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QUARTERLY BULLETIN NO 18
(1 January to 31 March 2001)

INTRODUCTION

This bulletin will concentrate on four issues which have come to the fore in the immediate past and which require publication.

In the first instance we will address the question of no and known gap policies and the access members have to these products;
secondly we will re-visit the voluntary code of practice;
thirdly there are still numerous problems associated with the full understanding of product complexity and how this is handled internally and by consumers; and
Finally there will be a review of the complaint statistics following Lifetime Health Cover.

No and Known Gaps

It is useful as an opening to this segment to focus on one of the numerous complaints lodged by consumers. In this particular case, the fund member of long standing residing in the ACT experienced difficulties accessing a specialist to carry out an orthopaedic procedure.

Mr N has been a member of his fund for 22 years. He requires knee surgery for which his referred specialist has indicated he charges $470 above the scheduled fee. Mr N was dissatisfied with this and having heard the publicity attached to the question of no gaps, approached his fund personally at the local shopping centre branch. He was advised the fund had arrangements with 70% of doctors and provided with a brochure outlining the scheme. He was advised to ring a national hotline number and they would be able to inform him of which doctors the fund had arrangements with. Unfortunately the fund could only respond with respect to individual practitioners as to whether they were associated with their scheme.

Mr N rang all appropriate specialists in Canberra only to find out that none of them had an arrangement with his fund. Indeed he was made aware in no uncertain terms on more than one occasion that the specialists were annoyed at even being asked the question.

Mr N had advised the fund, that if they could indicate which orthopaedic surgeons they had under agreement in Sydney, he would approach his doctor for a referral.

The fund was unable/unwilling to provide this specific information.

The very obvious question that arises from this (and other) complaints, is how can the no gap arrangements work for the benefit of consumers, if they or their general practitioners have no access to the names and specialties of the practitioners who have agreed to participate.

This office is well aware of the differences in opinion, which exist between insurers on one hand and sectors of the medical profession on the other, relating to the whole question of establishing lists of participants. We are also aware there are real concerns that the establishment of lists may introduce a quasi quality/price selection criteria which may not be seen as in the best interest of the patient. That is why the General Practitioner is of paramount importance in this whole process; they are the practitioners charged with the responsibility of referral. They must be part of the new equation.

It is impossible in this short bulletin to enunciate fully both sides of the argument. Although we recognise the concerns of all participants, we cannot accept a position where the patient's right to be fully informed, not only of their medical options but also financial is not available to them. It is time for the parties, Insurers, AMA, and Government to put in place safeguards to guarantee the probity of the lists and their purpose.

Consumers have identified the medical gap as being an issue of significance that needs resolution. The law has been changed to allow it to proceed without the need for individual contracts. A significant number of professionals have agreed to be part of the system. It is now up to the parties to make the system work for the consumer and the private health industry.

Voluntary Code of Practice

This issue was referred to in the previous quarterly bulletin. Unfortunately to some the raison díetre for the code is not understood or respected. The code provides a range of safeguards for all parties to contract negotiation and as a consequence also the consumer.

Underlying the code is the principle that there is no requirement for either party to enter into a contract if the result does not reflect the needs and aspirations of the party or parties.

The code then provides for a proper process to inform patients and potential patients, if and when negotiations do not result in a satisfactory arrangement. Both parties have a role. Fundamental to this process is that outcomes of negotiations must be communicated to patients affected in a fair and reasonable way and in a way that avoids adverse publicity or negative perceptions of either specific insurers or hospitals.

It is inappropriate to engage in recrimination between the parties in the press, either directly or indirectly. As indicated previously this office will step forward and make unsolicited comment if consumers are placed in a position of heightened concern by the actions of either negotiating party.

To use the words of the joint press release from APHA and AHIA, *"a principle objective of the Code is to introduce a framework based on the principles of fairness and reasonableness in order to minimise disputes."* The code has been developed to establish an orderly process and to protect the consumers of private health. For this

protection to be a reality, the principles on which the code is based need to be accepted and signed off by the private health participants.

Getting the Correct Information Across

The Green family of Tasmania joined during the life time health cover campaign. Their son was diagnosed in September with S V Tachycardia. The question naturally arose as to whether this was a pre-existing ailment.

The family asked for a ruling and in February received two written responses from the fund.

> *"This letter is to confirm that L's tachycardia is NOT a Pre-existing condition and therefore we will pay benefits for the hospital claim."*
>
> *And then the next day,*
>
> *"Based on the information supplied by Dr S, I advise that the above mentioned rule (PEA) will not be applied for the ailment illness or condition. Therefore, benefit will be payable on your current level of cover"*

The Green family could not have the surgery performed in Tasmania and travelled to Melbourne for the procedure at the Melbourne Private.

On the day of admission, the hospital fund check revealed that the policy under which L was covered had a benefit limitation on cardiac surgery. The Green family could not afford the theatre fees nor the possibility of costs associated with a lengthy stay if there were any complications. They were forced to return to Tasmania.

