PRIVATE HEALTH INSURANCE
COMPLAINTS COMMISSIONER

Quarterly Bulletin Issue 5
1 July - 30 September 1997

Welcome to our first Quarterly Bulletin for 1997/98, providing a statistical summary of the Complaints Commissioner's operations between 1 July 1997 and 30 September 1997. Comparisons with previous quarters are also provided.

Highlights this quarter

- 524 *complaints* were received (a substantial increase of 60% on the 325 complaints received in the previous quarter)

- the largest complained about issue was cost (30%). This represents a large shift from the previous quarter, when only 6% of complaint issues were specifically about cost

- 57% percent of complaints were resolved within a week (up from around 46% in the previous quarter)

- 355 *inquiries* were made during the September quarter (up slightly from 349 in the June quarter)

- Overwhelmingly, it is health fund members that make inquiries and lodge complaints.

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 AHIA, 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. Samantha is happy to take on board any suggestions for future issues of the Bulletin.

- To be included on our mailing list, please telephone Kathryn Gilhooley on the same number, or e-mail us at info@phicc.org.au.

Matthew Blackmore
ACTING COMPLAINTS COMMISSIONER
20 November 1997

Background

The Complaints Commissioner provides consumers and other key stakeholders with an independent means of resolving their health insurance problems.

PHICC's key features include:

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

A national freecall Complaints Hotline (1800 640 695) is staffed between 8.30 am and 5.00 pm (Sydney time), Monday through Friday. The Commissioner does not require complaints to be in writing before they are investigated.

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

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

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

Further printed information about the Complaints Commissioner is available by telephoning Kathryn Gilhooley on (02) 9261 5855. Available brochures include:

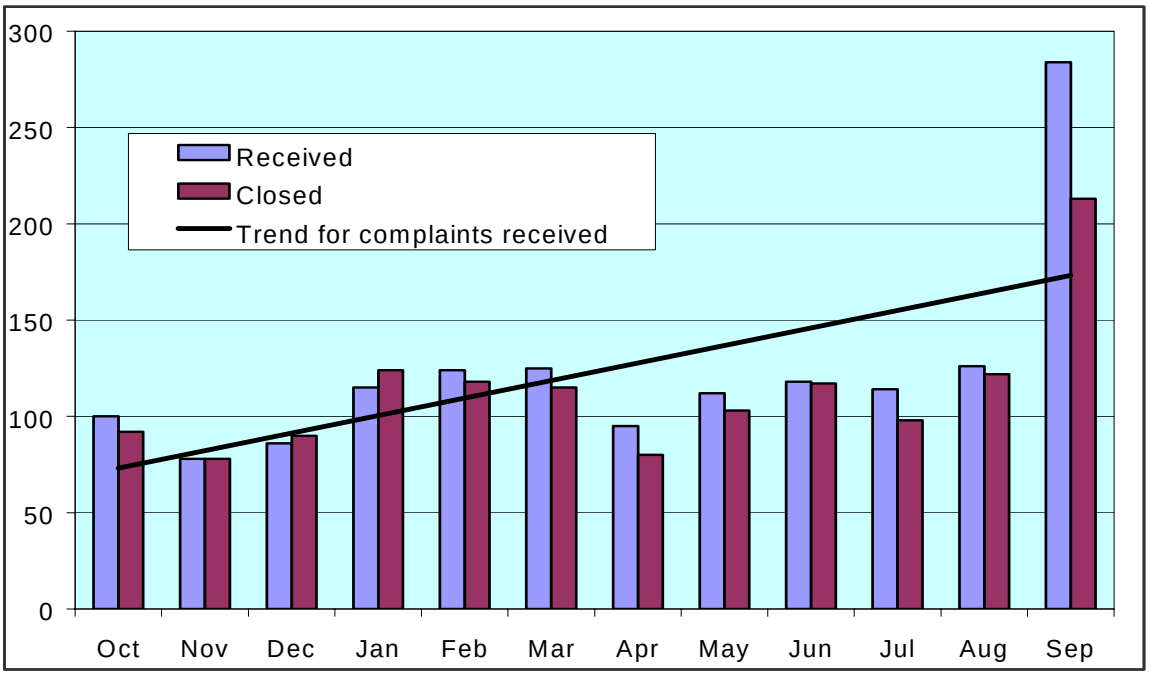
- The 10 Golden Rules of private health insurance
- Can we help with your health insurance complaint? (available in a variety of community languages)
- Service Charter
- Insure? Not Sure? Your quick guide to private health insurance
- Private Patients' Hospital Charter
- When the Doctor's bill makes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

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

Complaints

There was a significant increase in the number of complaints received in the September quarter compared with previous quarters (524 complaints compared with 325 and 359 in the two previous quarters). This increase was mainly due to a significant number of complaints being received from members of one fund following a price and product restructure.

