PRIVATE HEALTH INSURANCE
COMPLAINTS COMMISSIONER

Quarterly Bulletin Issue 3
1 January - 31 March 1997

Welcome to the third issue of our Quarterly Bulletin, which I hope will keep you informed of our activities and highlight trends and important developments at the PHICC. As well as providing a statistical overview of the Complaints Commissioner's operations for the period 1 January 1997 to 31 March 1997, I have included comparisons with the previous quarters and the previous reporting year.

The number of *complaints* received in the March quarter rose sharply to 364, compared with 264 previously. This represents an increase of 38%. Sixty percent of complaints were resolved within a week, up from around 50% last time and 45% in the previous quarter.

The number of *inquiries* rose from 232 to 340 in the March quarter, an increase of 47% from the previous quarter.

The increase in the number of complaints and inquiries received by the Commissioner is in line with expectations of a rise during 1997, as health funds are now required to include reference to the Complaints Commissioner in their brochures.

During the March quarter, the vast majority of complaints and inquiries were again from health fund members. The largest single specific type of complaint was the cost of premiums. Complaints about this issue were double the number received during the December quarter. This follows the announcement of premium increases by many funds during the past 6-9 months.

A number of complaints raised the issue of portability and agreement hospitals. Members are concerned that they face waiting periods for hospitalisation at their preferred hospital when they transfer from a fund which does not have a current contract with that hospital to a fund which does.

Other problems for members during the March quarter included the following perennials:

- communication, especially oral advice
- pre-existing ailments
- lack of notice about fund rule changes.

We are currently designing a new data base which will classify approaches to the Complaints Commissioner in a new way, into problems, grievances and complaints, as well as inquiries.

The Complaints Commissioner has been given jurisdiction to deal with complaints concerning the health funds' management of the Federal Government's new Private Health Insurance Incentives Scheme. The Commissioner will not, however, be dealing with complaints about tax rebates.

We are happy to take on-board your thoughts and ideas for future issues of the Quarterly Bulletin. Comments can be directed to Matthew Blackmore, Director, Policy and Customer Service on (02) 9261 5855.

To be included on our mailing list please telephone Kathryn Murray on the same number.

Mary Perrett
COMPLAINTS COMMISSIONER
May 1997

Background

The Complaints Commissioner provides consumers with an independent means of resolving problems with their health funds. The office opened for business on 1 March 1996.

PHICC's key features include:

- being easily accessible to those who are privately insured
- being driven by the needs of its customers
- being independent of Government and health funds, but working co-operatively with both
- providing high quality information and advice to people with, or who are seeking to take out, private health insurance
- being effective at resolving disputes.

A Complaints Hotline (1800 640 695) has been set up to resolve complaints as efficiently and effectively as possible. The Commissioner does not require complaints to be in writing before they are investigated.

Some callers do not want to make a complaint but want further information about private health insurance generally or about their own health insurance fund. These calls are regarded as "inquiries". Callers with complaints about private health insurance regulatory or policy issues are also recorded as inquiries.

Complaints can be made by health fund members, hospitals, doctors, some dentists, health funds and people acting on behalf of any of the above.

The Complaints Commissioner does not have the power to enforce her recommendations and relies on the health funds, hospitals, day surgery centres, doctors and dentists to implement the remedies that are proposed.

Further information about the Complaints Commissioner is available in a variety of community languages by telephoning Kathryn Murray on (02) 9261 5855.

The way we report

The information presented in this Bulletin covers the following:

- inquiries
- complaints
- actions taken by the Complaints Commissioner
- issues
- who is complained about (the “object” of a complaint)
- outcomes.

Inquiries
Any approach to the Commissioner’s office that does not meet the statutory definition of a complaint contained in the *National Health Act 1953*, is recorded as an inquiry.

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

Complaints
An approach to the Commissioner’s office is recorded as a complaint if it meets the complaint criteria contained in the *National Health Act 1953*. A complaint must be:

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

Most complaints are made by fund members about their health fund. Complaints can also be made by health fund members about hospitals or doctors, by hospitals about health funds or doctors, by health funds about other funds, hospitals or doctors, and by doctors about health funds or hospitals.