This is only one of many examples where only half the important information is provided and has led to significant difficulties for the members concerned. It is not usually quite as bad as this example where two different operatives provided written confirmation of what seemed to be cover. Other examples are where hospitals carry out a fund check and are told that the PEA does not apply but likewise are not told that the level of cover excludes or limits the benefits for the proposed procedure. These mistakes should not occur.

Complaint Statistics

The office has carried out a further review of the complaint statistics for the nine months following Lifetime Health Cover and cross-referenced these with the corresponding period last financial year.

This latest nine months has produced 2557 complaints as against 1172 the previous corresponding period, an increase of 118.2%. Likewise the higher level disputes category of complaint has risen 96.2% from 469 up to 920.

It is interesting to note that 50% of the current complaints come from members with less than 12 months standing. That is 30% of the membership account for 50% of the complaints.

On an individual fund basis, the statistics are even more revealing. Since the influx of new members, five funds have consistently returned results where their ratio of complaints to market share have been excessive. Two of these funds had not previously exhibited this characteristic.

Complaints (Problems, Grievances & Disputes) by health fund
1 January 2001 to 31 March 2001

Name of Fund	Total number of complaints (1)	% of total complaints	Total number of disputes (2)	% of total disputes	Health fund Market share (3)
ACA Health Benefits Fund	1	0.1	0	0.0	0.1
AMA Health Fund Limited	0	0.0	0	0.0	0.1
Australian Health Management Group Limited	14	1.8	7	2.5	2.6
Australian Unity Health Limited	40	5.1	16	5.8	2.8
AXA Australia Health Insurance	90	11.6	40	14.4	10.3
CBHS Friendly Society Limited	6	0.8	2	0.7	0.9
Cessnock District Health Benefits Fund	0	0.0	0	0.0	0.0
Credicare Health Fund	1	0.1	1	0.4	0.5
Defence Health Benefits Society	3	0.4	0	0.0	1.1
Federation Health	0	0.0	0	0.0	0.2
Geelong Medical & Hospital Benefits Assoc. Ltd	3	0.4	0	0.0	1.0
Goldfields Medical Fund (Inc.)	3	0.4	0	0.0	0.5
Grand United Corporate Health Limited	1	0.1	0	0.0	0.2
Grand United Health Fund Pty Ltd	5	0.6	3	1.1	0.5
Health Care Insurance Limited	2	0.3	2	0.7	0.1
Health Insurance Fund of W.A.	3	0.4	2	0.7	0.4
Health-Partners Inc.	4	0.5	2	0.7	0.5
Healthguard Health Benefits Fund Limited	0	0.0	0	0.0	0.1
HBF Health Funds Inc.	30	3.9	8	2.9	8.9
Hospitals Contribution Fund of Australia Limited	37	4.7	12	4.3	7.8
IOOF Health Services Limited	3	0.4	3	1.1	0.2
I.O.R. Australia Pty Limited	10	1.3	2	0.7	0.8
Latrobe Health Services Inc.	2	0.3	0	0.0	0.5
Lysaght Hospital and Medical Club	0	0.0	0	0.0	0.2
Manchester Unity Friendly Society In N.S.W.	34	4.4	12	4.3	1.3
Medibank Private Limited	260	33.4	92	33.2	29.7
Medical Benefits Fund of Australia Limited	160	20.5	49	17.7	17.3
Mildura District Hospital Fund Limited	0	0.0	0	0.0	0.3
Navy Health Limited	0	0.0	0	0.0	0.3
N.I.B. Health Funds Limited	38	4.9	17	6.1	5.4
NRMA Health Pty. Limited	12	1.5	4	1.4	1.5
N.S.W. Teachers' Federation Health Society	3	0.4	0	0.0	1.4
Phoenix Welfare Association Limited	0	0.0	0	0.0	0.1
Queensland Country Health Limited	0	0.0	0	0.0	0.2
Railway & Transport Emp'ees Friendly Soc.	0	0.0	0	0.0	0.3
Reserve Bank Health Society	0	0.0	0	0.0	0.1
SA Police Employees' Health Fund Inc.	1	0.1	0	0.0	0.1
St Luke's Medical & Hospital Benefits Ass. Ltd.	1	0.1	0	0.0	0.4
Transition Benefits Fund Pty Limited	0	0.0	0	0.0	0.1
Queensland Teachers' Union Health Fund Limited	3	0.4	2	0.7	0.4
Transport Friendly Society Limited	0	0.0	0	0.0	0.1
United Ancient Order of Druids Victoria	0	0.0	0	0.0	0.1
United Ancient Order of Druids G/L NSW	1	0.1	0	0.0	0.0
Western District Health Fund Ltd	8	1.0	1	0.4	0.7
Total for Registered Funds	**779**	**100.0**	**277**	**100**	**100.0**

1 Complaints = problems, grievances and disputes
2 Disputes require intervention by the Ombudsman and the fund
3 Proportion of people covered by health fund as at 30 June 2000 as reported in the PHIAC Annual Report.