PRIVATE HEALTH INSURANCE COMPLAINTS COMMISSIONER

Annual Report

1997

Contact Details

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

Street and postal address

Private Health Insurance
Complaints Commissioner

Suite 1201, Level 12
St Martins Tower,
31 Market Street
SYDNEY NSW 2000

Telephone, fax and e-mail

Inquiries and complaints
in Sydney (02) 9261 5944

Inquiries and complaints
all other areas 1800 640 695 (Freecall)

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

Deaf, hearing or speech impaired:
13 25 44 (National Relay Service)

E-mail: info@phicc.org.au

Home Page:
http://www.phicc.org.au

Administration: (02) 9261 5855

Facsimile: (02) 9261 5937

Hours of operation

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

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

Information for Senators and Members is available from Mary Perrett, Complaints Commissioner, at the above telephone and facsimile numbers.

ISSN 1327-5305

PRIVATE HEALTH INSURANCE
COMPLAINTS COMMISSIONER

The Hon Dr Michael Wooldridge MP
Minister for Health and Family Services
Parliament House
CANBERRA ACT 2600

Dear Minister

Section 63M of the Audit Act 1901, which applies to the Private Health Insurance Complaints Commissioner because of section 82ZVAof the National Health Act 1953, requires me to furnish a report of the Commissioner's operations for each financial year.

I have pleasure in submitting to you for presentation to the Parliament my second Annual Report as the Private Health Insurance Complaints Commissioner, for the period 1 July 1996 to 30 June 1997.

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

Yours sincerely

Mary Perrett
Complaints Commissioner

18 September 1997

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Commissioner's Overview

1996-97 was the first full year of the Complaints Commissioner's operation and a very eventful year for the Commissioner's office as well as the health insurance industry. The number of complaints and inquiries steadily increased as more people became aware of the Complaints Commissioner's existence.

During the year, commencing with the official launch of the office on 29 July 1996, we worked hard to increase public awareness of the office. Our strategies included media coverage associated with the launch, wide distribution of two brochures about the Complaints Commissioner's function and operations and advertisements in newspapers in all States and the Northern Territory, including the Land Newspaper. The Minister's direction to health funds requiring them to include in their general brochure advice about the Complaints Commissioner was the most important part of the strategy for increasing awareness.

Other priorities for the year included:

- developing an appropriate feedback mechanism for funds and the Government about the Complaints Commissioner's operations and the problems people are experiencing
- preparing submissions to the Senate Community Affairs Legislation Committee and the Productivity Commission regarding their inquiries into health insurance
- consulting with key stakeholders about the need to strengthen the Complaints Commissioner's powers to ensure it is an effective dispute resolution body
- refining policy and guidelines about the handling of complaints and inquiries and the management of the office
- preparing specifications for a computerised complaints management and reporting system.

Health fund contracting practices with private hospitals became more sophisticated as the year progressed. For some segments of the private hospital industry, the fear that utilisation and profits could be severely affected by hospital purchaser provider agreements became a reality.

Towards the end of the year, consumer groups and some health fund members began to express concern about whether the new approach of funds contracting with only some hospitals would have an unfair impact on health fund members. Would members have reasonable access to private hospitals of their choice, according to their needs? The main questions are whether the anticipated benefits of reduced premiums will outweigh the inconvenience of restricted access and what members may regard as reasonable access.

It is more important than ever that members get value for money in health insurance. This is because of the changes to the health insurance industry that have occurred and been foreshadowed in the last year and the "carrot and stick" approach adopted by the Government to encourage increased membership. Privately insured patients do not believe they get good value when they find that after paying increasing amounts for health insurance, they are not covered for treatment or their benefits are less than they expect. They particularly object to paying extra amounts for hospital related services that public patients get for free.

Many of the problems my office deals with arise out of ignorance. People tend to be ignorant about their own cover and health insurance in general. While this can be the members' fault, it is often due to poor communication on the part of health funds. In my view, it is crucial that the heath insurance industry works out how to communicate effectively and fairly with health fund members and potential members.

In the year ahead the two most significant objectives for my office are to have a greater impact in improving problems people face with their health insurance arrangements and to improve the service we provide to our complainants and other stakeholders.

To meet the first challenge, changes to the legislation are required to strengthen the role and function of the Complaints Commissioner. Installation of a more sophisticated computerised complaints

management and reporting system, together with improvements to our reporting arrangements will assist greatly. Guidelines for health insurance advertising, which the ACCC and my office are working on, should reduce both the scope for confusion about health insurance products and the creation of false expectations. To equip us to meet the second challenge I have commissioned a "customer satisfaction" survey which will identify areas for improvement.

Mary Perrett

Complaints Commissioner

INTRODUCTION

The Private Health Insurance Complaints Commissioner, referred to in this Annual Report as the Complaints Commissioner, is an independent statutory corporation established by the Health Legislation (Private Health Insurance Reform) Amendment Act 1995 (the 1995 reform legislation) which amended certain parts of the National Health Act 1953.

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

FUNCTIONS

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

- deal with complaints and conduct investigations
- publish aggregate data about complaints
- make recommendations to the Minister and Department of Health and Family Services
- make available and publicise the existence of the Private Patients Hospital Charter
- promote an understanding of the Complaints Commissioner's functions.

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

WHO CAN MAKE A COMPLAINT?

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

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

WHAT CAN THE COMMISSIONER DO WITH A COMPLAINT?

The Complaints Commissioner is able to deal with complaints by:

- referring the complaint to the health fund with a request to report to the Complaints Commissioner with its findings and any action it proposes to take. If the Complaints Commissioner is not satisfied with the fund's explanation or proposed action, the Complaints Commissioner may investigate the complaint
- referring the complaint to the Australian Competition and Consumer Commission
- referring the complaint to any other appropriate body.

At the request of the complainant, the Complaints Commissioner is able to conciliate complaints.

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

WHAT HAPPENS AT THE END OF A COMPLAINT OR INVESTIGATION?

The Complaints Commissioner is able to recommend that:

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

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

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

These include if the complaint is trivial, vexatious or frivolous, if the complainant has not taken reasonable steps to negotiate a settlement or if another organisation is dealing adequately with the complaint.

Back row: Matthew Blackmore, Jennifer Blyton, Sasha Andrews, Janelle Metry, Samantha Gavel, Steven Meadows
Front row: Kathryn Gilhooley, Mary Perrett, Patricia Sammut

HOW STAFF RESOLVE COMPLAINTS

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

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

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

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

Service Standards

This chapter sets out what we do, the service standards you can expect and the steps you may take if these standards are not met. A brochure (Service Charter) is available which provides this information.

WHAT WE DO

- provide a telephone inquiry service about private health insurance
- deal with health insurance complaints that are about health funds, hospitals, doctors and some dentists
- conduct investigations into the practices and procedures of health funds
- publish information about complaints
- provide information to the Department and Minister about the regulatory and industry practices of health funds.

OUR CUSTOMERS

- people with private health insurance
- people wanting information about private health insurance
- health funds, hospitals, doctors and some dentists
- the Minister for Health, Government and Parliament.

OUR VALUES

- we value openness, effectiveness, efficiency, professionalism and integrity in the way we perform our work
- we are driven by the needs of our customers
- we deal with complaints independently of the health funds, hospitals and government
- we will be helpful and friendly
- we will treat you with honesty and courtesy.

OUR COMMITMENT TO OUR CUSTOMERS

- we will answer your questions and inquiries promptly
- we will work co-operatively with you to solve your problems
- we will be objective in our dealings with you
- we will give you reasons for our decisions and recommendations.

OUR SERVICE DELIVERY STANDARDS

Accessibility

- we will be contactable in person and by telephone during normal business hours
- our switchboard and Complaints Hotline will be answered from 8.30 am - 5.00 pm each business day
- we will follow up any telephone messages within 24 hours
- wheelchair access to our office is available
- we have telephone access available for our customers from a non-English speaking background and with impaired hearing

Timeliness

- we will acknowledge all written complaints by telephone or in writing within 5 working days of receipt
- responses will be provided within 21 days, but where this is not possible, we will keep you informed of progress
- where it is not appropriate for us to help you, we will refer you to the appropriate organisation.

Courtesy and sensitivity

- we will identify ourselves to you over the telephone and at the counter
- our letters will have a contact name and telephone number on them
- we will respect your right to privacy and confidentiality, and ensure the confidentiality of personal information
- if we need to seek access to your medical records, we will seek your permission beforehand
- we will seek your permission before referring your complaint to a health fund or other organisation.

Advice

- we will provide you with high quality information and advice - by letter, by fax, over the telephone, in person, by e-mail
- we will provide our information and guidelines in plain language.

IF WE FAIL TO MEET THESE STANDARDS

- first try to sort it out with the staff member you're dealing with
- if you're not satisfied, ask to speak with the staff member's manager
- if you are still not satisfied, or if the above suggestions are not appropriate in the circumstances, write or telephone the Complaints Commissioner.

The Complaints Commissioner will respond to your complaint within 10 days of receipt.

We will advise you of other avenues to take your complaint if you are still not satisfied after receiving the Complaints Commissioner's response.

Matthew Blackmore, Director, Policy and Customer Service
Samantha Gavel, Policy and Project Officer

YOUR SUGGESTIONS

- we welcome your comments and feedback. Please write or telephone with your suggestions and comments
- we will evaluate our performance regularly, including surveys of our customers
- this charter will be evaluated in June 1999.

OTHER INFORMATION AVAILABLE FROM THE COMPLAINTS COMMISSIONER

- Can we help with your health insurance complaint?
- Our Mission
- 10 Golden Rules of private health insurance
- Private Patients Hospital Charter
- *Insure? Not Sure? Your quick guide to private health insurance*
- Service Charter

INTRODUCTION

The Complaints Commissioner received 2401 approaches from health fund members, hospitals, doctors, dentists and health funds in the reporting period 1 July 1996 to 30 June 1997. This was made up of 1211 complaints and 1190 inquiries. Figure 1 shows the number of complaints received each month in 1996/97, compared with the first four months of operation in 1995/96. Figure 2 shows the number of inquiries received each month for the same period. Information about the way complaints and inquiries are defined is outlined in an Appendix called "The way we report".

COMPLAINTS

All approaches to the office are recorded as Inquiries or 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), a health fund or someone acting on their behalf
- made about a health fund, hospital, doctor (including some dentists).

Complaints are further categorised by the way they are dealt with:

- Problems: Dealt with by referring the complainant back to the health fund, hospital, doctor or dentist. This occurs where, in the view of the Complaints Commissioner, the complainant has not made an adequate attempt to resolve the problem and/or the Commissioner is able to suggest to the complainant other ways to approach the problem with the health fund, hospital, doctor or dentist.
- Grievances: Dealt with by staff of the Complaints Commissioner dealing with the complainant's grievance directly by providing additional information or a clearer explanation.
- Disputes: Dealt with by contacting the health fund, hospital, doctor or dentist about the matter. This may be done by telephone or in writing.

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

Workload

The office received 1211 complaints in 1996/97 (an average of 101 complaints per month), compared with 244 complaints received in the four months of operation in 1995/96 (an average of 61 complaints per month).

The office finalised 1143 complaints during the year (an average of 95 per month), compared with 194 complaints finalised in the four months of operation in 1995/96 (an average 49 complaints per month). The number of complaints received and finalised each month is shown in Figure 3.

