** | 276,980 |
| **Total other commitments** | **1,228,872** | 1,613,730 |
| **NET COMMITMENTS BY TYPE** | **1,117,156** | 1,467,027 |
| | | |
| **BY MATURITY** | | |
| **Commitments receivable** | | |
| One year or less | **41,722** | 34,987 |
| From one to five years | **69,994** | 111,716 |
| **Total operating lease income** | **111,716** | 146,703 |
| **Commitments payable** | | |
| **Operating lease commitments** | | |
| One year or less | **297,377** | 269,450 |
| From one to five years | **769,923** | 1,067,300 |
| **Total operating lease commitments** | **1,067,300** | 1,336,750 |
| **Other commitments** | | |
| One year or less | **161,572** | 115,408 |
| From one to five years | **–** | 161,572 |
| **Total other commitments** | **161,572** | 276,980 |
| **NET COMMITMENTS BY MATURITY** | **1,117,156** | 1,467,027 |

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

Note: Commitments are GST inclusive where relevant.

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

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

# Schedule of Contingencies

As at 30 June 2012

There were no contingent assets and liabilities as at 30 June 2012.

# Table of Contents — Notes

# Note 1: Summary of Significant Accounting Policies

## 1.1 Objectives of the entity

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

The entity is structured to meet the following outcome:

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

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

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

## 1.2 Basis of preparation of the financial statements

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

The financial statements have been prepared in accordance with:

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

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

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

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

Unless an alternative treatment is specifically required by an accounting standard or the FMOs, assets and liabilities are recognised in the balance sheet when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under executor contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the schedule of commitments or the schedule of contingencies.

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

## 1.3 Significant accounting judgements and estimates

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

## 1.4 New Australian accounting standards

### *Adoption of new Australian Accounting Standard requirements*

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

***Future Australian Accounting Standard requirements***

Other new standards, revised standards, interpretations and amending standards that were issued prior to the sign-off date and are applicable to the future reporting period are not expected to have a future financial impact on the Private Health Insurance Ombudsman.

## 1.5 Revenue

Revenue from the sale of goods is recognised when:

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

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

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

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

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

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

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

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

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

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

***Resources received free of charge***

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

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

***Revenue from Government***

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

## 1.6 Gains

***Resources Received Free of Charge***

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

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

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

## 1.7 Transactions with the Government as owner

***Equity injections***

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

## Note 1: Summary of Significant Accounting Policies (continued)

***Restructuring of administrative arrangements***

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

***Other distributions to owners***

The FMOs require that distributions to owners be debited to contributed equity unless it is in the nature of a dividend. In 2011–12, there were no distributions to owners.

### 1.8 Employee benefits

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

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

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

***Leave***

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

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

***Separation and redundancy***

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

***Superannuation***

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

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

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

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

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

### 1.9 Leases

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

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

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

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

The entity has no finance leases.

## 1.10 Cash

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

a) cash on hand; and

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

## 1.11 Financial assets

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

## 1.12 Financial liabilities

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

## 1.13 Contingent liabilities and contingent assets

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

## 1.14 Acquisition of assets

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

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

## 1.15 Property, plant and equipment

### *Asset recognition threshold*

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

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

### *Revaluations*

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

| ASSET CLASS | FAIR VALUE MEASURED AT |
|---|---|
| Leasehold improvements | Depreciated replacement cost |
| Property, plant and equipment | Market selling price |

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

## Note 1: Summary of Significant Accounting Policies (continued)

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

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

***Depreciation***

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

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

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

| CLASS | 2012 | 2011 |
|---|---|---|
| Leasehold improvements | Lease term | Lease term |
| Property, plant and equipment | 4 to 10 years | 4 to 10 years |

***Impairment***

All assets were assessed for impairment at 30 June 2012. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

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

***Derecognition***

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

### 1.16 Intangibles

The entity's intangibles comprise internally developed software for internal use. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the entity's software are five to seven years (2010–11: five years).

All software assets were assessed for indications of impairment as at 30 June 2012.

### 1.17 Taxation

The entity is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses and assets are recognised net of GST except:

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

b) for receivables and payables.

## Note 2: Events after the Reporting Period

There were no events after the reporting period.