Figure 1: Complaints received and closed by month



Who Complains?

There was only one complaint made by a hospital in the September quarter; the remaining complaints were made by members of health funds. No complaints were made by doctors in the September quarter, which is the same as in the previous quarter.

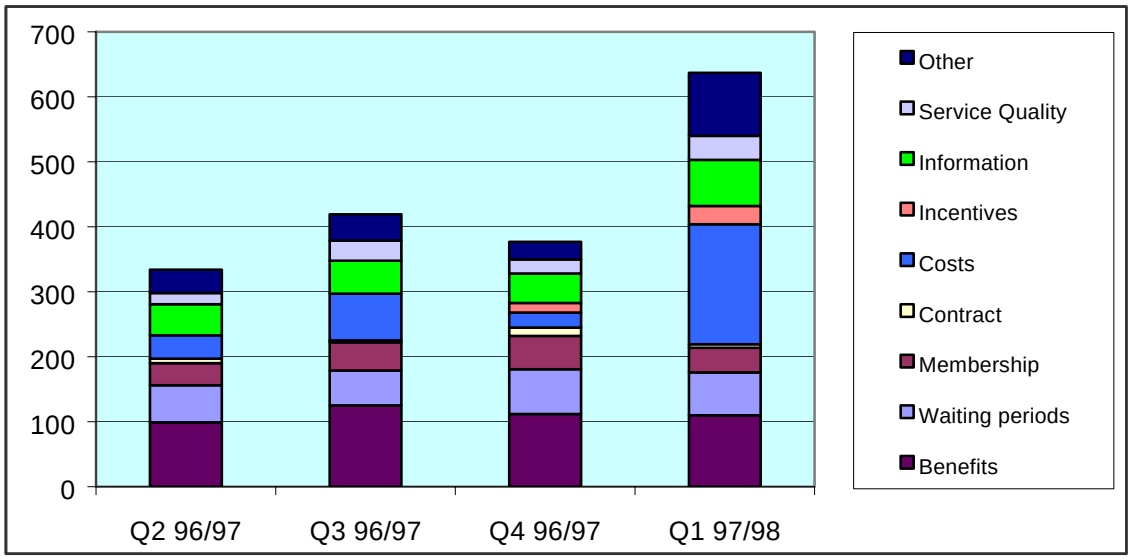
What issues are complained about?

The 524 complaints received were about 638 different issues.

The most complained about issue was cost (185 issues or 30%). In the previous quarter, only 23 complaints, or 6% of complaint issues, were specifically about cost. The rise in the number of cost related complaints in the September quarter followed premium increases by two large funds.

Complaints about benefits were the second most complained about issue during the September quarter (110 issues, or 17%). This was followed by waiting periods (66 issues, or 10%) - most of these complaints were specifically about the application of the pre-existing ailment rule (48 issues).

Figure 2: Complaint issues



Who is complained about?

Complaints received by the Complaints Commissioner can involve one or more of the following: a health fund, hospital, doctor or dentist. During the June 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 June quarter were made by telephone (92%, compared with 90% in the September quarter).

Other complaint vehicles included letter (6%, compared with 7% in the previous quarter), fax (1% in the June quarter, compared with 2% in the previous quarter), and personal visit (1%, up from 0.3% in the previous quarter). There were no complaints by Ministerial letter in the September quarter (down from 1% last quarter).

The Complaints Commissioner 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 Complaints Commissioner. These are recorded as complainant directed back to fund in Figure 3.