Actions taken by the Commissioner
Complaints may be dealt with in one of three ways:

- by referring the complainant back to the health fund, hospital or doctor (where, in the view of the Complaints Commissioner, the complainant has not made an adequate attempt to resolve the problem)

- by staff of the Complaints Commissioner dealing with the complainant’s grievance directly by providing additional information or a clearer explanation

- by contacting the health fund, hospital or doctor about the matter. This may be done by telephone or in writing.

Issues

An approach may raise more than one issue. The issues raised by inquiries and complaints are recorded separately. For example:

- an **inquiry** may be made by a consumer who is not a health fund member complaining about the cost of a recent visit to the doctor or by a health fund member wanting information about Medicare. The number of issues reported by the Complaints Commissioner for the number of inquiries received will always be equal to or greater than the number of inquiries. For example, the Commissioner received 340 inquiries about 344 issues in the March quarter 1997.

- a **complaint** may be made by a health fund member about the quality of information provided over the telephone by their fund **and** a problem with the benefit paid for a subsequent hospitalization. (In this case the two issues recorded will be Information - oral and Benefit - amount.)

The number of issues reported by the Complaints Commissioner for the number of complaints received will always be equal to or greater than the number of complaints. For example, in the March quarter 1997, the Commissioner received 364 complaints about 416 issues.

Who is complained about?
A complaint may be about more than one "object". For example, a complaint may be about a health fund, a hospital and two doctors. Objects are not recorded for inquiries.

Outcomes
The Commissioner records an outcome for each issue. Outcomes are recorded separately for inquiries and complaints.

Outcomes may range from providing complainants with additional information or an explanation, the fund providing an additional payment or reversing a previous decision (eg. where a decision to deny continuity of membership is reversed), referral to a health fund or other agency, or where a hospital or doctor's account is written off.

This means that the number of **complaints**, the number of **issues** and the number of **objects** is rarely the same.

The number of **outcomes** and **issues** will always be the same and the number of **objects** and **actions** will always be the same.

Complaints

The number of complaints received this quarter increased by 38% from the previous quarter (364 complaints compared with 264 last time). This may be due to the increasing awareness of the existence of the Complaints Commissioner, now that funds are required to include a reference to the office in their brochures.

Figure 1: Complaints received and closed by month

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Who Complains?

Most complaints in the March quarter were made by members of health funds (97% in the March quarter compared with 98.5% in the December quarter). Complaints were also made by hospitals (1% in the March quarter compared with 1.5% in the December quarter).

How do people complain?

The majority of complaints in the March quarter were made by telephone (91%, with 85.8% in the December quarter and 81% in the previous quarter).

Other complaint vehicles included letter (8%, compared with 12.4% and 16% respectively in previous quarters), fax (1% in the March quarter, compared with 1.5% in the two previous quarters), and personal visit and Ministerial letter (0.3% each which is similar to the December quarter).

The Complaints Commissioner encourages people to telephone with details of their complaint. It is not necessary to lodge a complaint in writing.

Where do complainant's live?

Most complaints were received from NSW, followed by Queensland and Victoria. In Queensland, the number of complaints received in the March quarter was more than double the number for the previous quarter (66 complaints compared with 28 in the December quarter). NSW and South Australia experienced a slight increase in complaints. In Victoria, Western Australia, Tasmania, Northern Territory and ACT, the number of complaints received remained fairly steady.

Figure 2: Complaints received by State/Territory

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Who is complained about?

Complaints received by the Complaints Commissioner can involve one or more of the following: a health fund, hospital, doctor or dentist. The following table provides information about who was complained about and how the complaint was dealt with. The majority of complaints involved health funds, with almost half the complaints referred to the relevant fund for investigation

What action is taken?

Where a complainant has not attempted to resolve their problem with the health fund, hospital, doctor or dentist, the complainant is usually referred back to the service provider on the spot over the telephone, so that the service provider has an opportunity to resolve the problem before the intervention of the Complaints Commissioner. These are recorded as complainant directed back to fund or service provider in Figure 3.

Some problems can be resolved by staff of the Complaints Commissioner without the need to directly contact the health fund, hospital, doctor or dentist concerned. These are shown in Figure 3 as complainant dealt with in-house.

Other complaints are referred to the health fund, hospital, doctor or dentist for investigation and/or comment. This may be done in writing or by telephone.

