Private Health Insurance
OMBUDSMAN

Quarterly Bulletin Issue 9
1 July – 30 September 1998

Welcome to the first Quarterly Bulletin for the 1998/99 financial year, summarising the Ombudsman's operations between 1 July and 30 September 1998.

Highlights this quarter

- 548 *complaints* were received.
- Most complaints were about benefits (35%) compared with the June quarter, when "cost" was the most complained about issue.
- 50% of complaints were resolved within a week, compared with 63% in the June quarter.
- 385 *inquiries* were recorded during the September quarter.
- Overwhelmingly, it is health fund members who lodge complaints.

New Complaints Management and Reporting System

With the installation of an updated Complaints Management and Reporting System in June 1998, the Ombudsman is now able to classify approaches to the office as *problems, grievances, disputes* or *inquiries.* A new graph which illustrates the proportion of problems, grievances and disputes for this quarter is included in this issue of the Quarterly Bulletin on page .

Distribution and Suggestions

- Quarterly Bulletins are provided to the Minister for Health and Family Services, members of the Senate Community Affairs Legislation Committee, health funds, the Australian Health Insurance Association (AHIA), Health Insurance Restricted Membership Association of Australia (HIRMAA) and officers of the Department of Health and Family Services.
- Please direct any questions or concerns you may have about this Bulletin to Samantha Gavel, Policy and Project Officer on 02 9261 5855, or e-mail sgavel@phicc.org.au. Samantha welcomes suggestions for future issues of the Bulletin.
- If you would like to be included on our mailing list, please telephone Jillian O'Shea on the same number, or e-mail us at info@phicc.org.au.

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Complaints Line 1800 640 695

Matthew Blackmore
A/Ombudsman
November 1998

Background

Who we are

The Ombudsman provides consumers and other key stakeholders with an independent means of resolving their health insurance problems. The Ombudsman aims to provide a world class complaints and advice service that:

- Is accessible to the privately insured
- Is effective at resolving disputes
- Is driven by the needs of its customers
- Is independent of health funds, private & public hospitals and government
- Works co-operatively with interested parties to resolve problems
- Provides high quality information and advice to people with, or who are seeking to take out, private health insurance.

Contacting the Ombudsman
A national freecall Complaints Hotline (1800 640 695) is staffed between 8.30 am and 5.00 pm (Sydney time), Monday through Friday. The Ombudsman does not require complaints to be in writing before they are investigated. Complaints may also be lodged from our Internet site.

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

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

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

Further Information
Further printed information about the Ombudsman is available by telephoning Jillian O’shea on (02) 9261 5855. Available brochures include:

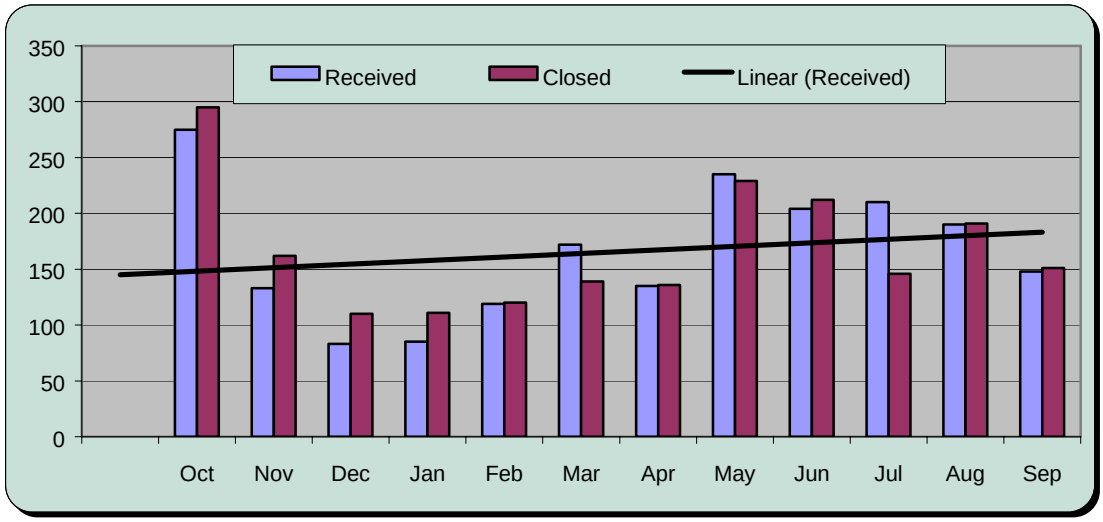
- The 10 Golden Rules of private health insurance
- Can we help with your health insurance complaint? (available in a variety of community languages)
- Service Charter
- Insure? Not Sure? Your quick guide to private health insurance
- Private Patients’ Hospital Charter
- When the Doctor’s bill makes you ill.