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

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

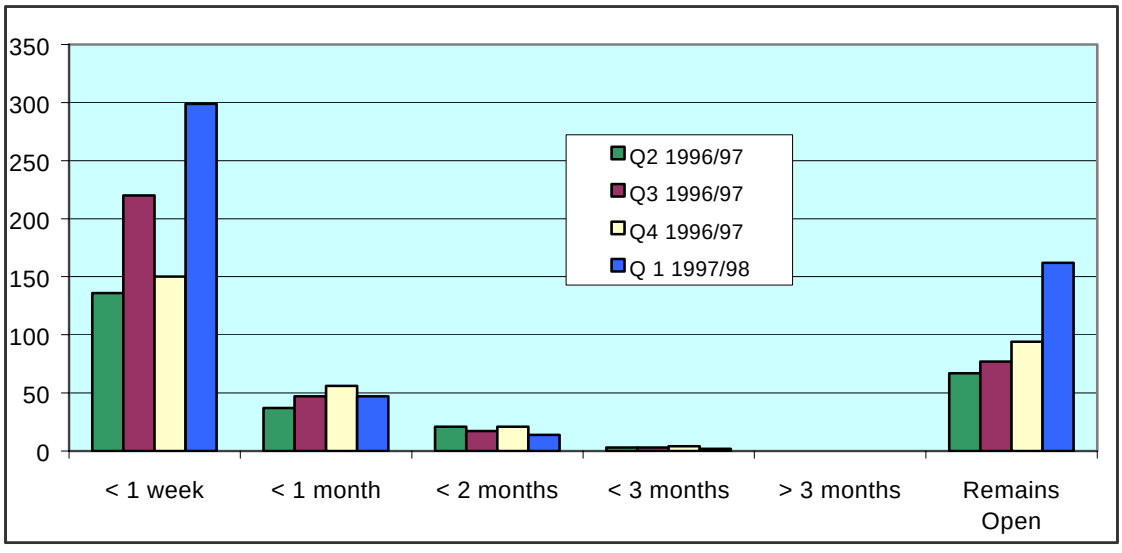
Figure 3: Object of complaint & type of action taken - July to Sep 1997

	1997/98		1997/98		
	1996/97	Sept Q	Jul	Aug	Sep
Action taken by Complaints Commissioner	%	%	No.	No.	No.
Complainant directed back to fund	19	16	26	16	39
Complainant dealt with in house	28	38	27	42	120
Complaint referred to fund	53	46	56	59	112
Total complaints about funds	*100*	*100*	*109*	*117*	*271*
Complainant directed back to hospital	13	23	2	1	2
Complainant dealt with in house	27	41	3	2	4
Complaint referred to hospital for comment	60	36	4	1	3
Total complaints about hospitals	*100*	*100*	*9*	*4*	*9*
Complainant directed back to doctor/dentist	27	38	1	2	2
Complainant dealt with in house	46	46	3	1	2
Complaint referred to doctor/dentist for comment	27	15	0	2	0
Total complaints about doctors/dentists	*100*	*100*	*4*	*5*	*4*

Time taken to resolve complaints

Around 57% of complaints received in the September quarter were resolved within a week, compared with 46% last quarter.

Figure 4: Time taken to resolve complaints

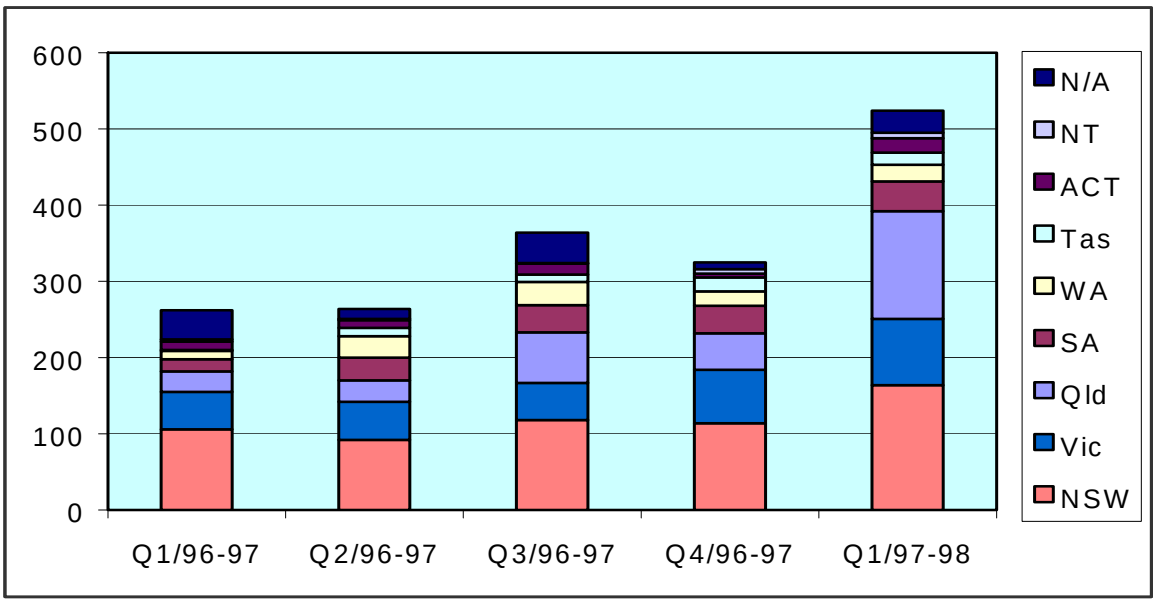


Where do complainants live?