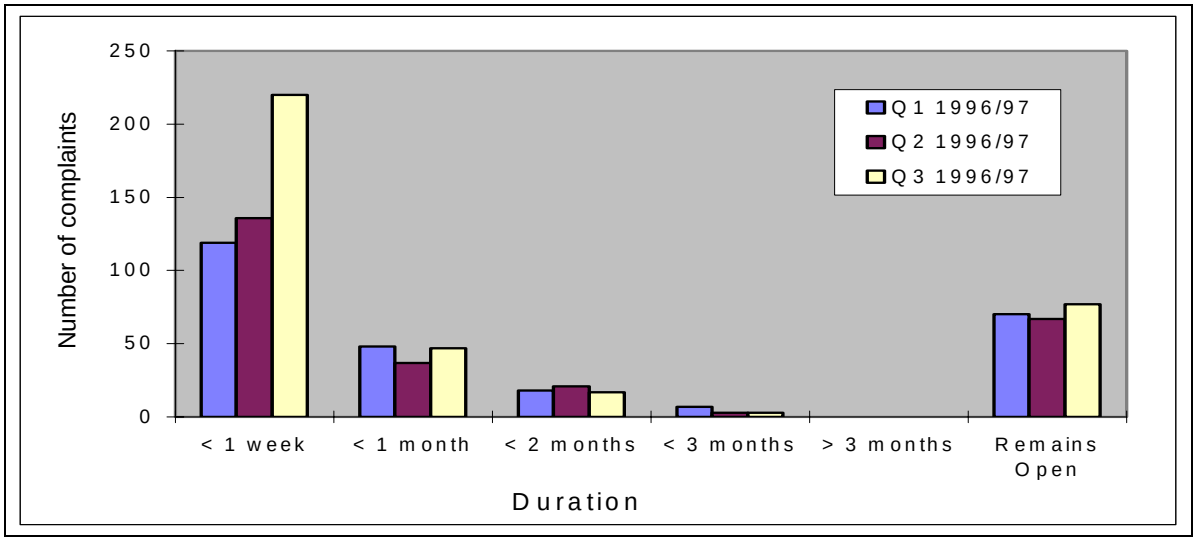
Figure 3: Object of complaint & type of action taken - July 1996 to March 1997

	Month 1996-97								
Action taken by Complaints Commisisoner	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Complainant directed back to fund	9	8	5	13	12	19	22	35	32
Complainant dealt with in house	22	43	20	38	18	18	33	43	28
Complaint referred to fund for investigation	41	44	56	44	47	41	56	38	59
Total complaints about funds	*72*	*95*	*81*	*95*	*77*	*78*	*111*	*116*	*119*
Complainant directed back to hospital	0	1	1	1	0	1	1	1	3
Complainant dealt with in house	2	2	1	2	3	3	0	1	1
Complaint referred to hospital for comment	7	5	2	1	2	4	10	5	2
Total complaints about hospitals	*9*	*8*	*4*	*4*	*5*	*8*	*11*	*7*	*6*
Complainant directed back to doctor/dentist	0	0	2	1	1	0	0	4	2
Complainant dealt with in house	1	4	1	0	0	3	3	3	1
Complaint referred to doctor /dentist for comment	1	0	0	0	0	0	1	0	1
Total complaints about doctors	*2*	*4*	*3*	*1*	*1*	*3*	*4*	*7*	*4*

Time taken to resolve complaints

Around 60% of complaints received this quarter were resolved within a week compared with around half in the last quarter.

Figure 4: Time taken to resolve complaints



What issues are complained about?

The Commissioner's office dealt with 416 issues in the March quarter.

Most complaints concern disputes about benefits (125 issues). This includes concerns about the amount of benefit or confusion about whether the service is included under the complainant's level of cover.