Figure 1: Complaints received

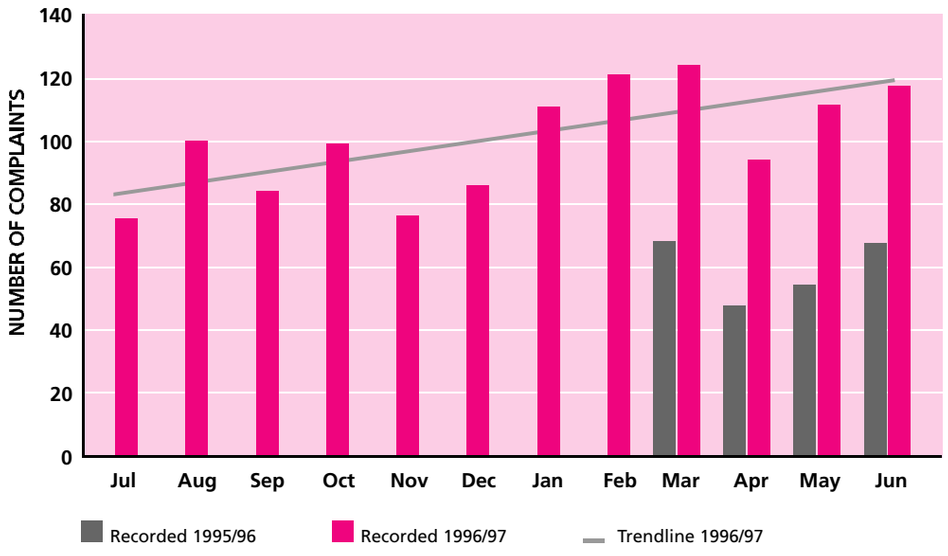
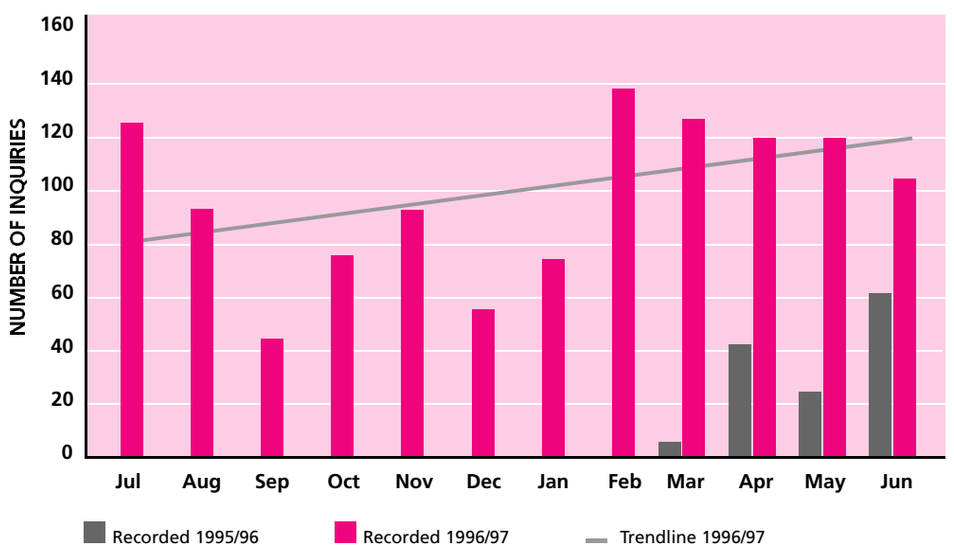


Figure 2: Inquiries received



Issues

Most complaints received by the Complaints Commissioner concerned the payment of benefits (33% compared with 43% in 1995/96), followed by complaints about waiting periods, including complaints about application of the pre-existing ailment rule (16% compared with 14% in the previous year). Complaints about information accounted for 12% of all complaints received (19% previously) and these dealt with issues such as misleading information, inadequate information and the lack of appropriate information.

Complaints about membership accounted for 11% of complaints received (7% previously) and included concerns about the cancellation or suspension of a health fund membership. Complaints about costs accounted for 11% of all complaints received (6% previously) and were overwhelmingly made about the cost of health fund premiums. Some cost related complaints concerned dual charging by some health providers.

The remaining 17% of complaints (12% previously) dealt with other issues such as the quality of service from a health fund, premium payment difficulties, private patient elections in public hospitals and other complaints not elsewhere counted (NEC).

Graphs of this information are provided in Figures 4-10.

Figure 3: Complaints by Month

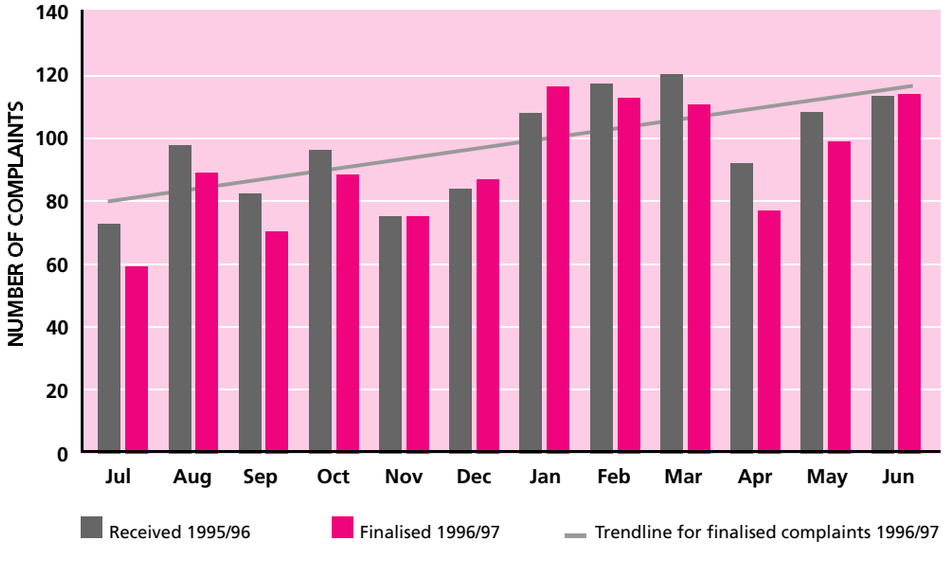


Figure 4: Complaint Issues

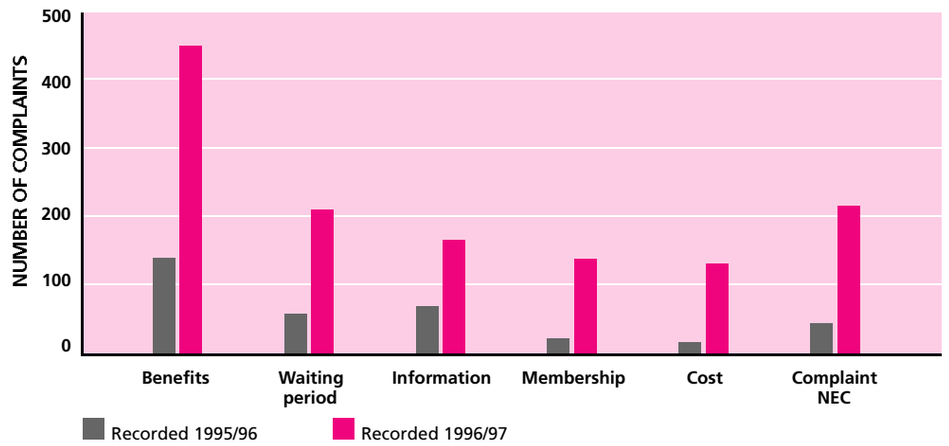


Figure 5: Benefit complaints

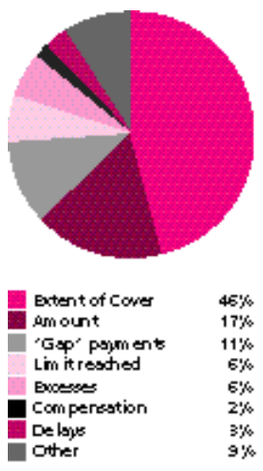


Figure 6: Information complaints

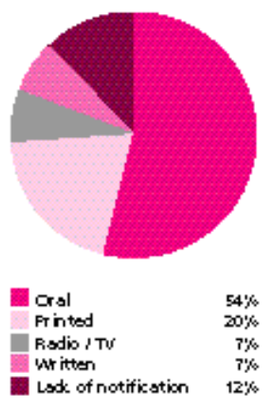


Figure 7: Cost complaints

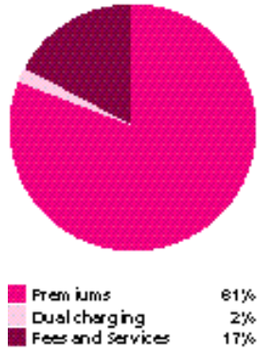


Figure 8: Membership complaints

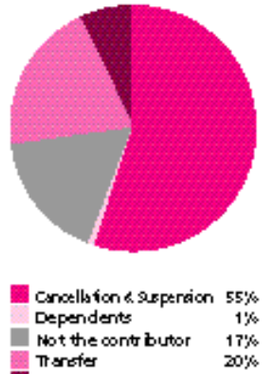


Figure 9: Waiting period complaints

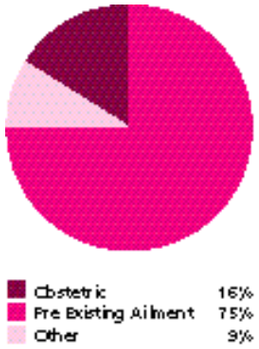
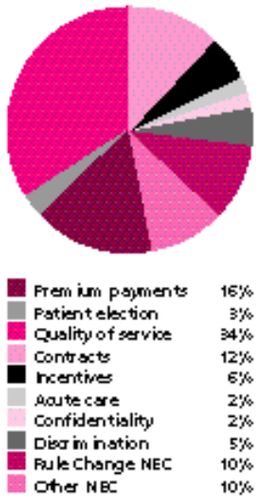


Figure 10: Other complaints



Complaints by State/Territory

Most complaints were received from NSW (34% same as the previous year), with 16% from Victoria (down from 22% in the previous year), 13% from Queensland and 9% from South Australia (both the same as the previous year). Complaints from Western Australia rose by 2% (from 5% to 7%) and those from Tasmania and the Northern Territory by 1% each. Details are provided in Figure 11.

Time taken to resolve complaints

Most complaints were resolved within one week (52% up from 39% in the previous year). Afurther 18% of complaints were resolved within 1 month (31 days), another 11% within 2 months (62 days) and a small number of complaints (5%) were resolved within 3 months. These proportions are similar to the previous year. 4% of complaints took longer than 3 months to resolve (up from 1% in the previous year), although the proportion of complaints still being dealt with at the end of the reporting period declined from 20% to 10% of complaints received in the year (see Figure 12).

Many health funds respond to informal telephone requests for information by Complaints Commissioner staff and this explains why many complaints are resolved in less than one week.

Figure 11: Complaints by State/Territory

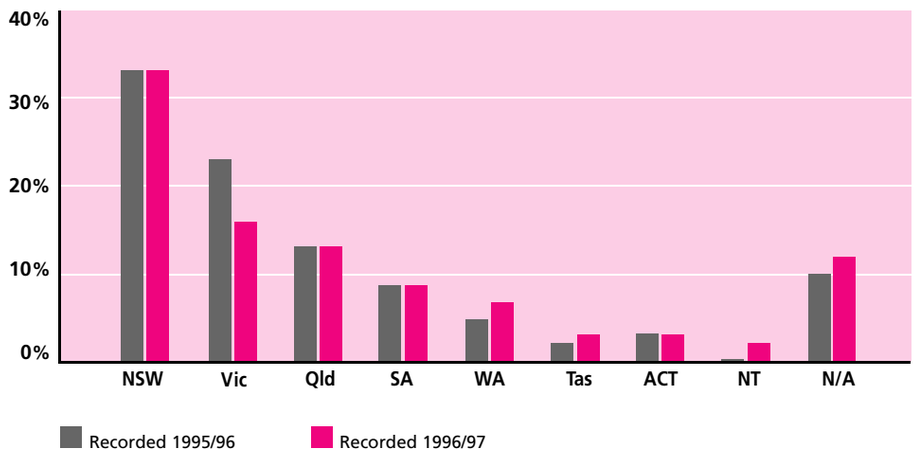
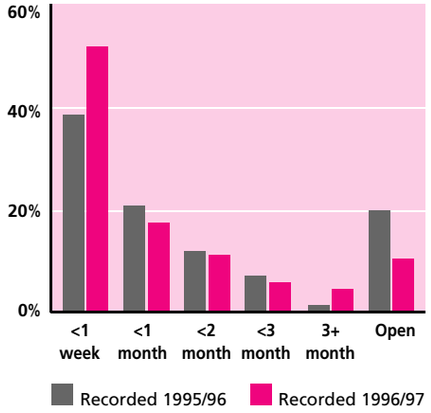


Figure 12: Time to finalise complaints



Who was complained about

Most complaints were made about health funds (1154), followed by hospitals (87) and doctors and dentists (37). Because some complaints concern a health fund as well as a hospital, doctor or dentist, the total number of organisations or people being complained about adds up to more than the total number of complaints (1211).

The number of complaints received each month against health funds, hospitals and doctors is provided at Figure 13. The information has been further broken up into problems, grievances and disputes that make up the three tiered complaint resolution process.