During the September quarter, most complaints were received from NSW, followed by Queensland and Victoria. All States and Territories recorded the same or an increase in the number of complaints. In NSW, the number of complaints increased to 164, up from 95 in the June quarter. In Queensland, the number of complaints increased to 141, up from 43 in the June quarter. In Victoria, complaints rose to 87, up from 52 in the previous quarter.

In South Australia, there was a small rise to 39 (up from 33 last quarter); similarly in Western Australia, where the number of complaints rose slightly to 22 (up from 18 in the previous quarter). In Tasmania, the number of complaints remained steady at 16 (16 previously). The Northern Territory experienced an increase to 7 in the September quarter (up from 5). The ACT also experienced an increase to 19 (5 previously.

Figure 5: Complaints by State



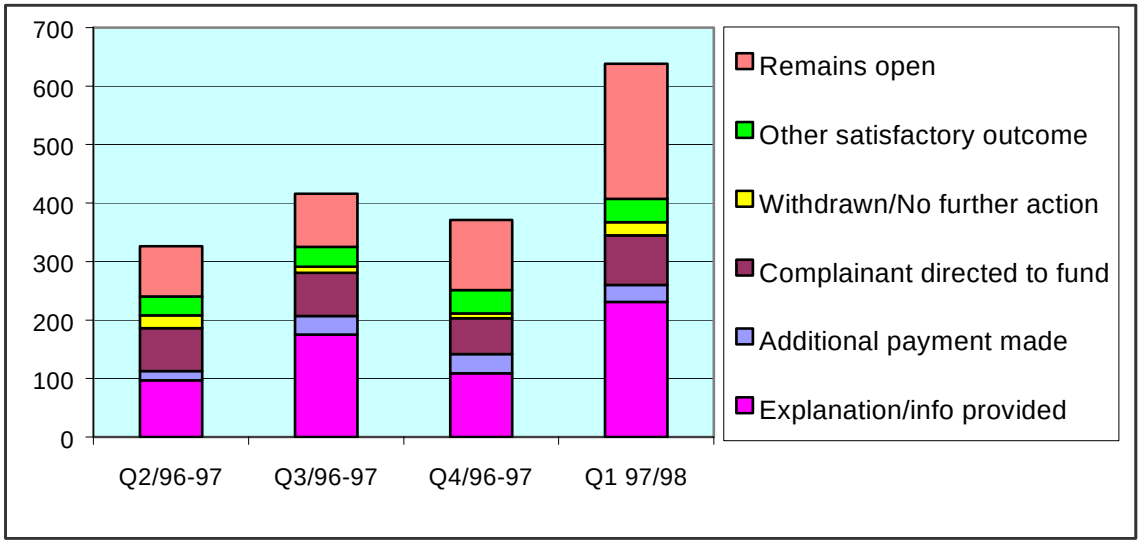
What were the outcomes?

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. 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 (57% of complaint issues were dealt with this way in the September quarter)
- the fund providing an additional payment or the hospital, doctor or dentist writing off all or part of an account (7% of complaint issues)
- the fund reversing its previous decision eg. to deny continuity of membership, or where a hospital or medical account is written off (10% of complaint issues).

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

Figure 6: Outcomes for complaints received



Inquiries

The Complaints Commissioner received 355 inquiries about 360 issues in the September quarter, a slight rise on the 349 inquiries received in the June quarter and 340 inquiries received in the March quarter.

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

The majority of inquiries came from NSW, followed by Queensland and Victoria. Callers in 50% 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 (72% of inquiries). 12.5% of inquiries were referred to another agency and 9% were referred to a health fund. The remaining 7% of inquiries required no action on the part of the Complaints Commissioner or were withdrawn before the inquiry could be dealt with.

Case Studies

Rate and benefit protection

A long-standing fund member rang to complain that his fund had lowered his level of cover and asked him to make extra premium payments, even though he had paid a full year's premium in advance two weeks earlier. When he rang the fund to complain, he was told that paying in advance did not guarantee rate or benefit protection during the period he had paid in advance. The member was not happy with this and contacted the Complaints Commissioner.

The Commissioner discussed the matter informally with the Australian Competition and Consumer Commission and wrote to the fund asking for its views. The fund replied that although it did not accept the notion that payments in advance represented a fixed contract between themselves and the fund, the fund decided that members who had paid in advance would be given the opportunity to maintain their previous level of cover until the time their next payment was due.