# Note 3: Expenses

| | 2012 $ | 2011 $ |
|---|---|---|
| **Note 3A: Employee benefits** | | |
| Wages and salaries | **1,039,535** | 967,473 |
| Superannuation: | | |
| Defined contribution plans | **64,267** | 45,852 |
| Defined benefit plans | **87,546** | 97,862 |
| Leave and other entitlements | **34,532** | 37,326 |
| Other employee expenses | **10,210** | 5,723 |
| **Total employee benefits** | **1,236,090** | 1,154,236 |
| **Note 3B: Suppliers** | | |
| **Goods and services** | | |
| Accounting and audit | **45,264** | 41,380 |
| Brochures and printing | **67,041** | 53,905 |
| Consultants | **1,898** | 24,597 |
| Insurance | **9,673** | 10,505 |
| Legal | **6,850** | 20,896 |
| Media and advertising | **40,898** | 45,708 |
| Mediation | **5,636** | 5,807 |
| Recruitment | **1,380** | 5,862 |
| Stationery | **1,622** | 2,878 |
| Staff development | **48,227** | 35,084 |
| Travel and accommodation | **56,211** | 56,067 |
| Website | **185,647** | 118,523 |
| Other | **110,241** | 161,184 |
| **Total goods and services** | **580,588** | 582,396 |
| **Goods and services are made up of:** | | |
| Rendering of services — external parties | **580,588** | 582,396 |
| **Total goods and services** | **580,588** | 582,396 |
| **Other supplier expenses** | | |
| Operating lease rentals — external parties: | | |
| Minimum lease payments | **257,834** | 260,039 |
| Workers compensation expenses | **9,563** | 4,335 |
| **Total other supplier expenses** | **267,397** | 264,374 |
| **Total supplier expenses** | **847,985** | 846,770 |

## Note 3: Expenses (continued)

| | 2012 $ | 2011 $ |
|---|---|---|
| **Note 3C: Depreciation and amortisation** | | |
| **Depreciation** | | |
| Property, plant and equipment | **20,986** | 27,387 |
| Leasehold improvements | **37,726** | 42,404 |
| **Total depreciation** | **58,712** | 69,791 |
| **Amortisation** | | |
| Web development | **288,404** | 237,765 |
| Intangibles | **7,493** | 6,139 |
| **Total amortisation** | **295,897** | 243,904 |
| **Total depreciation and amortisation** | **354,609** | 313,695 |
| **Note 3D: Finance costs** | | |
| Unwinding of discount | **4,719** | 1,676 |
| **Total finance costs** | **4,719** | 1,676 |
| **Note 3E: Write-down and impairment of assets** | | |
| **Asset write-downs and impairments from:** | | |
| Disposal of assets | **–** | 8,489 |
| **Total write-down and impairment of assets** | **–** | 8,489 |

## Note 4: Income

| | 2012 $ | 2011 $ |
|---|---|---|
| ***Own-source revenue*** | | |
| **Note 4A: Sale of goods and rendering of services** | | |
| Rendering of services — external parties | **19,636** | 24,591 |
| **Total sale of goods and rendering of services** | **19,636** | 24,591 |
| **Note 4B: Other revenue** | | |
| MoU for website improvements | **152,000** | 29,818 |
| Other income | **403** | 15,368 |
| **Total other revenue** | **152,403** | 45,186 |
| **Note 4C: Other gains** | | |
| Resources received free of charge | **16,000** | 16,000 |
| **Total other gains** | **16,000** | 16,000 |

## Note 4: Income (continued)

***Revenue from Government***

### Note 4D: Revenue from Government

| | 2012 $ | 2011 $ |
|---|---|---|
| Appropriations: | | |
| Departmental appropriation | **1,896,000** | 1,826,000 |
| **Total revenue from Government** | **1,896,000** | 1,826,000 |

## Note 5: Financial Assets

| | 2012 $ | 2011 $ |
|---|---|---|
| **Note 5A: Cash and cash equivalents** | | |
| Cash on hand or on deposit | **91,451** | 22,742 |
| **Total cash and cash equivalents** | **91,451** | 22,742 |
| **Note 5B: Trade and other receivables** | | |
| **Goods and services** | | |
| Goods and services — related entities | **–** | 200,000 |
| **Total goods and services** | **–** | 200,000 |
| **Appropriations receivable** | | |
| For existing programs | **1,882,722** | 2,116,722 |
| **Total appropriations receivable** | **1,882,722** | 2,116,722 |
| **Other receivables:** | | |
| GST receivable from the Australian Taxation Office | **22,325** | – |
| **Total other receivables** | **22,325** | – |
| **Total trade and other receivables (net)** | **1,905,047** | 2,316,722 |
| Receivables are expected to be recovered in: | | |
| No more than 12 months | **–** | 200,000 |
| More than 12 months | **1,905,047** | 2,116,722 |
| **Total trade and other receivables (net)** | **1,905,047** | 2,316,722 |
| Receivables are aged as follows: | | |
| Not overdue | **1,905,047** | 2,316,722 |
| **Total receivables (gross)** | **1,905,047** | 2,316,722 |