Figure 13: Problems, Grievances and Disputes about health funds, hospitals, doctors and dentists

Month 1996-97	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Type of Complaint													
About Health Funds													
Problem	9	8	5	13	12	19	22	35	33	18	21	26	221
Grievance	22	43	20	38	18	17	33	42	28	18	21	25	325
Dispute	41	44	56	44	47	43	56	38	58	54	64	63	608
Total about health funds	**72**	**95**	**81**	**95**	**77**	**79**	**111**	**115**	**119**	**90**	**106**	**114**	**1154**
About Hospitals													
Problem	0	1	1	1	0	1	1	1	3	0	2	1	12
Grievance	2	2	1	2	3	3	0	1	1	1	3	4	23
Dispute	7	5	3	2	2	4	10	5	2	3	4	5	52
Total about hospitals	**9**	**8**	**5**	**5**	**5**	**8**	**11**	**7**	**6**	**4**	**9**	**10**	**87**
About Doctors/Dentists													
Problem	0	0	2	1	0	0	0	4	2	0	0	1	10
Grievance	1	4	1	0	0	3	0	3	1	1	3	0	17
Dispute	1	0	0	0	1	0	1	0	1	4	1	1	10
Total about doctors/dentists	**2**	**4**	**3**	**1**	**1**	**3**	**1**	**7**	**4**	**5**	**4**	**2**	**37**
Total	83	107	89	101	83	90	123	129	129	99	119	126	1278

Figure 14: Comparison of Problems, Grievances and Disputes by health fund and membership coverage (n=1151)

Name of fund	Complaints %	Coverage (1) %
ACA	0.09	0.12
AMA	0.17	0.15
Army	0.70	1.44
Aust Health Mgmt	1.48	0.38
Australia Unity	3.30	3.33
Commonwealth Bank	0.43	1.01
CDH	0.00	0.04
CPS	0.09	0.14
Credicare	0.61	0.44
Druids - NSW	0.00	0.08
Druids - Vic	0.09	0.12
FAI	0.17	0.28
GMHBA	0.70	1.11
Goldfields	0.09	0.21
Govt Employees	8.43	3.01
Grand United	0.43	0.33
HBF of WA	2.61	8.01
HCF	8.69	8.30
HCI	0.09	0.11
HIF of WA	0.52	0.37
Healthguard	0.09	0.10
Health - Partners	0.26	0.53
IOOF	0.78	0.24
IOR	1.22	0.81
Latrobe	0.70	0.44
Lysaght	0.00	0.19
Manchester Unity	2.26	1.01
MBF	15.99	18.21
Medibank Private	28.84	25.71
Mildura	0.26	0.29
MIM	0.00	0.27
National Mutual	9.12	11.10
Naval	0.26	0.42
NIB	6.86	5.42
NSW Teachers	0.78	1.92
Phoenix	0.17	0.17
Qld Teachers	0.35	0.65
Queenstown	0.00	0.09
Railway & Transport	0.26	0.43
Reserve Bank	0.00	0.09
SA Police	0.09	0.16
SGIC Health	0.87	1.33
St Luke's	0.78	0.43
SMH fund	0.00	0.05
Transition	0.09	0.38
Transport	0.43	0.10
Westfund	0.78	0.33
Yallourn	0.09	0.15
Total for Registered Funds	**100.00**	**100.00**

(1) Proportion of people covered as at 30 June 1996, pages 76-81, 1995/96 PHIAC Annual Report

Complaints about health funds

A summary of problems, grievances and disputes regarding health funds compared with a health fund's market share is provided in Figure 14. Of the grievances, problems and disputes regarding health funds, most related to Medibank Private (29%), followed by MBF (16%), Government Employees Health Fund Limited / Australian Health Management (10%), National Mutual Health Insurance - including HBA, Mutual Community and Territory Mutual - (9%), HCF (9%) and NIB (7%). Australian Unity and HBF of WA were the subject of 3% of all problems, grievances and disputes, with Manchester Unity receiving 2% and IOR 1%. All other funds received less than 1% of the total number of complaints received.

The Complaints Commissioner received 10 or fewer complaints each about the other health funds complained about.

Care should be taken in interpreting the number of complaints received against each fund. The number of complaints will depend on many things including positive aspects, such as how well the fund advertises and promotes the services of the Complaints Commissioner to its members, as well as negative factors associated with the funds' practices.

Complaints about hospitals

Complaints about hospitals usually concern unexpected out of pocket expenses due to incomplete or misleading advice provided on admission or as a result of confusion by the health fund member about the extent of their health insurance cover. As the number of complaints about hospitals is small, no information is presented here about complaints received in relation to their geographic distribution, hospital speciality or ownership.

Complaints about doctors and dentists

Most complaints about doctors concern the lack of informed financial consent. As the number of complaints about doctors is small, no information is provided here about complaints received in relation to their geographic distribution or medical speciality.

Resolving complaints

Most complaints are resolved by providing an independent and impartial explanation of the health fund member's problem, or by providing additional information (46% in 1996/97, down from 49% in 1995/96). Payments were made by health funds or accounts written off by hospitals in response to 12% of complaints received (down from 14% previously). Payments by heath funds may have resulted from a health fund agreeing with the Commissioner that the fund member was entitled to payment of a benefit under the terms of the member's level of private health insurance cover, or the payment made on an ex gratia basis.

An additional 10% (previously 7%) of complaints were resolved by taking other remedial action, such as reinstating a membership or allowing the back payment of contributions where a membership had lapsed. In 16% of complaints (up from 4% previously), complainants were referred directly back to the health fund as the

complainant had not fully explored their problem with the health fund, hospital, doctor or dentist. In these circumstances, the Commissioner was able to suggest ways for the complainant to pursue the matter with the health fund, hospital or health provider.

The Complaints Commissioner did not refer any complaints to the Australian Competition and Consumer Commissioner under section 82 ZSBA of the National Health Act 1953. There was one referral to the ACT Commissioner for Health Complaints as provided for by section 82 ZSC of the Act. In other cases there were no direct referrals, rather, complainants were advised to contact specific agencies.

Information about the resolution of complaints is provided in Figure 15.

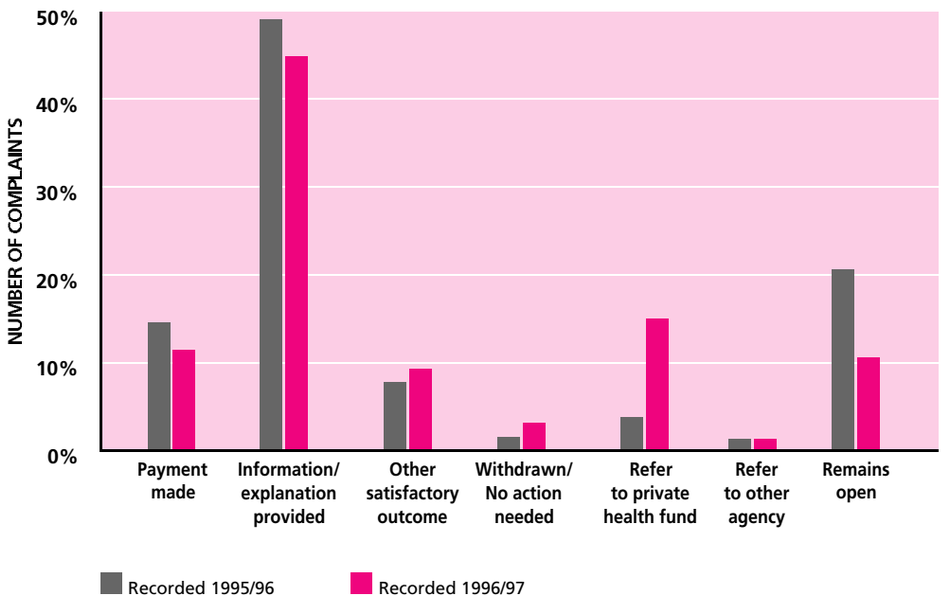
Type of complainant

The law provides that health fund members, hospitals, doctors, some dentists, health funds or persons acting on their behalf can make complaints. Overwhelmingly, complaints were made by health fund members (99%), followed by hospitals/day hospitals (1%). Doctors made two complaints and one health fund made a complaint.

How complaints were made

Most complaints were made by telephone (87% up from 77% in the previous year) and letter (10% down from 18% in the previous year). The remaining complaints were made by fax, personal visit or through a Member of Parliament.

Figure 15: Complaint Outcomes



INVESTIGATIONS INTO HEALTH FUND PRACTICES AND PROCEDURES

There was one investigation conducted under section 82ZT of the National Health Act 1953 during the reporting period. This investigation into a health fund's practices and procedures arose from a complaint by a member of NIB that the fund would not allow the complainant's same sex partner and child to take out "Family" membership. The NSW Supreme Court subsequently ruled that NIB's rules were discriminatory and in breach of the Anti Discrimination Act 1977 (NSW).

There were no investigations conducted under s.82ZTA of the National Health Act.

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.

Issues

Inquiries about specific health insurance issues or problems accounted for 50% of all inquiries (this compares with 22% in 1995/96). Questions about the payment of benefits accounted for 18%, and included questions about 'gap' payments, ways health funds calculate excesses, and delays in health funds making payments. Questions about the cost of services accounted for an additional 8% and mainly concerned the cost of health insurance premiums and dual charging by health providers. A quarter (24%) of all inquiries were about a wide variety of other specific issues concerning private health insurance, such as the application of waiting periods, suspension or cancellation of a contributor's health fund membership or the service received from a health fund.

A little over a third (38%) of all inquiries received by the Complaints Commissioner were about general health insurance issues - ranging from requests for advice about the merits of a specific health fund to questions from consumers wanting to change funds. This compares with about 50% of inquiries in 1995/96 dealing with general health insurance issues. In response to questions about the merits of joining a specific fund, the Commissioner does not recommend specific funds but provides the booklet *Insure? Not Sure?* which explains some of the health insurance terminology which consumers often find difficult to understand. This booklet also contains a list of all private health insurance funds in Australia and their telephone numbers. Other general health insurance inquiries were dealt with by providing telephone advice and a copy of the Private Patients' Hospital Charter.

The remaining 12% of callers wanted information outside the Complaints Commissioner's jurisdiction and concerned Medicare, travel insurance and general insurance issues and complaints about hospital

services. In 1995/96, callers with general inquiries accounted for 27% of all inquiries. A comparison of the issues dealt with in 1995/96 and 1996/97 is provided at Figure 16.

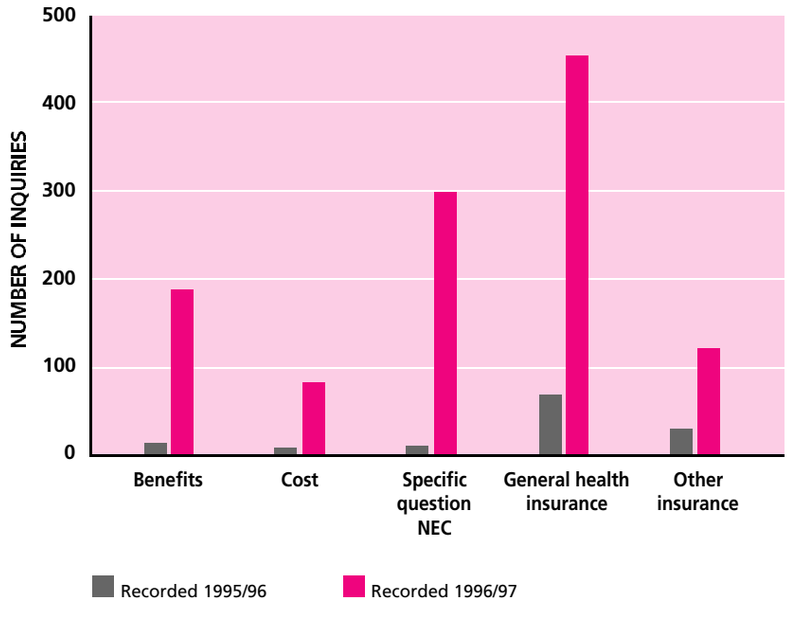
Response to inquiries

Most inquiries were dealt with by providing information, an explanation or brochure (74% compared with 71% in the previous year). Some inquiries received by the Complaints Commissioner (12% compared with 23% in the previous year) were more appropriately dealt with by another organisation and were referred elsewhere, such as the General Insurance Inquiries and Complaints Service or one of the State or Territory health complaints agencies. Nearly all inquiries were dealt with on the day they were received.

Inquiries by State/Territory

Most inquiries were received from NSW (22% down from 38%), followed by Victoria (11%) and Queensland (10%). There was a rise in the proportion of callers from Western Australia (up from 2% to 7%). In 40% of inquiries the geographic location of the caller was not recorded, up from 30% in the previous year.

Figure 16: Inquiry issues



Members' problems with their health insurance arise mainly because health fund members are confused. They don't know enough about their cover, the health system and how it operates, or the way health insurance fits in with overall health service delivery. Many do not know enough to even ask the right questions.

INTRODUCTION

The Complaints Commissioner has been in operation for over 18 months and it is apparent now that while there is scope for remedies in some individual cases, remedies for members' problems are very much limited by health funds' restrictive rules and industry practices.

Each health fund has its own fund rules and these rules govern members' entitlements in myriad ways and tend to change frequently, often on an ad hoc basis. Yet very few members are familiar with the rules and many are not aware of changes. Members tend to see health funds' brochures only when they first join their fund. These brochures are primarily marketing tools. They contain general outlines of benefits and conditions, which sometimes do not accurately reflect the rules.

On a more positive note, it is pleasing to note that overall, there has been some improvement in the accuracy and coverage of health fund brochures over the last year.

Most health fund members who complain to the Complaints Commissioner do so because they believe that the fund has not paid them their due benefits. The majority of these members have received the benefits payable under the fund rules. The essential problems in these cases are unfair rules, members' ignorance or distrust of their health funds.

CONSUMER PROTECTION

In a real sense, from the Complaints Commissioner's perspective, the dice can be loaded against health fund members. While health insurance legislation regulates many aspects of health fund activity and requires that their rules comply with the provisions of the National Health Act 1953 and any other laws that may apply, such as those governing the operation of friendly societies or incorporated associations, there is no apparent consumer protection policy underpinning this legislation. What provisions there are by way of consumer protection are prudential safeguards and a few random provisions in the legislation, including health fund conditions of registration.