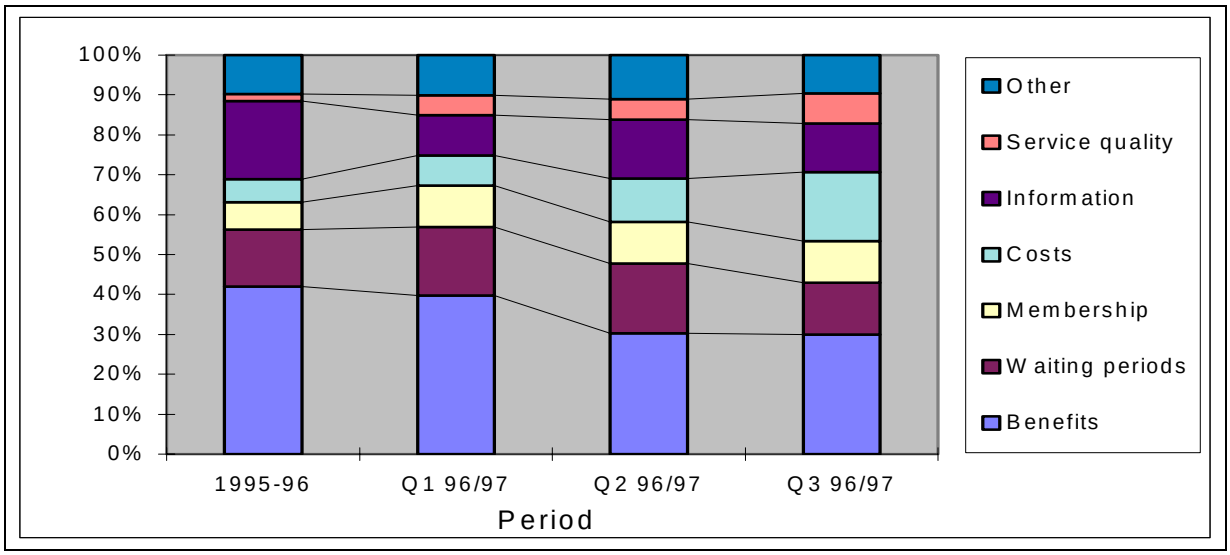
During the March quarter, cost was the second most complained about general issue (72 issues); most of these complaints were specifically about premium increases (61

issues). This follows the announcement of premium increases by many funds during the past 6 - 9 months.

Waiting periods are the third most complained about general issue (54 issues). Most of these complaints are about the application of the pre-existing ailment rule (38 issues) and the waiting period for obstetric benefits.

There were 416 issues dealt with in the 364 complaints received during the quarter. A complete summary of the issues complained about appears on the back page of this issue of the Bulletin.

Figure 5: Issues complained about



What were the outcomes?

23% of matters were referred directly back to the object of complaint, because there had been no attempt to resolve the problem with the fund, hospital, doctor or dentist.

The rest of the complaints that were closed were dealt with in the following way:

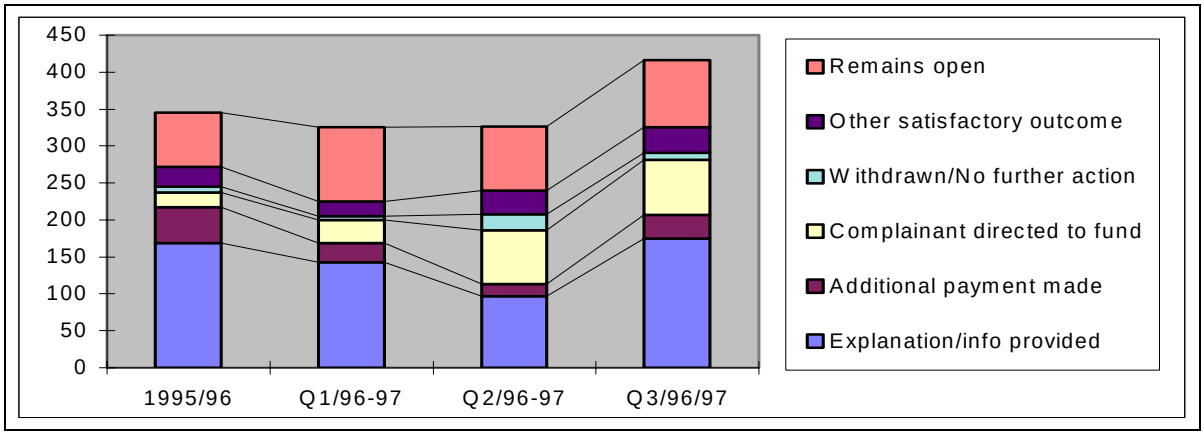
- providing complainants with additional information or an explanation of their problem, including confirmation of advice originally provided by a health fund (54% of complaint issues were dealt with this way in the March quarter)

- the fund providing an additional payment or the hospital, doctor or dentist writing off all or part of an account (10% of complaint issues)

- the fund reversing its previous decision eg. to deny continuity of membership, or where a hospital or medical account is written off (10% of complaint issues).