# Note 6: Non-Financial Assets

| Note 6A: Leasehold improvements | 2012 $ | 2011 $ |
|---|---|---|
| **Leasehold improvements:** | | |
| Fair value | **205,071** | 171,175 |
| Accumulated depreciation | **(43,421)** | (5,695) |
| **Total leasehold improvements** | **161,650** | 165,480 |

No indicators of impairment were found for leasehold improvements.

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

## Note 6: Non-Financial Assets (continued)

| Note 6B: Property, plant and equipment | 2012 $ | 2011 $ |
|---|---|---|
| **Property, plant and equipment:** | | |
| Fair value | **110,747** | 100,645 |
| Accumulated depreciation | **(45,587)** | (24,601) |
| **Total property, plant and equipment** | **65,160** | 76,044 |

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

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

***Revaluations of non-financial assets***

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

| Note 6C: Reconciliation of the opening and closing balances of property, plant and equipment (2011–12) | LEASEHOLD IMPROVEMENTS $ | PROPERTY, PLANT AND EQUIPMENT $ | TOTAL $ |
|---|---|---|---|
| **As at 1 July 2011** | | | |
| Gross book value | **171,175** | **100,645** | **271,820** |
| Accumulated depreciation and impairment | **(5,695)** | **(24,601)** | **(30,296)** |
| **Net book value 1 July 2011** | **165,480** | **76,044** | **241,524** |
| Additions | **33,896** | **10,102** | **43,998** |
| Depreciation expense | **(37,726)** | **(20,986)** | **(58,712)** |
| **Net book value 30 June 2012** | **161,650** | **65,160** | **226,810** |
| **Net book value as of 30 June 2012 represented by:** | | | |
| Gross book value | **205,071** | **110,747** | **315,818** |
| Accumulated depreciation and impairment | **(43,421)** | **(45,587)** | **(89,008)** |
| | **161,650** | **65,160** | **226,810** |

## Note 6: Non-Financial Assets (continued)

### Note 6C (continued): Reconciliation of the opening and closing balances of property, plant and equipment (2010–11)

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

### Note 6D: Intangibles

| | 2012 $ | 2011 $ |
|---|---|---|
| **Computer software** | | |
| Purchased | **1,815,797** | 1,560,409 |
| Accumulated amortisation | **(1,075,160)** | (786,756) |
| **Total computer software** | **740,637** | 773,653 |
| **Other intangibles** | | |
| Purchased | **75,262** | 67,922 |
| Accumulated amortisation | **(16,622)** | (9,129) |
| **Total other intangibles** | **58,640** | 58,793 |
| **Total intangibles** | **799,277** | 832,446 |

No indicators of impairment were found for intangible assets.

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

## Note 6: Non-Financial Assets (continued)

### Note 6E: Reconciliation of the opening and closing balances of intangibles (2011–12)

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

### Note 6E (continued): Reconciliation of the opening and closing balances of intangibles (2010–11)

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

## Note 6: Non-Financial Assets (continued)

### Note 6F: Other non-financial assets

| | 2012 $ | 2011 $ |
|---|---|---|
| Prepayments | **5,585** | 7,482 |
| **Total other non-financial assets** | **5,585** | 7,482 |
| **Total other non-financial assets — are expected to be recovered in:** | | |
| No more than 12 months | **5,585** | 7,482 |
| **Total other non-financial assets** | **5,585** | 7,482 |

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

## Note 7: Payables

### Note 7A: Suppliers

| | 2012 $ | 2011 $ |
|---|---|---|
| Trade creditors and accruals | **76,464** | 33,285 |
| **Total supplier payables** | **76,464** | 33,285 |
| **Supplier payables expected to be settled within 12 months:** | | |
| External parties | **76,464** | 33,285 |
| **Total** | **76,464** | 33,285 |
| **Total supplier payables** | **76,464** | 33,285 |

Settlement is usually made within 30 days.