For example, under the health insurance legislation:

- health fund members have no right of access to health fund rules which govern their liabilities and entitlements
- health fund rules about the cost of premiums, benefit entitlements and conditions can be changed at any time without prior warning
- health fund rule changes can be notified in any way at any time as long as the notice about adverse changes or premium increases is in writing

- there is no guarantee of premium rate protection for the periods covered by advance payments of premiums
- health fund members have no right of access to the terms and conditions of purchaser provider contractual arrangements between health funds and hospitals or doctors, even though these agreements are for the treatment of heath fund members
- hospitals can be required under purchaser provider agreements to give health funds access to members' medical records to verify accounts and the like, and this overrides usual privacy considerations
- there are intricate provisions governing the review and revocation of acute care certificates, although there is no requirement on the government agencies, hospitals, doctors or heath funds involved in the process to inform the health fund members that there is a review. This means that the health fund members involved can be faced with retrospective accounts for tens of thousand of dollars.

HEALTH FUND RULES

Members' access to health fund rules

Unlike the general insurance industry, except for one small regional fund, health insurers do not routinely give their members policy documents setting out the rules and outlining the exclusions, limitations and conditions that apply to the members' cover. However, when fund members' claims are rejected or benefits are less than members expect, the reason given by the fund is usually that the fund rules limit the scope or amount of benefits to be paid in the circumstances or do not provide for the payment of benefits. When members occasionally ask to see the rules, which the heath fund relies on to limit or deny benefits, some funds refuse to allow this.

Case Example

When Mr Gold became unemployed, he contacted his fund to find out whether he could take advantage of his fund's brochure promise to people that their premiums would be paid for a certain time if they became unemployed. His Table of cover did not allow for this option, but another table with a lower level of benefits did, so he inquired about switching to the lower level of cover. The fund refused his request and told him that he did not meet the requirements for unemployment cover.

Mr Gold said he found it very difficult to find out what those requirements were and he thought that the information the fund gave him was contradictory and confusing. He asked to see the rules that governed the situation without success.

Mr Gold complained to the Complaints Commissioner about the health fund's failure to give him access to the fund rules as well as its refusal to allow him to downgrade his cover so that he could suspend it.

At the Complaints Commissioner's request, the health fund agreed to send a copy of its rules regarding its unemployment arrangements to Mr Gold. (It said it could not allow Mr Gold to suspend his membership by downgrading his cover, because the rules of the underwriter excluded this option.) Despite the promise, at the time of writing the fund has still not supplied the rules.

In this case, the health fund member was equally frustrated by the fund's inability to give him access to the rules regarding his proposed change of membership as he was about their refusal to allow him to downgrade and suspend his cover.

Very few health funds have rules that are in a form that their members could readily understand. Most are too cumbersome to provide to members routinely. Some are virtually unintelligible.

The health fund industry has not taken up the Complaints Commissioner's suggestion that they develop plain English policy documentation for their members. Many funds say that it is impossible because health insurance rules are by necessity too complex and extensive. The Complaints Commissioner does not accept that it is impossible over time, with careful planning and an incentive to do it.

Already, two large funds have moved towards providing more accurate information in their brochures following complaints last year about misleading advertising. Other funds have made improvements along these lines. Some funds have also increased and improved the additional information they give to new members just after they join. Customised policy documentation should not be much more difficult to provide. One sizeable fund has advised it is working on issuing a policy document to its members.

At the very least, health funds should revise their rules into plain language, streamline and simplify them and be prepared to give their members ready access to them on request.

Changes to rules

Many complaints involve health fund rule changes, which have not been noticed by the member in the letters and other promotional material sent by the fund. Industry practices vary regarding rule changes; some funds notify them by way of general newsletters, which can be confusing for members, depending on the extent of the change and context in the newsletter. Others notify their members by personalised letters.

Unfortunately, some members believe that their benefit entitlements are as set out in the brochure they received when they first joined their fund. This is due to various reasons, ranging from a fund's failure to communicate rule changes in a meaningful fashion or at all, to laziness or disinterest on the part of some members to fully understand and appreciate the terms and conditions of their health insurance cover.

Case Example

More than a year after joining her health fund Ms Grey was advised by her doctor to have a "D and C" operation to terminate her pregnancy. Before going to hospital she called her health fund to check that she was fully covered for the procedure at a private hospital. She said she had to have a "D and C". The fund staff member checked her cover on the computer and then advised her that she was covered "100%".

After she was discharged from hospital, Ms Grey received a bill from the hospital for the full amount. The health fund had refused to pay any benefits. Unbeknown to Ms Grey, the health fund had changed its rules after she joined. Her cover no longer

covered obstetric conditions. Because her D and C was for termination of pregnancy, she was not covered at all.

When the Complaints Commissioner contacted the heath fund, it said that it had sent an advice about the rule change to members. The advice was buried in a newsletter that told members about several beneficial changes to their policies. The newsletter did not make clear to members that a major adverse change was also being made.

Concerning the wrong advice given on the telephone to the member, the health fund advised that it did not feel responsible because Ms Grey did not mention that she was having a termination of pregnancy.

Although the health fund did not concede wrongdoing on either front, it agreed to pay full benefits for Ms Grey.

The Complaints Commissioner believes that health funds should be required to give members advance notice about the impact of rule changes wherever possible, by personalised message that focuses on the change in question. Many health funds argue that this would be far too expensive. The costs could be contained if, for example, changes were planned and executed at the same time as advising members of rises in premiums.

While health funds rely on brochures as the main vehicle for defining members' entitlements, they should also on a regular basis provide members with up to date brochures that incorporate the changes relevant to their members' cover. It is not good enough to expect members to pick up their own new brochures when members often transact their business with the funds these days without needing to go to the funds' premises.

Members need advance notice of changes so they can review their cover and take action if need be before the change, for example by transferring to another table of insurance cover or to another health fund. Often members receive little advance warning. In any event, the traditional right to transfer to another fund without serving waiting periods again, has been eroded this year.

PROBLEMS WITH HEALTH FUNDS CONTRACTING WITH SELECTED HOSPITALS ONLY

Members left without adequate cover

Anumber of health fund members have approached the Complaints Commissioner for help because they have suddenly discovered that their health fund does not pay full benefits for treatment at the hospital of their choice. This is because their health fund and the hospital have not entered into an agreement about services to be provided to fund members. These people are insured with those health funds that are now contracting with only selected hospitals. The selected hospitals are known as "agreement" hospitals or "partnership" hospitals.

Sometimes, selective contracting can mean that people in regional areas can be left without any real access to private facilities in their regions.

Case Example

Ms Pink is a health fund member with top level hospital cover. She lives in a large regional centre and went into a private hospital there to have her baby. After sending her account to her fund, she was advised that the health fund did not have an agreement with the hospital and therefore she would be left with significant out of pocket expenses of over $1000. Ms Pink knew nothing about "agreement hospitals" and in any case, there was no "agreement" hospital with a maternity section for her health fund in the region where she lived.

After the Complaints Commissioner referred the case to the health fund, it agreed to pay benefits for the outstanding amount. However, the issue of the health fund leaving members in that particular region without the choice of a private maternity hospital remains unresolved.

This case demonstrates the need for health fund members to regularly check their cover to make sure it still meets their needs and to always check on what access they have to full hospital cover in their area.

Other people have problems because of sudden changes to their funds' arrangements with hospitals.

Case Example

Ms Blue, was temporarily living in NSW while on work experience. She had transferred from her family's membership based in another state to a single one when she became independent. This was just before she went to NSW. She became very ill suddenly and a specialist referred her to the local private hospital for tests and emergency surgery. Miss Blue had every reason to believe this treatment would be covered by her health fund. The brochure she had been given on joining the fund 7 months earlier indicated she would receive 100% accommodation cover at any private hospital in NSW.

Ms Blue was shocked to discover when she arrived at the hospital that she would have to pay out of pocket expenses of well over two thousand dollars. The hospital told her that it did not have an agreement with her health fund and the fund had recently decided not to pay the full amount for accommodation at the hospital. The health fund had given the hospital less than one week's notice of the change.

Following urgent discussions with the hospital and the fund at the hospital, Miss Blue decided that her only option was to try to organise an on the spot transfer to a different health fund.

(This case is very unusual in that another health fund was willing to transfer Ms Blue's membership to them immediately, even though she was about to undergo expensive hospital treatment. The new fund's representative actually drove to the hospital to arrange the transfer.)

Ms Blue later complained to the Complaints Commissioner that the original health fund had not notified her that she would no longer be fully covered in all NSW private hospitals. The fund claimed it had notified members living in other states, including NSW, of the change. It said that it would have notified Ms Blue if she had completed her membership form correctly, with a NSW address instead of her home state.

The first health fund agreed to refund Ms Blue's membership contributions.

This case highlights the difficulties for members who plan treatment at a particular hospital, only to discover at the last moment that their fund does not have a contract with that hospital. It also illustrates the importance of members checking whether they are covered with their fund before they present to the hospital.

Portability of health insurance - the right to transfer without penalty

Ms Blue was very lucky to have been able to transfer instantly with full cover at the hospital she was at. Other health fund members in her position have tried to transfer to a fund which has an agreement with the hospital of their choice only to be told that they would have to serve the standard waiting periods for treatment at the hospital. Until all relevant waiting periods were served, the new fund would only pay at the rate payable by the old fund for the particular hospital. This has been the attitude of most funds, regardless of the type of cover the person has with the "old" fund.

This is a new development. Until health funds began to selectively contract with hospitals, members could transfer from one fund to another on a similar cover, without serving any waiting periods for full hospital benefits. The legislation governing health insurance is unclear on this issue, but it seems that health funds are not in breach of the relevant legislation by insisting that waiting periods are to be served if the new cover is not exactly the same as the old in terms of individual hospitals.

The issue is a difficult one. On the one hand, while negotiations over hospital purchaser provider agreements are in a state of flux, members are vulnerable to constant change. They can be booked into hospitals or planning treatment on the basis that their health fund pays full benefits at a particular hospital only to find, without warning, that the fund's agreement with the hospital has expired. This means they are not fully covered for the accommodation costs. "Default" benefits only are payable, and this usually results in significant out-of-pocket expenses for the accommodation costs and theatre fees.

Some health funds will pay benefits at the old contracted rate for members who have booked or possibly only planned treatment before a hospital contract expires. Other health funds say they would negotiate with the hospital in question to come to some compromise for members who have booked in to a hospital before the agreement expired. This is not a solution for many people as negotiations between the parties take time and they need certainty of cover.

On the other hand, there are obvious problems for the health insurance industry regarding transferring members who are planning treatment at a particular hospital. The costs of a transferee's treatment will far outweigh the benefits they have paid to the new fund and the old fund has benefited from the transferee's premiums and avoided the costs. In some areas, the situation could be manipulated and result in significant cost shifting from one fund to another.

The current situation is unsatisfactory. Health funds effectively have a wide discretion about whether they will pay full benefits for transferees at the funds' agreement hospitals. The situation is also cumbersome as a lot of effort can be spent on negotiating about individual cases where contracts have expired, leaving members caught in a vacuum.

The Complaints Commissioner has written to the Department of Health and Family Services and health funds about the possibility of remedying this situation but at the time of writing, no solution is in sight.

Problems identified by private hospitals

Private hospitals have also approached the Complaints Commissioner with complaints about the approach some health funds are taking to the question of purchaser provider agreements with hospitals.

These hospitals have expressed concern at the way in which health funds are deciding which hospitals to contract with and say that funds are not giving proper consideration to standards of care and location. They say that health funds are tending to simply select the cheapest hospital. From the hospitals' point of view, it can be catastrophic if a fund decides not to contract with them, or declines to renew an existing contract, particularly if it is a large fund with a significant market share.

The law does not require health funds to be impartial or rely on any particular criteria in choosing which hospitals it wants to contract with. Nor does the law require them to give reasons for their decisions. The Commissioner has no basis for successfully intervening in commercial decisions of this nature unless there is a breach of the law or the effects on consumers are manifestly unfair. One safeguard is that it is clearly in the health funds' interest to contract with a good range of hospitals if they want to attract and keep members in the long term.

A major concern is that there is the potential for funds to contract with hospitals in such a way as to deter members seeking lengthy (and therefore expensive) treatment such as psychiatric, rehabilitation or palliative care. Currently, health funds are prevented from excluding these kinds of care from their products. However, there is potential for any type of care to be effectively excluded by stealth, by health funds selectively negotiating purchaser provider agreements.

The Complaints Commissioner is aware of one fund that at one stage had only one contracted psychiatric

hospital in the whole of NSW - and this hospital was not even in Sydney, the largest population centre. The health fund in question assured the Complaints Commissioner that it was negotiating with more hospitals and new ones were being added to the list.

The Complaints Commissioner wants to ensure that members continue to have access to a range of private facilities that meets their needs and that they are aware of any restrictions. Taking another tack, it may be possible to argue that health funds are acting contrary to law or at least improperly, if they are selling products to people who live in areas where the product is not available in reality.

The Complaints Commissioner intends to continue monitoring complaints to determine the effects of the new contracting environment on health fund members.

An emerging issue

It appears from comments made to the Complaints Commissioner by health fund members that they are beginning to expect their health funds to take some responsibility for the standard of care provided at agreement hospitals.

Case Example

Ms Puce contacted the Complaints Commissioner because she was unhappy with the standard of service she received at the hospital where she was treated and her health fund's lack of action about her dissatisfaction.