Some 3% of complaint issues are withdrawn by complainants or are closed by the Complaints Commissioner where the complainant fails to provide additional information requested by the Commissioner, is out of jurisdiction or no further action is warranted.

Figure 6: Outcomes for complaints received



Inquiries

The Complaints Commissioner received 340 inquiries about 344 issues in the March quarter 1997, a rise of 47%. The Commissioner received 232 inquiries (242 issues) in the December quarter 1996 and 267 inquiries (294 issues) in the September quarter 1996.

Most inquiries are about general health service and health insurance issues.

16% of inquiries came from NSW, followed by 12% from Queensland, 10% from each of Victoria and Western Australia and 6% from South Australia. In 43% of inquiries, callers did not identify the State/Territory of their residence.

Most complaints were resolved by providing additional information or an explanation, including providing a brochure (74%). 13% of inquiries were referred to another agency and 9% were referred to a health fund. The remaining 4% of inquiries required no action on the part of the Complaints Commissioner or were withdrawn before the inquiry could be dealt with.

Case Studies

Cost
Complaints about premium increases were the largest single specific type of complaint from health fund members in the March quarter. Since most health funds announced premium increases during the past 6-9 months, it was not surprising that the number of complaints concerning this issue was high.

Case history
One health fund member rang to complain about an increase in his premium, which he said was the “last straw”. The Complaints Commissioner advised that the member might be able to take steps to reduce the cost of his premium, either by

accepting an excess or considering a different level of cover that may be better tailored to suit his needs and expectations.

The Commissioner also informed the member about the Government's Private Health Insurance Incentives Scheme, which will commence on 1 July 1997, providing either a tax rebate or a discount from their health fund on the cost of their health insurance.

The Commissioner also noted the comments of the Productivity Commission about the reasons driving up health insurance premium increases.

Pre-existing ailments

Complaints about pre-existing ailments continued to be high on the list of the most complained about issues during the March quarter (37 issues). In some cases, general practitioners and specialists did not appear to be aware of how the rules about pre-existing ailments are applied by health funds.

Case history

A health fund member was hospitalized for endometriosis three months after joining a fund, and her claim was rejected as a pre-existing ailment. Her general practitioner stated that although the health fund member had had signs and symptoms for a number of years, in his opinion it could not be classified as a pre-existing ailment because endometriosis had not been diagnosed.

Staff of the Complaints Commissioner advised the member that diagnosis was not the issue in cases involving application of the pre-existing ailment rule, and because there was medical evidence of signs and symptoms of the problem in the six months before she joined the fund, the fund correctly rejected the claim.

After explaining the PEA rule, and acknowledging that many health fund members and their doctors do not fully understand its application, the member was satisfied with the Commissioner's explanation of why her fund had rejected her claim.

Portability of benefits between funds
The Commissioner has received a number of complaints about the portability of private health insurance, where members are seeking to transfer out of a fund which no longer has a contract with their local or preferred hospital to one which does.

Case history
A member who required treatment for a kidney disorder was referred to a specialist who only practices at one particular private hospital. When the member called his fund to check whether he would be covered for the treatment, the fund told him that its contract with that hospital had lapsed and therefore he would not be eligible for full benefits on the cost of the treatment. The fund agreed to give further consideration to his problem and contact him again in a few days' time.

The member then rang another fund which had a contract with the hospital to see if he could transfer his membership to them, and was told he would have to serve a twelve month waiting period before he could receive full benefits.

The member rang the Complaints Commissioner, who offered to take the matter up with his fund if the two funds were unable to come up with an acceptable solution to resolve his dilemma.

In the meantime, the member's existing fund renewed its contract with the hospital in question, and the member was once again covered for his treatment. While this solved this particular member's problem, it highlighted an issue which is likely to arise again as funds move increasingly towards contracts with individual hospitals.