### Note 7B: Other payables

| | | |
|---|---|---|
| GST payable to ATO | **–** | 1,625 |
| Unearned income | **–** | 152,000 |
| Lease liabilities | **68,711** | 106,216 |
| Other | **21,178** | 19,859 |
| **Total other payables** | **89,889** | 279,700 |

# Note 8: Provisions

## Note 8A: Employee provisions

| | 2012 $ | 2011 $ |
|---|---|---|
| Leave | **328,486** | 293,955 |
| **Total employee provisions** | **328,486** | 293,955 |
| **Employee provisions are expected to be settled in:** | | |
| No more than 12 months | **266,922** | 264,952 |
| More than 12 months | **61,564** | 29,003 |
| **Total employee provisions** | **328,486** | 293,955 |

## Note 8B: Other provisions

| | 2012 $ | 2011 $ |
|---|---|---|
| Provision for restoration obligations | **39,570** | 34,851 |
| **Total other provisions** | **39,570** | 34,851 |
| **Other provisions are expected to be settled in:** | | |
| More than 12 months | **39,570** | 34,851 |
| **Total other provisions** | **39,570** | 34,851 |

| | PROVISION FOR RESTORATION $ | TOTAL $ |
|---|---|---|
| **Carrying amount 1 July 2011** | **34,851** | **34,851** |
| Unwinding of discount | **4,719** | **4,719** |
| **Closing balance 2012** | **39,570** | **39,570** |

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

# Note 9: Cash flow reconciliation

| | 2012 $ | 2011 $ |
|---|---|---|
| ***Reconciliation of cash and cash equivalents as per Balance Sheet to Cash Flow Statement*** | | |
| **Cash and cash equivalents as per:** | | |
| Cash flow statement | **91,451** | 22,742 |
| Balance sheet | **91,451** | 22,742 |
| **Difference** | **–** | – |

## Note 9: Cash flow reconciliation (continued)

| | 2012 $ | 2011 $ |
|---|---|---|
| ***Reconciliation of net cost of services to net cash from operating activities*** | | |
| Net cost of services | **(2,255,364)** | (2,239,089) |
| Add revenue from Government | **1,896,000** | 1,826,000 |
| **Adjustments for non-cash items** | | |
| Depreciation / amortisation | **354,609** | 313,695 |
| Net write down of non-financial assets | **–** | 8,489 |
| Finance cost | **4,719** | 1,676 |
| **Changes in assets / liabilities** | | |
| Decrease in net receivables | **411,675** | 39,000 |
| Decrease in prepayments | **1,897** | 5,718 |
| Increase in employee provisions | **34,531** | 37,327 |
| Increase / (decrease) in supplier payables | **43,179** | (109,204) |
| Increase / (decrease) in other payables | **(189,811)** | 276,233 |
| **Net cash from operating activities** | **301,435** | 159,845 |

# Note 10: Senior Executive Remuneration

### Note 10A: Senior Executive Remuneration Expense for the Reporting Period

| | 2012 $ | 2011 $ |
|---|---|---|
| **Short-term employee benefits:** | | |
| Salary | **213,748** | 204,325 |
| Annual leave accrued | **16,179** | 15,708 |
| **Total short-term employee benefits** | **229,927** | 220,033 |
| **Post-employment benefits:** | | |
| Superannuation | **31,746** | 30,673 |
| **Total post-employment benefits** | **31,746** | 30,673 |
| **Other long-term benefits:** | | |
| Long-service leave | **7,281** | 7,068 |
| **Total other long-term benefits** | **7,281** | 7,068 |
| **Total** | **268,954** | 257,774 |

Notes:

1. Note 10A was prepared on an accrual basis.
2. Note 10A excludes acting arrangements and part-year service where remuneration expensed for a senior executive was less than $150,000.

## Note 10: Senior Executive Remuneration (continued)

### Note 10B: Average annual remuneration packages for substantive senior executives as at the end of the reporting period

| As at 30 June 2012 | SENIOR EXECUTIVES NO. | FIXED ELEMENTS | | |
|---|---|---|---|---|
| | | SALARY $ | ALLOWANCES $ | TOTAL $ |
| **Total remuneration (including part-time arrangements):** | | | | |
| $180,000 to $209,999 | **1** | **171,230** | **33,724** | **204,954** |
| **Total** | **1** | | | |

| As at 30 June 2011 | SENIOR EXECUTIVES NO. | FIXED ELEMENTS | | |
|---|---|---|---|---|
| | | SALARY $ | ALLOWANCES $ | TOTAL $ |
| **Total remuneration (including part-time arrangements):** | | | | |
| $180,000 to $209,999 | 1 | 166,240 | 32,887 | 199,127 |
| **Total** | 1 | | | |

**Variable elements:**
With the exception of bonuses, variable elements were not included in the 'Fixed Elements and Bonus Paid' table above. The following variable elements were a part of senior executives' remuneration package:
- leave entitlements; and
- super contributions.