Ms Puce knew that her health fund had a special agreement with the hospital. It was the only hospital in her area contracted by the fund so she was effectively forced to use it. When she contacted the health fund to complain, the fund staff member told Ms Puce that the hospital's standard of service had nothing to do with the fund.

After the Complaints Commissioner raised the matter with the health fund, it agreed to take on board the members' comments about the standard of care in the hospital during the contract re-negotiations with the hospital.

This raises the issue of who is responsible for monitoring contracts and ensuring patients are receiving an appropriate standard of care and service in agreement hospitals, particularly where health fund members have no other private facility where they can reasonably go.

HEALTH FUND MEMBERSHIP AND "DEPENDENTS"

Several people have approached the Complaints Commissioner about problems arising because, although they are covered by a private health insurance policy, they are not a "contributor" or a "member" of the health fund in question. They are only "dependents" of a contributor or member.

All health funds operate on the basis of having only one "contributor" per membership policy, with all other people attached to that membership being classed as a "partner" and/or as a "dependent". This can cause problems for family, single parent and couple memberships, usually in the context of a domestic dispute. This is because the "contributor" appears to be the only person able to make changes to the membership or gain information held by the health fund regarding people covered by the membership policy.

Case Example

Ms Tan, who had previously been a dependant member on her ex-husband's membership, contacted the health fund to obtain information concerning benefits the fund had paid for her son's orthodontic treatment. Ms Tan needed the information because her son's orthodontist was suing her for non-payment of his account.

Even though Ms Tan's son was still covered under her ex-husband's membership, the health fund refused to provide the information, on the grounds that it would be in breach of privacy legislation if it did, because Ms Tan was not the legal contributor.

The Complaints Commissioner wrote to the fund requesting an explanation of why the information could not be provided. The fund eventually agreed to release the information following receipt of a summons from Ms Tan's solicitors.

While the particular circumstances of this case are unlikely to recur, it does illustrate the difficulties faced by ex-dependents of contributors who need to obtain information concerning their membership or that of their dependent children.

Other problems people have identified include situations where:

- the "contributor" has removed their former partner or dependent child from the membership without the "contributor" or the fund notifying the former partner or dependent child that this has occurred. This then leads to a break in health insurance coverage, with the former partner or dependent child being asked by the existing or new fund to re-serve all waiting periods
- former partners (and dependent children) are unable to take out their own individual membership because the "contributor" refuses to allow the fund to remove the former partner (and dependent children) from the membership. (Most funds maintain that the "contributor" is the only person able to add or remove people from a membership.) This results in most funds not allowing new memberships for former partners or dependent children (as funds believe that the legislation prevents people being covered by two hospital tables). Nor will these funds provide a Clearance Certificate so that the former partner and dependent children are able to take out private health insurance with another fund.

Adult partners and adult dependants of a contributor should be able to remove themselves from a membership and there should be no barrier to this. The situation where there are child dependants is more difficult to resolve. Additionally, where a contributor has removed a person from a membership, the fund should be obliged to attempt to

advise that person that they have been removed, to allow them the opportunity to make other arrangements. Also, adult members covered by a private health insurance policy should be entitled to gain access to fund records about themselves, particularly records of claims.

In many family disputes, the parenting responsibilities of children are increasingly shared by the separated parents. This means that the old ideas of custody and access are being replaced by newer ideas of residence and contact. This sits uneasily with the way health insurance policies provide many rights to a contributor and comparatively fewer rights to anyone else covered on the policy. It is recognised that this is a complex problem, probably not easily resolved by legislation or a condition of registration.

These matters have been raised with the Department of Health and Family Services recently.

REVIEW AND REVOCATION OF ACUTE CARE CERTIFICATES WITHOUT WARNING

As reported in last year's Annual Report, the revocation of acute care certificates can cause serious problems for health fund members and their families. Benefits for acute care in hospitals after 35 continuous days are payable only if a doctor certifies that acute care, rather than nursing home care, is warranted. There are elaborate provisions for reviewing certificates where health funds believe that members who have been in hospital more than 35 days are not receiving acute care and are really more suited to nursing home care. The review application is passed through many agencies' hands.

None of these agencies involved in the review of the certificate, nor the doctor, hospital or health fund involved, are required to tell the patient that the certificate, which gives them the right to attract benefits, is under review. Often the first indication the health fund member has is a telephone call from the Acute Care Advisory Committee, one of the bodies involved in the process, seeking more information. This can often occur many months after the certificate was signed. During this time the hospital's bills have continued to mount, sometimes reaching many tens of thousands of dollars.

This situation is unacceptable. If the acute care certificate system or something like it is to remain, the relevant legislation needs to be changed. Health funds should be required to notify their members as soon as possible when a certificate is under challenge and that there is a danger that only nursing home benefits will be paid. Hospitals and doctors should also be required to inform their patients of the ramification of the certificate at the time the patient's doctor signs the certificate. Perhaps there should be provision on the certificate for certification that the import and ramification of the certificate has been explained to the patient.

WAITING PERIODS

All health funds apply waiting periods before new members (or members who are upgrading their cover) can claim benefits. These vary from 2 months to several years for some expensive treatments such as IVF. The waiting periods that cause the most difficulty are the 12 months for illnesses and ailments which were showing signs or symptoms at any time in the six months before the date of joining, and the nine to twelve month waiting period for obstetric related conditions.

What waiting period applies to ancillary benefits?

People seeking assistance from the Complaints Commissioner are sometimes confused about the waiting periods applicable to ancillary benefits such as dentistry, optometry and physiotherapy. Health fund brochures clearly indicate various and specific periods for these categories of benefits, usually ranging from two to six months.

Unfortunately, people tend not to notice that ancillary benefits may also be subject to the 12 months "pre existing ailment" waiting period. All funds impose a separate waiting period of twelve months regarding ailments that can be described as pre existing. (An ailment is defined as pre existing where there are signs or symptoms of it at any time in the six months before a person joins a health fund.)

Case Example

Before Mr Taupe came to Australia, his relatives made inquiries on his behalf about private health insurance waiting periods. Mr Taupe needed expensive orthopaedic surgery. To fit in with the waiting periods and to save costs, they decided that he should stage his health insurance. Mr Taupe came to Australia and put the plan into action. He arranged for hospital cover with a health fund as soon as he arrived and then two months before his operation, he took ancillary cover to obtain benefits for the extensive post surgical physiotherapy he knew he would need.

Unfortunately for Mr Taupe, neither he nor his relatives appreciated the finer points of his health fund's rules as set out in its brochures. Although the brochure advertised two month waiting periods for physiotherapy procedures, it also stated on another page that there was a 12 month waiting period for cover for "pre existing ailments". The health fund applied the 12 month period to Mr Taupe's physiotherapy because it clearly related to an ailment that showed signs and symptoms in the six months before he took up his ancillary cover.

Even though the Taupes obviously carefully studied health fund brochures and sought advice about waiting periods, they did not get it right. The Taupes say that even the health fund staff they spoke to misunderstood the waiting periods. They say that the staff of the fund he joined advised Mr Taupe to wait until two months before his operation to take out ancillary cover.

The Complaints Commissioner is still discussing the factual discrepancies in this case with the health fund. It is fair to say that the fund is not

prepared to give any benefit of the doubt to Mr Taupe because it regards him as a probable "hit and run" member. (A hit and run member is one who joins a fund to obtain benefits for planned treatment, pays the minimum, gets the benefits and then leaves the fund as soon as the treatment is finished). All health funds are hostile to them. These members take out much more than they put in, at the expense of the longer term fund members.

This complaint illustrates the difficulty people face in working out the intricacies of waiting periods. If the Taupe family, who obviously took great care and time to study waiting periods, can get it wrong, a lot of other people would too. The Complaints Commissioner has had a spate of complaints about Mr Taupe's fund on this issue, all claiming that this fund's staff misled them. It may be that the fund involved has recently changed its policy, is now taking a more stringent approach to ancillary benefits and it has taken a while for all the staff to absorb the change.

It seems that health funds apply the pre existing ailment rule to ancillary benefits sporadically and new members need to carefully check health fund brochures for the fine print on this issue.

Waiver of waiting periods

Many health funds continue to market their products with the inducement that waiting periods are waived. It seems that marketing campaigns aimed at new corporate accounts often involve the promise to waive waiting periods.

The problem is that all waiting periods are very rarely waived. The waiver is invariably confined to items attracting a wait of 2 or 6 months, usually for ancillary benefits. People are genuinely confused by this and sign up with a health fund believing they have immediate cover for everything. When they seek to claim for treatment for obstetric related conditions, pre existing ailments or other things not included in the limited waiver on offer, they are often bitterly disappointed.

Case Example

Ms Brown was excited when she opened mail at her office and read a special offer from a health fund. The fund was encouraging senior members of her firm to take out health insurance at very attractive rates, without waiting periods.

Ms Brown and her husband had just decided to participate in an IVF program and private health insurance cover from the outset would be terrific for them. Ms Brown contacted the nearest branch of the fund immediately. None of the staff there knew anything about the special offer but organised an appointment for her the following week.

Ms Brown then received a phone call from the health fund to say that she was not eligible for the offer as it was confined to senior staff. The caller said that, as she had read the details of the offer, she and anyone else she had discussed it with at the firm could take advantage of the offer, if they paid 12 months in advance.

When a health fund representative called at Ms Brown's workplace to discuss the offer the next day, Ms Brown indicated she was on a fertility program. The representative then revised the premium price for Ms Brown on the spot, increasing the annual premium by $140. The representative told Ms Brown that the papers she needed to sign, to join the fund, would be available soon.

One week later, Ms Brown was told that the special offer to her was withdrawn and she would be subject to all waiting periods.

Ms Brown lodged a complaint alleging improper discrimination. After the Complaints Commissioner referred the complaint to the health fund, the original offer was restored.

This complaint provided an interesting insight into corporate deals that some health funds are apparently offering as well as being an example of the need to avoid misleading statements.

The position is that unless a health fund's advertisement or promotional material clearly identifies all waiting periods which are both waived and not waived, it is likely to be in breach of trade practices law. If a health fund member has been misled about waiting periods, the health fund should provide benefits in accordance with the misleading impression given.

9 months waiting period can be 12 months in reality

Health insurance legislation allows health funds to impose a 9 month waiting period for obstetrics benefits. Despite this, the Department of Health and Family Services has allowed some health funds to change their rules to impose a 12 month waiting period for benefits above the basic rate. (The basic rate, now known as the default rate, is set by the Minister and it is less than half the usual fee charged by the larger private hospitals.) This means that a member who has a baby after 9 months but before 12 months of joining (or upgrading her cover), is entitled to default benefits only. In other words, they are fully covered if they are treated as a private patient in a public hospital but not at a private hospital.

Other health funds impose a 9 months waiting period before the payment of any obstetric benefits and an additional 3 month "benefit limitation period" for the payment of the very limited default benefit. The way funds refer to these periods in their brochures can often be confusing or misleading, although the effect is the same. Total benefits are excluded for the first 9 months and anything but the default benefit is excluded for the next three months. It is very difficult for ordinary people to appreciate these nuances in a brochure which describes in different places both a waiting period of 9 months and a 12 month "benefit limitation period" applying to the same condition.

Some people have approached the Complaints Commissioner about health funds refusing to pay full benefits after the initial 9 month waiting period. They have not realised that there is a longer limitation period, even after carefully studying their fund's brochure.

Case Example

Ms Green was planning a family and decided to join a health fund. She phoned several funds and examined their brochures carefully. She joined the fund of her choice on 20 December 1995 and shortly after she received a letter from the fund giving her some more details about her cover.

Ms Green says she then phoned the health fund to make sure she was fully covered. She says she told the fund she was planning to have a baby as soon as possible and even identified the private hospital and the doctor she would be using. The health fund confirmed she was fully covered if she had the baby more than 9 months after joining. (Ms Green has no details of when she called or whom she spoke to.)

Ms Green fell pregnant and in September 1996 phoned the health fund again to confirm she was fully covered. The fund then told her that although she would give birth outside the 9 months waiting period, she was not entitled to full benefits at a private hospital until she had been a member for 12 months. Ms Green had the baby on 19 November 1996, one month short of the deadline.

There is no doubt that Ms Green misunderstood the brochure and the letter the health fund sent her describing her cover. She thought there was only a nine month waiting period and completely missed the additional three month exclusion.

When the Complaints Commissioner contacted the health fund, the fund argued that its brochure and letter were not misleading. It denied that Ms Green had phoned to confirm her cover when she first joined. The fund said that its staff at the small branch where Ms Green did business were experienced and very well trained. It said the staff could not possibly have confirmed Ms Green's cover at the private hospital she nominated, for treatment in less than 12 months.

Further, the health fund had a record that Ms Green had telephoned just before the birth and alleged she had been told before that she only had to wait 10 months. Because of this small inconsistency the health fund refused to consider paying full benefits to cover the birth of the baby.

Health funds take a very stringent approach to obstetric cases like this one and refuse to give people the benefit of the doubt. People who join up around the time of conception are regarded as "hit and runners", who want to take out in benefits much more than the premiums they pay into the health fund. While this may be true of some people, it is not the case with everyone. Many new members join for the first time when they are planning to start a family and go on to be long term supporters of the health fund.