We also have an internet site. The address is http://www.phicc.org.au. Complaints may be lodged from our internet site.

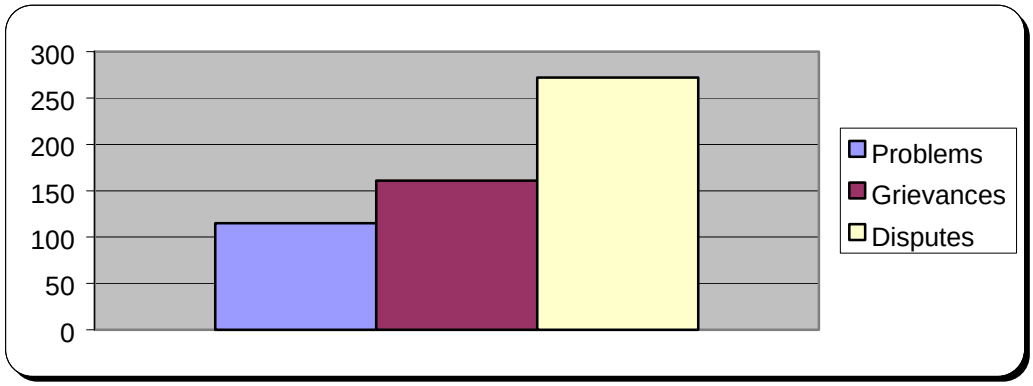
Complaints

Complaints received
There was a slight decrease in the number of complaints received in the September quarter compared with the previous quarter (548 complaints compared with 578 in the June quarter).

Figure 1: Complaints received and closed by month



How are complaints categorised?
The Ombudsman's upgraded Complaints Management and Reporting System enables complaints to be further broken down into *problems, grievances* and *disputes.* A *problem* is a complaint which is referred directly back to the fund, where the complainant has not sufficiently attempted to resolve the complaint with the service provider. A *grievance* is a complaint where advice provided by the Ombudsman's staff resolves the issue. A *dispute* is a complaint where the Ombudsman's staff contact the fund or the person being complained about concerning the complaint. During the September Quarter, 115 complaints were categorised as *problems*, 161 as *disputes* and as 272 as *grievances*.



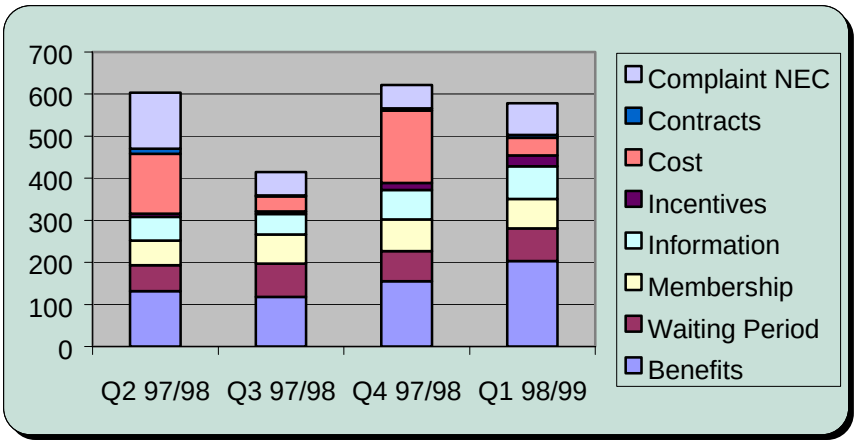
Who Complains?
During the September quarter, the overwhelming majority of complaints was again made by members of health funds. There were two complaints by doctors and none by hospitals during the quarter.