## Note 11: Remuneration of Auditors

| | 2012 $ | 2011 $ |
|---|---|---|
| Financial statement audit services were provided free of charge to the entity. | | |
| **Fair value of the services provided:** | | |
| Revenue received free of charge | **16,000** | 16,000 |
| **Total** | **16,000** | 16,000 |

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

# Note 12: Financial Instruments

| Note 12A: Categories of financial instruments | 2012 $ | 2011 $ |
|---|---|---|
| **Financial Assets** | | |
| Cash and cash equivalents | **91,451** | 22,742 |
| Trade and other receivables | **–** | 200,000 |
| **Total** | **91,451** | 222,742 |
| **Carrying amount of financial assets** | **91,451** | 222,742 |
| **Financial Liabilities** | | |
| Trade creditors | **76,464** | 33,285 |
| **Total** | **76,464** | 33,285 |
| **Carrying amount of financial liabilities** | **76,464** | 33,285 |

| Note 12B: Fair value of financial instruments | 2012 CARRYING AMOUNT $ | 2012 FAIR VALUE $ | 2011 CARRYING AMOUNT $ | 2011 FAIR VALUE $ |
|---|---|---|---|---|
| **Financial assets** | | | | |
| Cash and cash equivalent | **91,451** | **91,451** | 22,742 | 22,742 |
| Trade and other receivables | **–** | **–** | 200,000 | 200,000 |
| **Total** | **91,451** | **91,451** | 222,742 | 222,742 |
| **Financial liabilities** | | | | |
| Trade creditors | **76,464** | **76,464** | 33,285 | 33,285 |
| **Total** | **76,464** | **76,464** | 33,285 | 33,285 |

## Note 12C: Credit risk

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

## Note 12D: Liquidity risk

The exposure to liquidity risk is based on the notion that the Private Health Insurance Ombudsman will encounter difficulty in meeting its obligations associated with financial liabilities. This is unlikely due to appropriations funding and mechanisms available to the Ombudsman and internal policies and procedures put in place to ensure there are appropriate resources to meet its financial obligations.

## Note 12E: Market risk

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

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

# Note 13: Appropriations

*Table A: Annual appropriations ('Recoverable GST exclusive')*

| | 2012 APPROPRIATIONS | | | APPROPRIATION APPLIED IN 2012 (CURRENT AND PRIOR YEARS) $ | VARIANCE $ |
|---|---|---|---|---|---|
| | *APPROPRIATION ACT* ANNUAL APPROPRIATION $ | *FMA ACT* SECTION 31 $ | TOTAL APPROPRIATION $ | | |
| **Departmental** | | | | | |
| Ordinary annual services | **1,970,000** | **172,039** | **2,142,039** | **2,204,000** | **(61,961)** |
| **Total departmental** | **1,970,000** | **172,039** | **2,142,039** | **2,204,000** | **(61,961)** |

| | 2011 APPROPRIATIONS | | | APPROPRIATION APPLIED IN 2011 (CURRENT AND PRIOR YEARS) $ | VARIANCE $ |
|---|---|---|---|---|---|
| | *APPROPRIATION ACT* ANNUAL APPROPRIATION $ | *FMA ACT* SECTION 31 $ | TOTAL APPROPRIATION $ | | |
| **Departmental** | | | | | |
| Ordinary annual services | 1,964,000 | 69,777 | 2,033,777 | 2,066,558 | (32,781) |
| **Total departmental** | 1,964,000 | 69,777 | 2,033,777 | 2,066,558 | (32,781) |

*Table B: Departmental and administered capital budgets ('Recoverable GST exclusive')*

| | 2012 CAPITAL BUDGET APPROPRIATIONS | | CAPITAL BUDGET APPROPRIATIONS APPLIED IN 2012 (CURRENT AND PRIOR YEARS) | | VARIANCE $ |
|---|---|---|---|---|---|
| | *APPROPRIATION ACT* ANNUAL CAPITAL BUDGET $ | TOTAL CAPITAL BUDGET $ | PAYMENTS FOR NON-FINANCIAL ASSETS[2] $ | TOTAL PAYMENTS $ | |
| **Departmental** | | | | | |
| Ordinary annual services — Departmental Capital Budget[1] | **74,000** | **74,000** | **74,000** | **74,000** | **–** |

| | 2011 CAPITAL BUDGET APPROPRIATIONS | | CAPITAL BUDGET APPROPRIATIONS APPLIED IN 2011 (CURRENT AND PRIOR YEARS) | | VARIANCE $ |
|---|---|---|---|---|---|
| | *APPROPRIATION ACT* ANNUAL CAPITAL BUDGET $ | TOTAL CAPITAL BUDGET $ | PAYMENTS FOR NON-FINANCIAL ASSETS[2] $ | TOTAL PAYMENTS $ | |
| **Departmental** | | | | | |
| Ordinary annual services — Departmental Capital Budget[1] | 138,000 | 138,000 | 138,000 | 138,000 | – |