One health fund, without warning to members, changed its waiting period for obstetric cases from 9 to 12 months.

There was an outcry from members. After a few complaints, the fund reassessed its position and agreed to pay full benefits for all existing members who were caught by the new rule. The Department of Health and Family Services subsequently insisted on a modification of the rule so that it did not apply to existing members.

The number of complainants about this issue from this health fund was surprising. It presumably reflected a recent new membership drive rather than an indication of the proportion of new members who joined specifically to obtain cover for obstetric related conditions.

CONFUSION ABOUT COVER FOR NEW BORN BABIES

People continue to contact the Complaints Commissioner because they cannot get private health insurance benefits for paediatricians' fees for examination and care of newborn babies in hospital.

Case Example

Ms Black had the fullest possible family cover with her health fund when she went to a private hospital to have her baby. When her doctor noticed foetal distress and called in a paediatrician to be present at the birth, Ms Black assumed that she would be covered for the extra cost.

Thinking she would be covered in the same way that she was covered for her obstetrics bills, Ms Black claimed the Medicare rebate for the paediatrician's fees. She expected her fund to pay benefits for the difference between the rebate amount and the scheduled fee. Her fund refused to pay.

Unfortunately, under health insurance law, Ms Black was not entitled to private health insurance benefits for the paediatrician's fees. Because the baby was not admitted to the hospital as a patient in its own right, health insurance benefits could not be paid to cover medical treatment for the baby.

Most people do not realise that they will have to pay the gap fees for paediatrician's attendances on their newborn babies themselves, unless the baby is being treated in an intensive care nursery.

REFUSAL TO PAY BENEFITS WHEN COMPENSATION IS INVOLVED

Most health funds have rules that give them discretion to refuse to pay benefits for treatment that could be covered by a compensation or damages claim. While some funds will pay on the condition that the member will reimburse the fund when the compensation is paid, some funds flatly refuse to pay under any circumstances. This means that health insurance members can be forced to pay for their own treatment unless their claims for workers compensation or damages are accepted very quickly. Some have to go without proper treatment at all.

Case Example

Ms White had just passed through the check out counter of a large supermarket chain store when the store's trolley collecting tractor went out of control. Ms White was at the cigarette counter when the load of trolleys being pushed by the tractor rammed into her and pinned her against the counter. Ms White suffered severe soft tissue damage to her legs, back and neck.

Unfortunately for Ms White, there are three entities that are potentially liable for her accident - the store, the company that had the contract to collect the store's trolleys and the company's sub contractor who was driving the tractor at the time of the accident. The insurers for these three entities have been arguing about liability for over two years. In the meantime, Ms White's health insurer refuses to pay for any of the physiotherapy or chiropractic treatments she has needed even though her policy covers these services. Ms White has had to rely on Medicare and her own funds to pay for all of the treatment she has received to date.

The health fund is refusing to use its discretion to pay benefits for treatment related to a compensible injury. Its policy is not to pay benefits for injuries covered by civil damages and compensation claims.

It seems that health funds that refuse to pay under any circumstances in compensation and damages situations want to avoid the administrative difficulties associated with ensuring they recover the money later. The Complaints Commissioner believes that all health funds should be prepared to provide their members with a helpful service when they are injured and in need of support.

Health funds should be required to pay benefits for treatment covered by damages and compensation rights, as long as the members concerned enter enforceable undertakings with the health funds to take reasonable steps to pay back the money eventually. Repayment would occur if and when the claims for damages or compensation were finalised successfully.

SUSPENSION OF MEMBERSHIP

Some health fund members are confused about their funds' rules regarding suspension of benefits and get caught short as a result. There is no industry standard about suspension of membership and most health fund brochures do not spell out their rules about suspension. Some health fund rules make little mention of suspension conditions.

Suspension of membership is allowed by many health funds in a variety of circumstances, including unemployment, overseas travel and imprisonment. The following aspects of suspension have caused difficulties during the reporting year and alert consumers need to check them out:

- entitlement to benefits during the suspension - there is usually no entitlement
- how the fund treats a claim for benefits for treatment received after the suspension but related to a condition arising during the suspension
- the date the suspension comes into effect and how the fund calculates it
- the maximum suspension period allowed
- what the member needs to do to reactivate the suspension - can include proof that social security benefits have ceased or passport evidence of re-entry to Australia
- the date membership is reactivated and how the fund calculates it
- effect of suspension on waiting periods and the accrual of benefits under the policy.

DOCTORS' BILLS

Some health fund members have approached the Complaints Commissioner about their specialist doctors' bills. Invariably, these consumers are complaining about their doctors charging them an amount over and above the Medicare Benefits Scheduled fee, for treatment they have while in hospital.

In this context, health fund members approach the Commissioner for two reasons. The first is because they have received unexpected bills. Secondly, members are often aggrieved that, by electing to be a private patient, they have been confronted by bills that public patients do not have to pay. They tend to be particularly unhappy when they have been treated in a public hospital by the same doctors who treat public patients they know.

The Complaint Commissioner's approach to complaints about medical fees above the Medicare Benefit Schedule is based on the principle that patients should have the opportunity to give informed consent to all procedures, including informed financial consent.

The Commissioner believes that there should be an agreement about costs between a health fund member and the doctors involved in treatment of the member, before the treatment is carried out. This is extremely important where the amount involved is significant for the member. Obviously, for some people, $50 can be a large amount.

If a patient has not agreed to pay a particular amount regarding treatment, a person is liable to pay only a reasonable amount. There is no set formula for determining this. If the question of payment goes to court, the court would determine what is reasonable. Courts in the past have latched onto various amounts, sometimes the Schedule fee. It is anyone's guess what a court may decide is reasonable in the circumstances of a particular case - anywhere between the Schedule fee and the account rendered.

This is what the Complaints Commissioner advises health fund members and she encourages them to discuss fees and out of pocket costs with their doctors before treatment.

ACCESS AND PUBLIC AWARENESS

Official launch

Dr Brendan Nelson MP, officially opened the Complaints Commissioner's office on 29 July 1996. Dr Nelson, a former president of the Australian Medical Association and well known for his interests in medical health and social issues, was elected to the Federal Parliament at the 1996 General Election as the Member for Bradfield.

In opening the office, Dr Nelson said that establishment of the Complaints Commissioner will help make private health funds more competitive and accountable.

Mr Russell Schneider, Chief Executive of the Australian Health Insurance Association, also spoke at the official launch. Mr Schneider said, "establishment of the Private Health Insurance Complaints Commissioner is a further step in ensuring consumers feel confident about the quality of the product they are purchasing".

The launch received wide media coverage and together with the Complaints Commissioner's radio and television interviews, resulted in a significant increase in the inquiries and complaints received in July and August 1996.

Public awareness

Because the Complaints Commissioner was established for the benefit of health fund members, it is vital that they know about their right to approach the Complaints Commissioner for assistance.

Recognising this, the Minister for Health and Family Services amended the conditions of registration for health funds in September 1996 and they are now required to publish the contact details for the Complaints Commissioner in their main product brochures.

There is a greater need for public awareness of the Complaints Commissioner's functions following introduction of the Government's health insurance incentives initiative. The Commissioner has jurisdiction to deal with complaints from health fund members about their health fund's handling of their application for the incentives. This means that the Commissioner is well placed to assist people who are having problems understanding or accessing the program.

Internet Strategy

The Complaints Commissioner is developing an Internet Web site. Members of the public can access the following information from the Commissioner's site:

- **Private Health Insurance Complaints Commissioner's Brochures:**
  - Our Mission
  - Can We Help With Your Health Insurance Complaint?
  - 10 Golden Rules
- **Other Brochures:**
  - The Private Patients' Hospital Charter
  - When The Doctor's Bill Makes You Ill
- **Private Health Insurance Complaints Commissioner's Annual Reports**

People can access the Commissioner's Home Page to lodge complaints and make inquiries and request printed copies of the Commissioner's brochures (including community language) and all other documents displayed.

Links to other useful sites are provided.

The Commissioner's Home Page is: http://www.phicc.org.au

Advertising

The Commissioner placed advertisements in most major metropolitan newspapers and attended public forums organised by the Health Issues Centre and the Consumers' Health Council of WA during the year.

Change of name

Some consumer bodies have reported that some health consumers, particularly older ones, are reluctant to complain and are discouraged by the word "complaints" in the Complaints Commissioner's title. Some health funds have urged that the Complaints Commissioner's name be changed to one with more positive connotations. A consensus appears to have emerged that a change of name to the Private Health Insurance Ombudsman may be more appropriate.

The Government is currently considering this and other changes to the legislation governing the operation of the Commissioner's office and of private health insurance arrangements in general.

Conferences and Seminars

The Complaints Commissioner was invited to speak at numerous conferences, public and community meetings during the year and was a Guest Lecturer in Advanced Administrative Law for students at the University of Technology, Sydney in November 1996.

The Commissioner's Director, Policy and Customer Service, outlined the role of the Complaints Commissioner in a presentation for the "Medicine, Hospitals and the Law" conference in September 1996, jointly sponsored by the NSW Private Hospitals Association and the Health Services Association of NSW.

Submissions

The Senate Community Affairs Legislation Committee conducted a Review of the Health Legislation (Private Health Insurance Reform) Amendment Act 1995 and held public hearings in Sydney and Melbourne in July 1996. The Complaints Commissioner appeared before the Committee in Sydney on 24 July 1996.

The Committee requested a supplementary submission from the Complaints Commissioner and this was provided on 13 August 1996.

The Senate Committee report was tabled in September 1996 and made 24 recommendations. Of direct interest to the Complaints Commissioner, the Committee recommended that:

- a re-assessment of the functions, powers and funding arrangements of the Private Health Insurance Complaints Commissioner be part of the ongoing monitoring of the legislation
- all health funds be required to include information about the Complaints Commissioner in their published information
- the Purchaser Provider Panel be convened and be provided with access to purchaser-provider agreements to assist in the monitoring role relating to contractual arrangements.

The Productivity Commission also conducted an inquiry into private health insurance during the year. The Complaints Commissioner held discussions with members of the Commission in Sydney and provided a submission to the Inquiry on 25 October 1996.

Submissions by the Complaints Commissioner to the Senate Review and the Productivity Commission Inquiry addressed defects in the legislation governing the effective operation of the Complaints Commissioner. Hopefully these defects will be addressed in 1997-98, when the Government's responses to the Senate Community Affairs Legislation Committee's Review and the Productivity Commission's Inquiry are actioned.

DEFECTS IN THE LEGISLATION GOVERNING OPERATION OF THE COMPLAINTS COMMISSIONER

As outlined in last year's Annual Report, there are several problems with the parts of National Health Act 1953 governing the creation and operation of the Complaints Commissioner. These problems can be divided into two areas - effective complaint handling and matters of practical administration - and are outlined below.

Effective Complaint Handling

- The Complaints Commissioner has a general power to investigate but no provisions to support specific investigative practices and procedures.
  - For example, the Commissioner cannot insist that health funds provide any information when it investigates complaints about health funds (or others)
  - While the Complaints Commissioner can examine health funds' records and rules when investigating health funds' practices and procedures, either at the request of the Minister or under the Commissioner's own initiative, the Commissioner has no specific power to do so in the course of investigating a complaint.
- There is no requirement on health funds to respond to the Complaints Commissioner's recommendations relating to complaints although the Commissioner is supposed to advise complainants and Parliament of the outcomes.

Matters of Practical Administration

- The Complaints Commissioner cannot delegate any of the legislative powers conferred on the office. This is necessary for the efficient and effective functioning of the office.
- The person holding office as Complaints Commissioner and the staff of the office are not protected from civil litigation. One major health fund has threatened legal action.
- The legislation does not give the Complaints Commissioner power to decline to take action on complaints in situations that call out for such power. Experience of other dispute resolution bodies shows that complaint organisations need these powers to provide the flexibility to manage resources and caseloads.
- The National Health Act requires the Complaints Commissioner to write to complainants where it is not necessary - for example, where the Commissioner has advised a complainant over the phone to first contact the health fund to resolve their complaint.

PRIVATE HEALTH INSURANCE INCENTIVES

Legislation to introduce the Private Health Insurance Incentives Scheme (PHIIS) was passed and the incentives became available from 1 July 1997. The Complaints Commissioner has jurisdiction for problems that health fund members may have with their fund about the administration of the incentives.

RELATIONS WITH STAKEHOLDERS

With the exception of one major health fund, relations with stakeholders have been cordial. Most health funds have been co-operative in responding to approaches by staff about complaints, although sometimes reluctant to take remedial action.

After 15 months of operation, it is clear to the Complaints Commissioner that there are contentious industry practices which impact adversely on members. It is difficult to canvass these issues meaningfully with the industry. The industry does not embrace suggestions for change coming from outside the industry. Dialogue about issues is difficult because the private health insurance industry is rather fragmented and there are no consumer groups dedicated to health insurance members' interests.

The Complaints Commissioner would be greatly assisted by advice and feedback from a consultative forum regarding operational and policy matters and comprising representatives of consumer groups and health funds. The preferable option would be for the forum to mirror, as far as possible, another group that meets regularly about health insurance matters. The ideal one would be the Purchaser - Provider Panel (or similar body) which has not been established yet.