The Complaints Commissioner believes that health fund members must be able to plan for procedures at the hospital of their choice (or their doctor's choice). If their fund does not contract with that hospital, they need to be able to transfer to one which does, without the imposition of lengthy waiting periods. In theory, the law already allows members to do this, but because they must transfer to a cover offering equal benefits with the new fund to avoid waiting periods, in practice, there can be a "grey area" over the definition of "equal benefits".

Accordingly, the Commissioner has written to the Department of Health and Family Services, as well as the Australian Health Industry Association, Health Insurance Restricted Members' Association and a number of individual funds regarding her concerns about this issue.

It is hoped that a solution can be found which enables health fund members to transfer to another fund without the imposition of waiting periods, if their current fund does not have a contract with the hospital they wish to use.

Figure 7: What issues are complained about?

Complaints received by issue												
	Sept Qtr 1996/97				Dec Qtr 1996/97				Mar Qtr 1996/97			
Issue	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***
Benefits												
Extent of cover			54	41.9%			50	50.5%			56	44.8%
Amount			16	12.4%			11	11.1%			30	24.0%
Delay			10	7.8%			1	1.0%			2	1.6%
Excess			8	6.2%			7	7.1%			6	4.8%
Limit reached			9	7.0%			5	5.1%			6	4.8%
Gap payment			17	13.2%			15	15.2%			12	9.6%
Out of State			1	0.8%			1	1.0%			0	0.0%
Other			14	10.9%			9	9.1%			13	10.4%
Subtotal Benefits	***129***	***39.7%***		*100.0%*	***99***	***30.3%***		*100.0%*	***125***	***30.0%***		*100.0%*
Information												
Oral			15	45.5%			30	62.5%			27	52.9%
Printed			10	30.3%			11	22.9%			11	21.6%
Radio/TV			3	9.1%			1	2.1%			6	11.8%
Written			2	6.1%			3	6.3%			3	5.9%
Lack of notification			3	9.1%			3	6.3%			4	7.8%
Subtotal Information	***33***	***10.2%***		*100.0%*	***48***	***14.7%***		*100.0%*	***51***	***12.3%***		*100.0%*
Waiting Periods												
General			7	12.5%			2	3.5%			5	9.3%
Obstetrics			9	16.1%			9	15.8%			11	20.4%
Pre existing ailment			40	71.4%			46	80.7%			38	70.4%
Subtotal Waiting Periods	***56***	***17.2%***		*100.0%*	***57***	***17.4%***		*100.0%*	***54***	***13.0%***		*100.0%*
Membership issues												
Who is the contributor?			8	23.5%			6	17.6%			7	16.3%
Arrears			3	8.8%			3	8.8%			1	2.3%
Cancellation/suspension			22	64.7%			20	58.8%			18	41.9%
Transfer/continuity			1	2.9%			5	14.7%			17	39.5%
Subtotal Membership	***34***	***10.5%***		*100.0%*	***34***	***10.4%***		*100.0%*	***43***	***10.3%***		*100.0%*
Costs												
Premiums			17	70.8%			30	83.3%			61	84.7%
Fees and services			7	29.2%			6	16.7%			9	12.5%
Dual charging			0	0.0%			0	0.0%			2	2.8%
Subtotal Costs	***24***	***7.4%***		*100.0%*	***36***	***11.0%***		*100.0%*	***72***	***17.3%***		*100.0%*
Other specific issues												
Acute Care Certificates			1	2.2%			1	2.2%			2	3.1%
Discrimination			3	6.5%			1	2.2%			5	7.7%
Language & culture			1	2.2%			0	0.0%			0	0.0%
Quality of service			16	34.8%			17	37.0%			31	47.7%
Private patient election			2	4.3%			2	4.3%			3	4.6%
Contracts			6	13.0%			7	15.2%			3	4.6%
Confidentiality			3	6.5%			1	2.2%			1	1.5%
Premium payments			5	10.9%			10	21.7%			15	23.1%
Other complaint NEC			9	19.6%			7	15.2%			5	7.7%
Subtotal Other	***46***	***14.2%***		*100.0%*	***46***	***14.1%***		*100.0%*	***65***	***15.6%***		*100.0%*
Fund Rule Changes	***3***	***0.9%***			***7***	***2.1%***			***6***	***1.4%***		
TOTAL	325	100%			327	100%			416	100%		