Notes:

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

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

## Note 13: Appropriations (continued)

| *Table C: Unspent departmental annual appropriations ('Recoverable GST exclusive')* | 2012 $ | 2011 $ |
|---|---|---|
| **Authority** | | |
| *2005–2006 Appropriation Act 1* | **–** | 1,514,722 |
| *2007–2008 Appropriation Act 1* | **1,742,722** | 338,000 |
| *2008–2009 Appropriation Act 1* | **140,000** | 230,000 |
| *2007–2008 Appropriation Act 3* | **–** | 34,000 |
| **Total** | **1,882,722** | 2,116,722 |

# Note 14: Reporting of Outcomes

The Private Health Insurance Ombudsman is structured to meet one outcome, namely public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting.

| Note 14A: Net cost of outcome delivery | OUTCOME 1 | |
|---|---|---|
| | 2012 $ | 2011 $ |
| **Expenses** | | |
| Departmental | **2,443,403** | 2,324,866 |
| **Total** | **2,443,403** | 2,324,866 |
| **Other own-source income** | | |
| Departmental | **188,039** | 85,777 |
| **Total** | **188,039** | 85,777 |
| **Net cost / (contribution) of outcome delivery** | **2,255,364** | 2,239,089 |

## Note 14: Reporting of Outcomes (continued)

| Note 14B: Major classes of departmental expense, income, assets and liabilities by outcome | OUTCOME 1 | |
|---|---|---|
| | 2012 $ | 2011 $ |
| **Departmental expenses** | | |
| Employee benefits | **1,236,090** | 1,154,236 |
| Supplier expenses | **847,985** | 846,770 |
| Depreciation and amortisation | **354,609** | 313,695 |
| Write-down and impairment of assets | **–** | 8,489 |
| Finance cost | **4,719** | 1,676 |
| **Total** | **2,443,403** | 2,324,866 |
| **Departmental income** | | |
| Revenue from Government | **1,896,000** | 1,826,000 |
| Other own-source revenue | **188,039** | 85,777 |
| **Total** | **2,084,039** | 1,911,777 |
| **Departmental assets** | | |
| Financial assets | **1,996,498** | 2,339,464 |
| Non-financial assets | **1,031,672** | 1,081,452 |
| **Total** | **3,028,170** | 3,420,916 |
| **Departmental liabilities** | | |
| Payables | **166,353** | 312,985 |
| Provisions | **368,056** | 328,806 |
| **Total** | **534,409** | 641,791 |

# Note 15: Net Cash Appropriation Arrangements

| | 2012 $ | 2011 $ |
|---|---|---|
| **Total comprehensive income (loss) less depreciation / amortisation expenses previously funded through revenue appropriations**[1] | **(4,755)** | 587 |
| Plus: depreciation / amortisation expenses previously funded through revenue appropriation | **(354,609)** | (313,695) |
| **Total comprehensive loss — as per the Statement of Comprehensive Income** | **(359,364)** | (313,108) |

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

# Glossary:

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

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

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

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

**Health fund**: see Health insurer.

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

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

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

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

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

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

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

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

**Medicare**: Australia's universal public healthcare system.

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

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

**Overseas Student Health Cover**: A type of health cover designed for overseas student visa holders which can be purchased from some Australian private health insurers. Overseas Visitors Health Cover: A type of health cover designed for people without Medicare benefits.

**PHIO**: Private Health Insurance Ombudsman.

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

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

**Restrictions**: Condition or services which a hospital insurance policy covers to a limited extent and which are eligible for only reduced benefits on hospital admissions. It is not sufficient to cover the cost of a private room in a public hospital or any room in a private hospital.