What issues are complained about?
The 548 complaints received were about 578 different issues.

The most complained about issue was benefits (203 issues or 35%), compared with the June quarter when cost was the most complained about issue (28% of issues).

Complaints about waiting periods were the second most complained about issue during the September quarter (78 issues, or 14%). This was followed by information (77 issues or 13%) and “other” issues (75 issues, or 12%); these issues included complaints about service issues, premium payment problems and private patient election in public hospitals.

Figure 2: Complaint issues



Who is complained about?
Complaints received by the Ombudsman can involve one or more of the following: a health fund, hospital, doctor or dentist. During the September quarter, as in previous quarters, the majority of complaints involved health funds, with almost half the complaints referred to the relevant fund for investigation.

How do people complain?
The majority of complaints in the September quarter were made by telephone (90%, which is similar to the June quarter).

Other complaint vehicles included letter (8%, compared with 9% in the previous quarter), fax (1% in the September quarter, which is the same as the previous quarter), and parliamentary representation (0.7%). There were no complaints by Ministerial letter in the September quarter, which is the same as the previous quarter.

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

What action is taken about complaints?

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

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

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

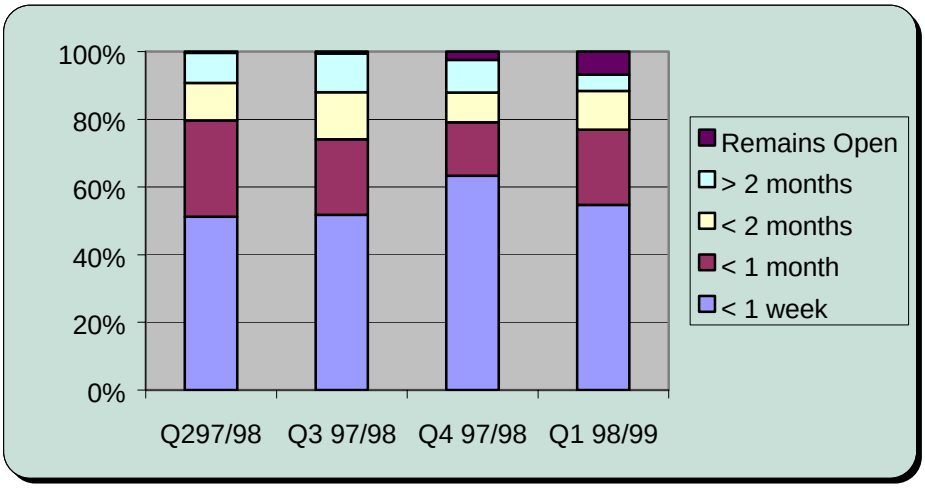
Figure 3: Object of complaint & type of action taken - 1998

	1997/98				
	July		*August*		*September*
Action by Ombudsman	*No.*	*%*	*No.*	*%*	*No.*
Complainant directed back to fund	48	15%	37	38%	24
Complainant dealt with in house	65	29%	48	50%	36
Complainant referred to fund	90	56%	91	13%	82
Total complaints about funds	**203**	100%	**176**	100%	**142**
Complainant directed back to hospital	3	20%	0	67%	0
Complainant dealt with in house	1	0%	1	33%	1
Complainant referred to hospital for comment	4	80%	4	0%	1
Total complaints about hospitals	**8**	100%	**5**	100%	**2**
Complainant directed back to doctor	2	22%	2	22%	1
Complainant dealt with in house	2	78%	7	56%	2
Complainant referred to doctor for comment	0	0%	1	22%	2
Total complaints about doctors/dentists	**4**	100%	**10**	100%	**5**

Time taken to resolve complaints

Around 50% of complaints received in the September quarter were resolved within a week, compared with 64% last quarter.