Sasha Andrews, Director, Corporate Services
Janelle Metry, Temporary Office Manager
Kathryn Gilhooley, Administrative Assistant

ADVERTISING GUIDELINE FOR THE INDUSTRY

Some health fund advertising is unhelpful to consumers, and can be misleading on occasions. At the beginning of the reporting year, the main problem in this area was advertisements and promotions that purported to offer "100% hospital cover".

What the term really means is that hospital accommodation charges and theatre fees are covered 100%, with members having to bear various additional charges for such items as medical fees above the Medicare Benefits Schedule, pharmaceuticals and occasionally associated treatments such as physiotherapy and dietary advice.

After discussions between the Complaints Commissioner and the Australian Competition and Consumer Commission (ACCC), and approaches from the ACCC, the health funds that were approached eventually dropped this form of advertising. However, the legacy in the States where this type of advertising was heavy is a general, false assumption in the community that private hospital care comes free of all out of pocket costs to members.

The other form of disturbing promotional and advertising activity is a promise of "immediate cover" or a "waiver of waiting periods". Some funds make these promises without specifying that only some, less onerous waiting periods are waived. People with ailments are induced to join, only to be disappointed when the claims they lodge in the first year are rejected because there is waiting period of one year for pre-existing ailments.

There is an urgent need for industry guidelines for fair advertising and promotions in the health insurance industry. The ACCC and the Complaints Commissioner prepared draft guidelines for circulation just after the close of the reporting period.

INFORMATION TECHNOLOGY

Shortly after the commencement of operations, the Complaints Commissioner decided to invest in a temporary complaints database system. Atemporary system was developed quickly and inexpensively to record details of complaints and to be used as a testing ground to assess the Commissioner's data collection and reporting needs.

The needs of the office are now clear and the Complaints Commissioner's staff have prepared detailed specifications for a more sophisticated complaints management and reporting system, with the assistance of a specialist consultant. The Commissioner has recently sought tenders for the provision of a new complaint management and reporting system and intends to replace the temporary one during 1997/98.

From left: Patricia Sammut, Steven Meadows, Jennifer Blyton
our Customer Service Officers

STAFFING

As at 30 June 1997, the staff employed by the Private Health Insurance Complaints Commissioner comprised:

Permanent & Part-Time Employees	Female	Male
Complaints Commissioner	1	-
Director, Policy & Customer Service	-	1
Director, Corporate Services	1	-
Customer Service Officers	2	1
Policy and Project Officer	1	-
Administrative Assistant	1	-
Total	**6**	**2**

Towards the end of the reporting period a temporary Office Manager was employed to assist with running the office of the Complaints Commissioner.

STATUTORY POSITIONS

The Private Health Insurance Complaints Commissioner comprises one statutory office holder:

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

STAFF DEVELOPMENT AND TRAINING

During the 1996-97 financial year $7,768.70 was spent on training courses, conferences and seminars. Eight staff participated in these training programs.

The Complaints Commissioner has undertaken a staff skills audit and is implementing a staff development and training plan, which will run during 1997/98.

Topic	Provider	Attending
Health & Health Insurance		
New Regime in Health Insurance	AIC Conferences	1 Staff
Industry Codes of Conduct	Conference Solutions	1 Staff
National Health Care Complaints Conference	Institute of Public Administration Australia	4 Staff
General Business Related		
Business Consumers & Information	Society of Consumer Affairs Professionals	1 Staff
Tendering & Managing Consultancies	Public Service & Merit Protection Commission	1 Staff
New Privacy Laws	Communications Law Centre	1 Staff
Using Business Process Re-Engineering	Public Service & Merit Protection Commission	1 Staff
Administrative Law	Australian Institute of Admin Law Inc	1 Staff
Negotiation Theory & Practice	Australian Graduate School of Management University of NSW	1 Staff
The Senate & Legislative Process	Senate Procedures Office	1 Staff
Assertiveness Skills	Forum of Commonwealth Agencies	1 Staff
Effective Writing	Forum of Commonwealth Agencies	2 Staff
1996/97 Tax Workshop	Australian Wide Taxation Training Services	1 Staff
Conflict Resolution	Forum of Commonwealth Agencies	1 Staff
Industrial Relations		
New Industrial Relations Law	Attorney General's Department	1 Staff
IR Issues	Dept of Industrial Relations	1 Staff
Understanding Your Superannuation	Forum of Commonwealth Agencies	1 Staff
Information Technology		
Microsoft Word	Pollak Partners	2 Staff
Windows NT	Pollak Partners	1 Staff
Mind Your Own Business	Tailored Solutions Pty Ltd	2 Staff
Windows	Pollak Partners	1 Staff
Access	Pollak Partners	1 Staff
Excel	Pollak Partners	2 Staff
Microsoft Windows	Pollak Partners	1 Staff

EQUAL EMPLOYMENT OPPORTUNITY

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

The following table sets out the number of staff in the EEO target groups, including temporary staff who were employed or separated in 1996-97.

OCCUPATIONAL HEALTH & SAFETY

Responsibility for the safety and health of all staff rests with the Complaints Commissioner, who is required to be aware of all dangers to health and safety in the workplace.

There were no reportable incidents during the past year, hence no staff days were lost.

The Commissioner complies with provisions of the Occupational Health and Safety (Commonwealth Employment) Act 1990.

INDUSTRIAL DEMOCRACY

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

PERFORMANCE APPRAISAL

The Complaints Commissioner has developed a performance appraisal system that is used by the Commissioner to measure staff performance and as a tool to assist the Commissioner with annual salary reviews. All staff are subject to an annual performance appraisal.

Occupational Group	NESB1	NESB2	ATSI	PWD	Women	Total Staff
SES	-	-	-	-	1	1
Other	-	1	-	-	6	8
Total	**-**	**1**	**-**	**-**	**7**	**9**

Note:

SES Senior Executive Service

Other All other staff - temporary and permanent

NESB1 Non-English speaking background, 1st Generation

NESB2 Non-English speaking background, 2nd Generation

ATSI Aboriginal and Torres Strait Islander

PWD People with a disability

CONSULTANTS ENGAGED

The Complaints Commissioner engaged specialist consultants to provide expertise in the areas of legal advice, information technology and recruitment.

During the financial year 9 consultants were engaged for a total cost of $59,057.08. Details of consultants who were paid more than $2000 are set out below.

INFORMATION SYSTEMS

The Complaints Commissioner's information system is based upon a Windows NT network using ASI personal computers. Software used consists of the Microsoft Office 97 suite, which includes word processing, spreadsheet, desktop publishing, mail and database facilities. Accounting software used is Mind Your Own Business, and Pollak Partners have developed a temporary complaints database in Microsoft Access.

The Commissioner is currently selecting a consultant for the provision of a permanent Complaints Management and Reporting system.

ACCOUNTING SERVICES

The Complaints Commissioner has engaged Love & Rodgers Chartered Accountants to assist it with its accounting functions.

PAYROLL SERVICES

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

SOCIAL JUSTICE, ACCESS AND EQUITY

The Complaints Commissioner provides a speedy and informal complaints and inquiry service, free of charge and actively pursues access and equity goals and strategies in planning and delivering all its services.

Complaints and inquiries can be made from anywhere in Australia on the free call Hotline 1800 640 695. Complaints may be lodged by letter telephone, fax and E-mail.

Consultant	Project	Total Cost of Consultancy	1996/97 Payments
Blake, Dawson & Waldron	Legal Advice	$ 3,827.25	$ 3,827.25
PA Consulting	Human resource advice & recruitment	$10,500.00	$10,500.00

Note: The services of consultants were required to provide assistance and expertise not available within the current skills mix within the office.

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

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

The Complaints Commissioner is in the process of producing a home page on the Internet, which will enable people to access information about us via computer.

Access and equity goals and strategies are incorporated in the current corporate plan. A primary goal is to raise community awareness about the Complaints Commissioner through advertising and through the wide distribution of pamphlets and our annual report to community groups, private hospitals, doctors' surgeries, health funds, Ombudsmans' offices, consumer affairs organisations and Members of Parliament.

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

This statement is published to meet the requirements of Section 8 of the Freedom of Information Act 1982 (FOI Act). It is correct as at 30 June 1997.

ESTABLISHMENT

The Private Health Insurance Complaints Commissioner (the Complaints Commissioner) was established by the Health Legislation (Private Health Insurance Reform) Amendment Act 1995 (the 1995 reform legislation) to resolve complaints about any matter arising out of or connected with a private health insurance arrangement. The Complaints Commissioner is an independent statutory corporation.

The relevant part of the 1995 reform legislation commenced on 1 October 1995.

PUBLIC INFORMATION

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

REQUESTS

The Complaints Commissioner received many requests for information about its activities during the reporting year but did not receive any requests for information under the FOI Act.

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

DOCUMENTS HELD BY THE COMPLAINTS COMMISSIONER

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

- a brochure "Service Charter"
- a brochure "Can We Help With Your Health Insurance Complaint?"
- a brochure "Our Mission"
- a brochure "10 Golden Rules of Private Health Insurance"
- a booklet "Private Patients' Hospital Charter"
- a booklet *"Insure, Not Sure?"*
- Complaints Register and Complaints files
- Correspondence and working papers relating to the administration of the Complaints Commissioner, including personnel and financial papers
- Guideline for staff "Complaints and Inquiry Policy and Procedures"
- other guidelines for staff of an administrative nature to assist in the efficient and effective operation of the office.

DOCUMENTS AVAILABLE FREE OF CHARGE

The following categories of documents are available free of charge upon request:

- a brochure entitled "Can We Help With Your Health Insurance Complaint?"
- a brochure "Our Mission"
- a brochure "10 Golden Rules of Private Health Insurance"
- a booklet and brochure "The Private Patients' Hospital Charter"
- a booklet *"Insure? Not Sure?"*
- a Service Charter.

Complainants can have access to material held on the complaints register and complaint files relating to them. (Material that would be exempt from disclosure under the FOI Act may be withheld if necessary.)

ACCESS TO DOCUMENTS

People may obtain documents:

- from the office of the Complaints Commissioner located at

  Suite 1201, Level 12,
  St Martins Tower,
  31 Market Street,
  Sydney, NSW, 2000
- by telephoning (02) 9261 5855 or 1800 640 695 (freecall)
- by fax on (02) 9261 5937
- from the web site http://www.phicc.org.au.

INFORMATION AND PROCEDURES FOR FREEDOM OF INFORMATION ACT REQUESTS

Requests under the FOI Act should be made in writing and accompanied by a $30 application fee, as required by the Act, and directed to:

Director, Policy and
Customer Service

Suite 1201, Level 12
St Martins Tower
31 Market Street
SYDNEY NSW 2000.

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

COURTS

During the year there were no applications to any courts.

OMBUDSMAN

During the year there were no complaints to the Ombudsman or investigations notified.

OTHER

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

Anational market research company, Reark Research, was engaged to conduct a client satisfaction survey of health fund members who have contacted the Private Health Insurance Complaints Commissioner with an inquiry or complaint, and health fund staff with whom the customer service staff of the Complaints Commissioner have dealt during the past year.

The aim of the survey is to find out whether we are meeting our clients' needs and identify any areas where improvements could be made.

The information in this Annual Report and other Complaints Commissioner publications about the way we record and report on approaches made to the office is based on the following concepts.

APPROACHES

All approaches to the office are recorded as Inquiries or 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.

Complaints

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.

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.

THREE TIERED COMPLAINT HANDLING PROCESS

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 and/or the Commissioner is able to suggest to the complainant other ways to approach the problem with the health fund or hospital). This is recorded as a Problem
- by staff of the Complaints Commissioner dealing with the complainant's grievance directly by providing additional information or a clearer explanation. This is recorded as a Grievance
- by contacting the health fund, hospital or doctor about the matter. This may be done by telephone or in writing. This is recorded as a Dispute.

WHO CAN BE COMPLAINED ABOUT?

Complaints may be made about health funds, private and public hospitals and day surgery centres, doctors and some dentists. A complaint may be about more than one of these. For example, a complaint may be about a health fund, a hospital and two doctors. This information, about the object of a complaint, is not recorded for inquiries.

ISSUES

An approach to the office, whether it is a complaint or an inquiry, may raise more than one issue. The issues raised by complaints and inquiries are recorded separately. For example:

- 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 hospitalisation. (In this case the two issues recorded will be "Information - oral" and "Benefit - amount".)

  The number of issues reported by the Complaints Commissioner in a given time will always be equal to or greater than the number of complaints. For example, in 1996/97, the Commissioner received 1211 complaints about 1440 issues.

- an **inquiry** may be made by a consumer who is not a health fund member wanting information about doctors' fees or by a health fund member wanting information about Medicare Schedule Fees. 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 1190 inquiries about 1236 issues in 1996/97.

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 complaint objects are 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.

Australian National Audit OFFICE

INDEPENDENT AUDIT REPORT

To the Minister for Health and Family Services

Scope

I have audited the financial statements of the Private Health Insurance Complaints Commissioner for the year ended 30 June 1997. The financial statements comprise:

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

The Commissioner is responsible for the preparation and presentation of the financial statements and the information they contain. I have conducted an independent audit of the financial statements in order to express an opinion on them to the Minister for Health and Family Services.