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

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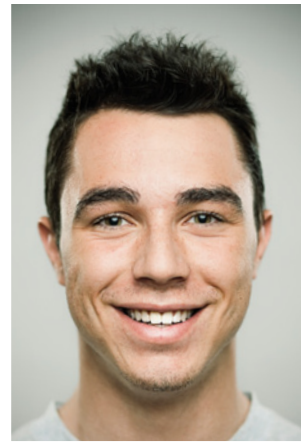
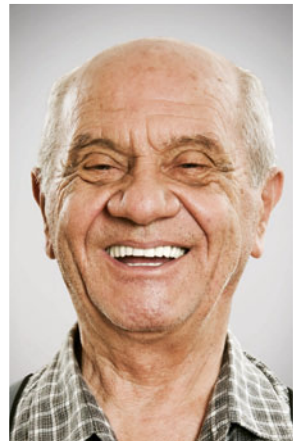
| A.5 | Index | Mandatory | 89 |
| A.5 | Glossary | Mandatory | 88 |
| A.5 | Contact officer(s) | Mandatory | 1 |
| A.5 | Internet home page address and Internet address for report | Mandatory | 1 |
| **PART 9—REVIEW BY SECRETARY** | | | |
| 9(1) | Review by departmental secretary | Mandatory | 5 |
| 9(2) | Summary of significant issues and developments | Suggested | 5 |
| 9(2) | Overview of department's performance and financial results | Suggested | 5 |
| 9(2) | Outlook for following year | Suggested | 14 |
| 9(3) | Significant issues and developments—portfolio | Portfolio departments—suggested | 5 |
| **PART 10—DEPARTMENTAL OVERVIEW** | | | |
| 10(1) | Role and functions | Mandatory | 15 |
| 10(1) | Organisational structure | Mandatory | 52 |
| 10(1) | Outcome and program structure | Mandatory | 18 |
| 10(2) | Where outcome and program structures differ from PB Statements/PAES or other portfolio statements accompanying any other additional appropriation bills (other portfolio statements), details of variation and reasons for change | Mandatory | N/A |
| 10(3) | Portfolio structure | Portfolio departments—mandatory | N/A |
| **PART 11—REPORT ON PERFORMANCE** | | | |
| 11(1) | Review of performance during the year in relation to programs and contribution to outcomes | Mandatory | 18 |
| 11(2) | Actual performance in relation to deliverables and KPIs set out in PB Statements/PAES or other portfolio statements | Mandatory | 18–19 |
| 11(2) | Where performance targets differ from the PBS/ PAES, details of both former and new targets, and reasons for the change | Mandatory | N/A |
| 11(2) | Narrative discussion and analysis of performance | Mandatory | 18–19 |
| 11(2) | Trend information | Mandatory | 18–19 |
| 11(3) | Significant changes in nature of principal functions/ services | Suggested | N/A |
| 11(3) | Performance of purchaser/provider arrangements | If applicable, suggested | N/A |

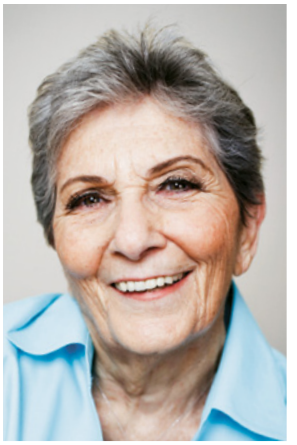
| REF | DESCRIPTION | REQUIREMENT | PAGE |
|---|---|---|---|
| **REPORT ON PERFORMANCE (CONTINUED)** | | | |
| 11(3) | Factors, events or trends influencing departmental performance | Suggested | 5–16 |
| 11(3) | Contribution of risk management in achieving objectives | Suggested | N/A |
| 11(4) | Social inclusion outcomes | If applicable, mandatory | N/A |
| 11(5) | Performance against service charter customer service standards, complaints data, and the department's response to complaints | If applicable, mandatory | 46, 54–55 |
| 11(6) | Discussion and analysis of the department's financial performance | Mandatory | 57 |
| 11(7) | Discussion of any significant changes from the prior year, from budget or anticipated to have a significant impact on future operations. | Mandatory | 57 |
| 11(8) | Agency resource statement and summary resource tables by outcomes | Mandatory | 57 |
| **PART 12—MANAGEMENT AND ACCOUNTABILITY** | | | |
| **Corporate Governance** | | | |
| 12(1) | Agency heads are required to certify that their agency comply with the Commonwealth Fraud Control Guidelines. | Mandatory | 55 |
| 12(2) | Statement of the main corporate governance practices in place | Mandatory | 53 |
| 12(3) | Names of the senior executive and their responsibilities | Suggested | 52 |
| 12(3) | Senior management committees and their roles | Suggested | N/A |
| 12(3) | Corporate and operational planning and associated performance reporting and review | Suggested | N/A |
| 12(3) | Approach adopted to identifying areas of significant financial or operational risk | Suggested | N/A |
| 12(3) | Policy and practices on the establishment and maintenance of appropriate ethical standards | Suggested | N/A |
| 12(3) | How nature and amount of remuneration for SES officers is determined | Suggested | N/A |
| **External Scrutiny** | | | |
| 12(4) | Significant developments in external scrutiny | Mandatory | 55 |
| 12(4) | Judicial decisions and decisions of administrative tribunals | Mandatory | 55 |
| 12(4) | Reports by the Auditor-General, a Parliamentary Committee or the Commonwealth Ombudsman | Mandatory | 55 |
| **Management of Human Resources** | | | |
| 12(5) | Assessment of effectiveness in managing and developing human resources to achieve departmental objectives | Mandatory | 52–53 |
| 12(6) | Workforce planning, staff turnover and retention | Suggested | 52–53 |
| 12(6) | Impact and features of enterprise or collective agreements, individual flexibility arrangements (IFAs), determinations, common law contracts and AWAs | Suggested | 52 |
| 12(6) | Training and development undertaken and its impact | Suggested | 53 |
| 12(6) | Work health and safety performance | Suggested | 55 |
| 12(6) | Productivity gains | Suggested | N/A |
| 12(7) | Statistics on staffing | Mandatory | 52–53 |
| 12(8) | Enterprise or collective agreements, IFAs, determinations, common law contracts and AWAs | Mandatory | 52 |
| 12(9), B | Performance pay | Mandatory | 53 |