Figure 4: Time taken to resolve complaints

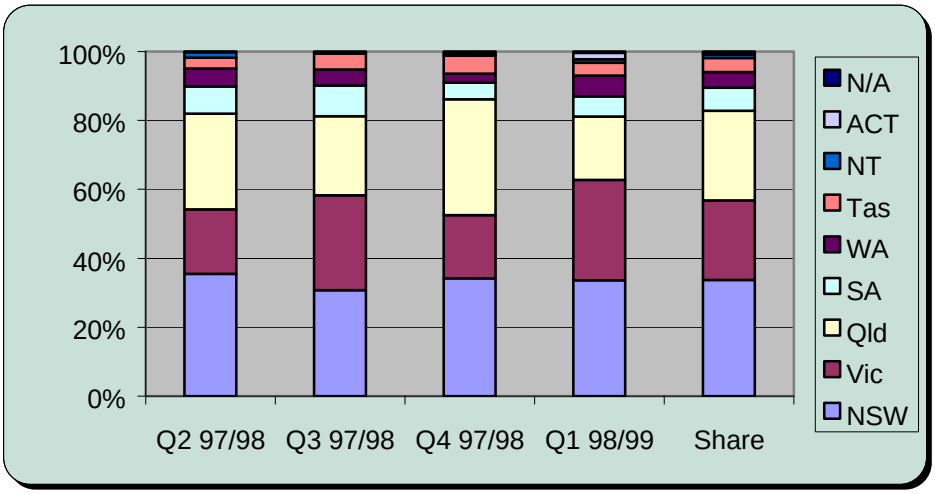


Where do complainants live?

During the September quarter, NSW recorded the most complaints (184), followed by Victoria (159) and Queensland (101). This compares with the193 complaints received from NSW and from Queensland during the last quarter.

Tasmania received 20 complaints, South Australia received 32, WA received 33, the ACT received 10 and the Northern Territory received 6.

Figure 5: Complaints by State

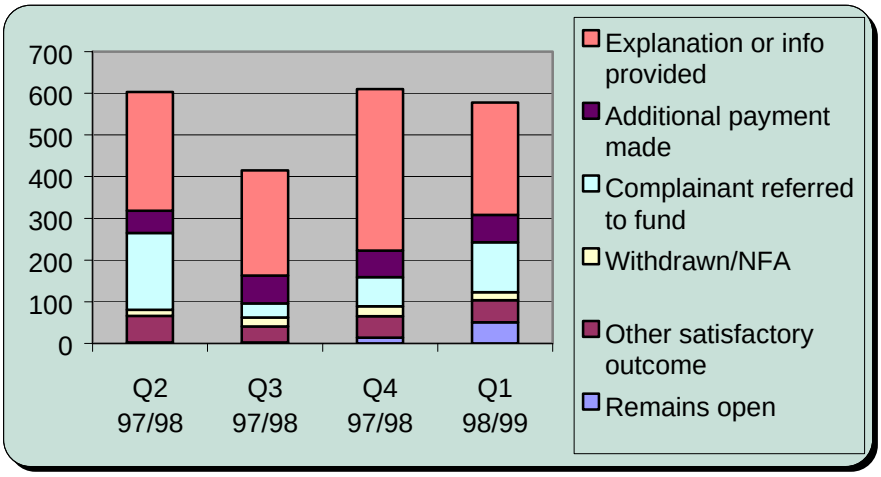


What were the outcomes?
Of the complaints closed, 21% were referred directly back to the object of complaint, because there had been no attempt to resolve the problem with the fund, hospital, doctor or dentist. This compares with 12% last quarter. The rest of the complaints that were closed were dealt with in the following way:

- providing complainants with additional information or an explanation of their problem, including confirmation of advice originally provided by a health fund (47% of complaint issues were dealt with this way in the December quarter, compared with 62% in the previous quarter);
- the fund providing an additional payment or the hospital, doctor or dentist writing off all or part of an account (11% of complaint issues);
- the fund reversing its previous decision eg. to deny continuity of membership, or where a hospital or medical account is written off (9% of complaint issues).