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

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

Audit Opinion

In accordance with section 63M(2) of the *Audit Act 1901*, I now report that the financial statements are in agreement with the accounts and records of the Private Health Insurance Complaints Commissioner and in my opinion:

(i) the statements are based on proper accounts and records;

(ii) the statements present fairly, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements, the financial transactions and results, and cash flows, for the year ended 30 June 1997 and the state of affairs of the Private Health Insurance Complaints Commissioner as at that date;

(iii) the receipt, expenditure and investment of moneys, and the acquisition and disposal of assets, by the Private Health Insurance Complaints Commissioner during the year have been in accordance with *National Health Act 1953*, and

(iv) the statements are in accordance with the Guidelines for Financial Statements of Commonwealth Authorities.

Australian National Audit Office

Russ Chantler
Executive Director

For the Auditor-General

Sydney
6 August 1997

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PRIVATE HEALTH INSURANCE COMPLAINTS COMMISSIONER

STATEMENT BY THE COMMISSIONER

In my opinion, the attached financial statements present fairly the information required by the Minister for Finance Guidelines on Financial Statements of Commonwealth Authorities.

Mary Perrett
Complaints Commissioner

Dated: 5/8/1997

Operating Statement
Year Ended 30th June 1997

	Note	1997 $	1996 $
NET COSTS OF SERVICES			
Operating Expenses			
Suppliers	**2A**	**318,468**	104,664
Employees	**2B**	**427,912**	202,099
Depreciation and Amortisation	**2C**	**50,903**	9,993
Total Operating Expenses		**797,283**	316,756
Operating Revenue From Independent Sources			
Interest	**3**	**23,189**	8,481
Total Operating Revenue From Independent Sources		**23,189**	8,481
Net Cost Of Services		**774,094**	308,275
REVENUES FROM GOVERNMENT			
Parliamentary Appropriations Received	**4A**	**705,000**	700,000
Resources Received Free of Charge	**4B**	**–**	8,042
Grant	**4C**	50,000	–
Total Revenues From Government		**755,000**	708,042
Surplus (deficit) of Revenues From Government Over Net Costs of Services		**(19,094)**	399,767
(Loss) on Extraordinary Items	**5**	**–**	(56,932)
Surplus (deficit)		**(19,094)**	342,835
Accumulated Surpluses at beginning of Reporting Period		**342,835**	–
Accumulated Surpluses at end of Reporting Period		**323,741**	342,835

The accompanying notes form part of these financial statements

Statement of Assets and Liabilities
Year Ended 30th June 1997

	Note	1997 $	1996 $
PROVISIONS AND PAYABLES			
Suppliers	6A	**91,428**	20,688
Employees	6B	**92,858**	77,847
Total provisions and payables		**184,286**	98,535
Total liabilities		**184,286**	98,535
EQUITY			
Accumulated Surpluses		**323,741**	342,835
Total equity		**323,741**	342,835
Total liabilities and equity		**508,027**	441,370
FINANCIAL ASSETS			
Cash	7A	**291,652**	242,334
Receivable	7B	**4,803**	1,797
Total financial assets		**296,455**	244,131
NON FINANCIAL ASSETS			
Infrastructure, plant and equipment	8A	**190,313**	187,532
Other	8B	**21,259**	9,707
Total non-financial assets		**211,572**	197,239
Total Assets		**508,027**	441,370
CURRENT LIABILITIES		**134,892**	51,197
NON-CURRENT LIABILITIES		**49,394**	47,338
CURRENT ASSETS		**317,714**	253,838
NON-CURRENT ASSETS		**190,313**	187,535

The accompanying notes form part of these financial statements

Statement of Cashflows
Year Ended 30th June 1997

	Note	1997 $	1996 $
OPERATING ACTIVITIES			
Cash Received			
Appropriations		**705,000**	698,203
Interest		**23,189**	8,481
Other		**50,000**	–
Total cash received		**778,189**	706,684
Cash used			
Suppliers		**(243,330)**	(63,231)
Employees		**(431,857)**	(203,594)
		(675,187)	(266,825)
Net cash from operating activities	15	**103,002**	439,859
INVESTING ACTIVITIES			
Cash Used			
Purchase of Infrastructure, Plant & Equipment		**(53,684)**	(197,525)
Net cash from investment activities		**(53,684)**	(197,525)
Net increase in cash held		**49,318**	242,334
add cash at 1 July		**242,334**	–
Cash at 30 June		**291,652**	242,334

The accompanying notes form part of these financial statements

Schedule of Commitments
Year Ended 30th June 1997

	Note	1997 $	1996 $
BY TYPE			
OTHER COMMITMENTS			
Operating Lease Commitments		**122,533**	186,463
Project commitments		**60,000**	–
		182,533	186,463
BY MATURITY			
One Year or Less		**123,930**	63,930
From one to two years		**58,603**	63,930
From two to five years		–	58,603
		182,533	186,463

Schedule of Contingencies
Year Ended 30th June 1997

	1997 $	1996 $
CONTINGENT LOSSES	–	–
CONTINGENT GAINS	–	–
Net Contingencies	**0**	0

Notes to and Forming Part of the Financial Statements Year Ended 30th June 1997

1. STATEMENT OF ACCOUNTING POLICIES

The financial statements are a general purpose financial report. They have been prepared on an accrual basis from the records of the entity for the year ended 30th June 1997. They are based on historical costs and do not take into account the changing values of money. Cost is based on the fair values of the consideration given in exchange for assets.

The accounts have been prepared in accordance with the Guidelines on Financial Statements of Commonwealth Authorities issued by the Minister of Finance which require compliance with relevant Australian Accounting Standards and related Guidance Releases and have regard to Australian Statements of Accounting Concepts and have been prepared in accordance with Urgent Issues Group consensus views.

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

INFRASTRUCTURE, PLANT & EQUIPMENT

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

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

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

LEASES

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

RESOURCES RECEIVED FREE OF CHARGE

Resources received free of charge are recognised in the Operating Statement where the amounts can be reliably measured. Use of the resources is recognised as an expense or where there is a long term benefit an asset is recognised.

EMPLOYEE ENTITLEMENTS

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

The provision for annual leave reflects the value of total annual leave entitlements of all employees at 30 June 1997 and is recognised at its nominal value.

The liability for long service leave is recognised and measured at present value of the estimated future cash flows to be made in respect of all employees at 30 June 1997.

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

TAXATION

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

CASH

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

COMPARITIVE FIGURES

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

	1997 $	1996 $
2. GOODS AND SERVICES EXPENSES		
2A. Suppliers Expenses		
Accounting Fees	**3,420**	–
Auditor's Remuneration	**2,900**	3,500
Bad Debts	**428**	–
Consultancy Fees	**59,057**	24,482
Department of Health Incidental Expenses	–	22,042
Establishment Costs	**1,776**	12,509
Insurance	**6,447**	2,128
Legal Fees	**4,839**	150
Motor Vehicle Expenses	**6,394**	2,820
Printing & Stationery	**13,372**	7,963
Plant & Equipment	**3,088**	1,512
Public Awareness	**40,357**	–
Rent	**63,563**	13,815
Subscriptions & Donations	**7,719**	1,224
Telephone	**16,914**	4,828
Travelling Expenses - Local	**26,321**	6,126
Other Administration Expenses	**11,873**	1,565
Expenditure Under Grant	**50,000**	–
	318,468	104,664
2B. Employee Expenses		
Annual Leave Provision	**11,185**	9,187
Fringe Benefits Tax	**6,992**	1,800
Long Service Leave	**2,056**	8,662
Salaries & Wages	**326,849**	146,655
Staff Recruitment	**12,871**	7,127
Staff Training & Welfare	**7,769**	6,125
Superannuation Contributions	**47,207**	21,684
Other Employee Expenses	**12,983**	859
	427,912	202,099
2C. Depreciation And Amortisation		
Depreciation	**38,706**	6,883
Amortisation - Lease Fitout	**12,197**	3,110
	50,903	9,993

Notes Continued

	1997 $	1996 $
3. REVENUES FROM INDEPENDENT SOURCES		
Interest		
Deposits	**23,189**	8,481
4. REVENUES FROM GOVERNMENT		
4A. Parliamentary Appropriations		
Appropriation Act No. 1	**705,000**	700,000
4B. Resources Received Free Of Charge		
Provision of Facilities by Department of Human Services & Health	**–**	8,042
4C. Grant		
Grant from Department of Health	**50,000**	–
5. EXTRAORDINARY ITEM		
Employee Entitlements Transferred Under Mobility Provisions	**–**	56,932
6. PROVISIONS AND PAYABLES		
6A. Suppliers		
Trade Creditors	**85,108**	17,688
Accruals	**6,320**	3,000
	91,428	20,688
6B. Employees		
Salaries and Wages	**4,837**	3,067
Annual Leave	**38,627**	27,442
Long Service Leave	**49,394**	47,338
	92,858	77,847
7. FINANCIAL ASSETS		
7A. Cash		
Cash on Hand	**250**	250
Cash at Bank	**291,402**	242,084
	291,652	242,334
7B. Receivables		
Other Debtors	**4,803**	1,797

Notes Continued

	1997 $	1996 $
8. NON FINANCIAL ASSETS		
8A. Infrastructure, Plant & Equipment		
Leasehold Fitout - at Cost	**71,745**	71,745
Less: Accumulated Amortisation	**15,307**	3,110
	56,438	68,635
Plant & Equipment - at Cost	**179,464**	125,780
Less: Accumulated Depreciation	**45,589**	6,883
	133,875	118,897
Total Property, Plant & Equipment at Written Down Value	**190,313**	187,532
8B. Other Assets		
Prepaid Property Rentals	**–**	5,530
Other Prepayments	**21,259**	4,177
	21,259	9,707

MOVEMENT SUMMARY 1996-97 FOR ALL ASSETS IRRESPECTIVE OF VALUATION BASE

Item	Leasehold Fitout $	Plant and Equipment $	Total $
Gross value as at 1 July 1996	**71,745**	**125,780**	**197,525**
Additions:	–	53,684	53,684
Revaluations	–	–	–
Disposals	–	–	–
Other movements	–	–	–
Gross Value as at 30 June 1997	**71,745**	**179,464**	**251,209**
Accumulated Depreciation / Amortisation as at 1 July 1996	**3,110**	**6,883**	**9,993**
Depreciation / amortisation charge for assets held 1 July 1996	12,197	36,572	48,769
Depreciation / amortisation charge for additions	–	2,134	2,134
Adjustment for revaluations	–	–	–
Adjustment for disposals	–	–	–
Adjustment for other movements	–	–	–
Accumulated Depreciation / Amortisation as at 30 June 1997	**15,307**	**45,589**	**60,896**
Net book value as at 30 June 1997	**56,438**	**133,875**	**190,313**
Net book value as at 1 July 1996	**68,635**	**118,897**	**187,532**

	1997 $	1996 $
9. REMUNERATION OF OFFICERS		
Total income received or due and receivable by the Commissioner:	**121,639**	73,669
Number of Commissioners whose total income falls within the following bands:		
$ 70,000 - $ 79,999	–	1
$ 120,000 - $129,999	**1**	–
10. REMUNERATION OF AUDITORS		
Remuneration to the Auditor-General for Auditing the Financial Statements	**2,900**	3,500

No other services were provided by the Auditor-General during the reporting period.

11. SUPERANNUATION

The Commissioner contributes to the Commonwealth Superannuation (CSS) and the Public Sector Superannuation (PSS) schemes which provide retirement, death and disability benefits to employees. Contributions to the scheme are at rates calculated to cover existing and emerging obligations. Current contribution rates are 20.1% of salary (CSS) and 11.0% of salary (PSS). An additional amount of up to 3% is contributed for employer productivity benefits.

12. ECONOMIC DEPENDENCY

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

13. SEGMENT REPORTING

The Commissioner operates in a single industry and geographic segment, being provision of complaint resolution services in Australia.

Notes Continued

	1996 $	1997 $
14.CASH		
For the purposes of this Statement of Cash Flows, cash includes cash on hand and in banks.		
Cash on Hand	**250**	250
Cash at Bank	**291,402**	242,084
	291,652	242,334
15.CASH FLOW RECONCILIATION		
Reconciliation of net cash flows from operating activities to Net Cost of Services		
Net Cost of Services	**(774,094)**	(308,275)
Parliamentary Appropriation	**705,000**	700,000
Grant	**50,000**	–
Operating Surplus	**(19,094)**	391,725
Amortisation - Lease Fitout	**12,197**	3,110
Annual Leave Provision	**11,185**	9,187
Depreciation	**38,706**	6,883
Long Service Leave	**2,056**	8,662
Resources Provided Free of Charge	–	8,042
Increase in Other Debtors	**(3,007)**	(1,797)
Increase in Trade Creditors	**67,420**	17,687
Increase in Accruals	**5,091**	6,067
Decrease in Prepaid Property Rentals	–	(5,530)
Increase in Other Prepayments	**(11,552)**	(4,177)
Net Cash Provided by Operating Activities	**103,002**	439,859

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The training undertaken by staff during the year is summarised below.

Staff also participated in part-time studies at formal educational