| REF | DESCRIPTION | REQUIREMENT | PAGE |
|---|---|---|---|
| **MANAGEMENT AND ACCOUNTABILITY (CONTINUED)** | | | |
| **Assets** | | | |
| 12(10)–(11) | Assessment of effectiveness of assets management | If applicable, mandatory | N/A |
| 12(12) | Assessment of purchasing against core policies and principles | Mandatory | N/A |
| 12(13)–(24) | The annual report must include a summary statement detailing the number of new consultancy services contracts let during the year; the total actual expenditure on all new consultancy contracts let during the year (inclusive of GST); the number of ongoing consultancy contracts that were active in the reporting year; and the total actual expenditure in the reporting year on the ongoing consultancy contracts (inclusive of GST). The annual report must include a statement noting that information on contracts and consultancies is available through the AusTender website. | Mandatory | 53–54 |
| 12(25) | Absence of provisions in contracts allowing access by the Auditor-General | Mandatory | N/A |
| **Exempt** | | | |
| 12(26) | Contracts exempt from the AusTender | Mandatory | N/A |
| **PART 13—FINANCIAL STATEMENTS** | | | |
| 13 | Financial Statements | Mandatory | 57 |
| **PART 14—OTHER MANDATORY INFORMATION** | | | |
| 14(1), C.1 | Work health and safety (Schedule 2, Part 4 of the *Work Health and Safety Act 2011*) | Mandatory | 55 |
| 14(1), C.2 | Advertising and Market Research (Section 311A of the *Commonwealth Electoral Act 1918*) and statement on advertising campaigns | Mandatory | 55 |
| 14(1), C.3 | Ecologically sustainable development and environmental performance (Section 516A of the *Environment Protection and Biodiversity Conservation Act 1999*) | Mandatory | 55 |
| 14(1) | Compliance with the agency's obligations under the *Carer Recognition Act 2010* | If applicable, mandatory | N/A |
| 14(2), D.1 | Grant programs | Mandatory | 55 |
| 14(3), D.2 | Disability reporting – explicit and transparent reference to agency level information available through other reporting mechanisms | Mandatory | 55 |
| 14(4), D.3 | Information Publication Scheme statement | Mandatory | 56 |
| 14(5) | Correction of material errors in previous annual report | If applicable, mandatory | N/A |
| F | List of Requirements | Mandatory | 89 |

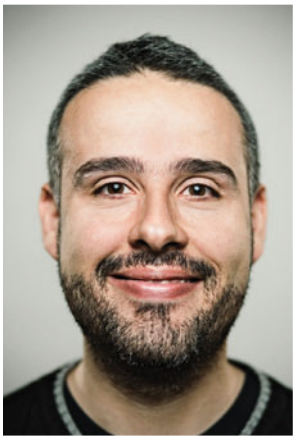
# Notes







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



Australian Government

Private Health Insurance Ombudsman