In a small number of cases the complaint was withdrawn by the complainant or closed by the Ombudsman where the complainant failed to provide additional information requested by the Ombudsman.

Figure 6: Outcomes for complaints received



Inquiries

The Ombudsman received 385 inquiries about issues in the September quarter, a significant increase on the 174 inquiries received in the June quarter. Some of this increase could be due to better reporting of inquiries during the September quarter.

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

The majority of inquiries in the September quarter came from Victoria (88), followed by NSW (80) and Queensland (50). Callers in 25% of cases did not identify the State/Territory of their residence.

Most inquiries were resolved by providing additional information or an explanation, including providing a brochure (76% of inquiries). 13% of inquiries were referred to another agency and 5% were referred to a health fund. The remaining 7% of inquiries required no action on the part of the Ombudsman or were withdrawn before the inquiry could be dealt with.

Case Studies

Oral Advice

Complaints about oral advice received from funds continue to be a significant cause of complaint, as the following case study shows.

A fund member had had a single membership with her fund for a number of years. When she became pregnant, she rang the funs for advice about upgrading her cover to a family membership in time for the baby's birth. Fund staff advised her to upgrade her membership two months before the baby was due, to ensure the baby was covered after birth. She asked what would happen if the baby came early and was told she would be covered if this happened.

Several months later, the member went into the local fund branch and was given a form for family membership to take home and fill in. Two days later, she went into labour and the baby was born ten weeks early.

The baby required hospitalisation and although the fund agreed to reduce the baby's waiting period to three months instead of twelve, it refused to cover the baby's first hospitalisation. The member contacted the fund's information line and asked, hypothetically, what she needed to do to ensure coverage for a newborn baby. She was given the same advice that she received earlier; that a family membership had to be taken out two months before the baby was due and if the baby came early, it would be covered.

She then contacted the Ombudsman, who contacted the fund on her behalf. The Ombudsman argued that the member should not be out of pocket because she had received incorrect oral advice on several occasions. The fund was convinced by the Ombudsman's view and agreed to cover the baby from birth.

Complaints about oral advice are usually very difficult to solve, as there is usually no way of confirming whose version of events is correct. However, in this case, the Ombudsman believed it was clear that incorrect advice had been given on a number of occasions and that the member should not be left out of pocket as a result.

Fund Contracts with Service Providers

The Ombudsman receives regular complaints from fund members about fund contracts with service providers. The following case study concerns a member's confusion about whether the service provider was accredited or not.

A fund member had a cataract operation in a private clinic. When he was admitted for the surgery, he was assured by clinic staff that his fund would cover him for the operation. However, when he submitted his claim to the fund, it denied benefits on the grounds that it did not have a contract with the clinic in question.

The Ombudsman contacted the clinic and was assured that it was a registered day procedure facility. The receptionist also advised that the eye clinic shared its premises with an accredited day surgery.

The Ombudsman then contacted the fund to ask why the member was being denied benefits. The fund investigated and found that the member had incorrectly advised fund staff that his operation had taken place in the eye clinic, which was not accredited with the fund. The operation had actually taken place in the day surgery, which shared the same premises and was accredited. The fund therefore reversed its earlier decision and agreed to pay benefits.

Refusal to pay benefits where compensation may be involved

This is a difficult area, which has recently been the subject of a discussion paper issued by the Ombudsman. The problem usually arises when a fund denies benefits because an injury may be compensable. However, as the following case study shows, not every fall is compensable.

An elderly fund member fell over in the street and was admitted to hospital as a result. The fund refused to pay any benefits on her hospital bill of around $1500 until she had had exhausted every opportunity to establish liability on the part of the local council and road authority.

The member was very upset about this, because she believed the fall was a simple accident and not the result of negligence on the part of anyone else.

The Ombudsman contacted the fund, who explained that the member's accident report stated that she had fallen on "broken concrete"; hence the question of third party liability. The fund then contacted the local council, who explained that the concrete "was not and never had been, broken" and offered to send photographs as proof of this assertion.

In the circumstances, the fund agreed to pay full benefits for the member's hospitalisation.