Benefits

A fund member damaged her spine in a skiing accident and was unable to walk. She was taken by ambulance to a nearby medical centre, then to the closest hospital. The fund refused to pay benefits to cover the ambulance journeys, on the ground that the member was only covered for “emergency” ambulance transport and that the ambulance transport to the nearest hospital was not “emergency” transport. The member contacted the Complaints Commissioner, because she believed her ambulance transport was an emergency.

The Commissioner contacted the ambulance service, which advised that the complainant had suffered an unstable spinal fracture and could not have been transported to hospital by normal means, because there was a risk of paralysis. In view of this advice, the Commissioner contacted the fund and requested that it re-examine the member’s claim. The fund requested that the member re-submit her claim and said it would be paid.

Portability

The National Health Act provides arrangements for members to transfer between funds without having to re-serve waiting periods. The Commissioner regularly receives complaints from members who have transferred from a level of cover with one fund to a similar level of cover with another fund, only to find that waiting periods are imposed. Ten complaints were received about this issue in the September quarter.

A long-standing health fund member contacted the Commissioner about problems she was experiencing after transferring funds. Before transferring, the member had “shopped around” and read through a number of brochures before making her choice. She relied on the advice given in her new fund’s brochure that no waiting periods would apply if she transferred to a comparable level of cover. Some months later, the member was admitted to hospital for a same day procedure. When she received her bill, the fund applied a $300 excess, even though their brochure stated that same day surgery did not attract the excess.

When the member disputed this with the fund, she was subsequently sent a letter advising that the pre-existing ailment rule had been applied. The member did not understand why the pre existing ailment rule had been applied as she was a transferee and not a new member, and had taken out a similar level of cover with the new fund. The member then contacted the Complaints Commissioner.

The Complaints Commissioner contacted the member’s new fund and queried the brochure statement that same day surgery does not attract an excess.

The fund advised that the member's previous fund would have applied the excess and therefore the member would have to pay the excess for any hospitalisation within the first 12 months of transferring. Staff of the Complaints Commissioner contacted the member's previous fund and were told that the fund did not apply an excess to same day surgery. On receipt of this information, the member's new fund agreed not to impose the excess.

Complaints received by issue								
	Total 1996/97				September Qtr 1997/98			
Issue	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***
Benefits								
Extent of cover			209	44.9%			54	48.6%
Amount			81	17.4%			21	18.9%
Delay			13	2.8%			2	1.8%
Excess			27	5.8%			8	7.2%
Limit reached			28	6.0%			4	3.6%
Gap payment			53	11.4%			8	7.2%
Out of State			4	0.9%			1	0.9%
Other			50	10.8%			13	11.7%
Subtotal Benefits	***465***	***32.3%***		*100.0%*	***111***	***17.4%***		*100.0%*
Information								
Oral			96	53.9%			41	57.7%
Printed			35	19.7%			13	18.3%
Radio/TV			12	6.7%			2	2.8%
Written			13	7.3%			4	5.6%
Lack of notification			22	12.4%			11	15.5%
Subtotal Information	***178***	***12.4%***		*100.0%*	***71***	***11.1%***		*100.0%*
Waiting Periods								
General			22	9.3%			5	7.6%
Obstetrics			38	16.1%			13	19.7%
Pre existing ailment			176	74.6%			48	72.7%
Subtotal Waiting Periods	***236***	***16.4%***		*100.0%*	***66***	***10.3%***		*100.0%*
Membership issues								
Who is the contributor?			29	17.9%			8	21.1%
Arrears			12	7.4%			2	5.3%
Cancellation/suspension			88	54.3%			18	47.4%
Transfer/continuity			33	20.4%			10	26.3%
Subtotal Membership	***162***	***11.3%***		*100.0%*	***38***	***6.0%***		*100.0%*
Costs								
Premiums			123	80.9%			176	95.1%
Fees and services			27	17.8%			8	4.3%
Dual charging			2	1.3%			1	0.5%
Subtotal Costs	***152***	***10.6%***		*100.0%*	***185***	***29.0%***		*100.0%*
Other specific issues								
Acute Care Certificates			4	1.6%			2	1.2%
Contracts			29	11.7%			5	3.0%
Confidentiality			4	1.6%			2	1.2%
Discrimination			9	3.6%			0	0.0%
Incentives			15	6.1%			28	16.8%
Language & culture			3	1.2%			0	0.0%
Quality of service			86	34.8%			37	22.2%
Private patient election			8	3.2%			1	0.6%
Premium payments			39	15.8%			22	13.2%
Other complaint NEC			26	10.5%			6	3.6%
Fund rule change NEC			24	9.7%			64	38.3%
Subtotal Other	***247***	***17.2%***		*100.0%*	***167***	***26.2%***		*100.0%*
TOTAL	1440	100%			638	100%		